

SAFER UK

**Preventing sexual maltreatment
of unaccompanied asylum seeking
minors and improving services for them**

M. Lay, I. Papadopoulos, A. Gebrehiwot

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Foreword

Unaccompanied asylum seeking minors are amongst the most vulnerable groups of children and young people in UK society. Uprooted from their own communities, many of which are torn apart by war and conflict, they move into an alien culture, with a different language, which is difficult to comprehend and navigate. Often these young people are isolated and lack the support and protection of their families. They may face racism and discrimination. This set of circumstances leaves young unaccompanied asylum seekers vulnerable. The risk of sexual abuse adds to their vulnerability and means that they can face a triple jeopardy. A significant challenge to our child welfare institutions is posed. How do they measure up to that challenge?

Safer UK – preventing sexual maltreatment of unaccompanied asylum seeking minors and improving services for them reports on a study conducted by the Research Centre for Transcultural Studies in Health at Middlesex University and the Ethiopian Community Centre in the UK. The research looked at the experiences of young Ethiopian, Somalian, and Eritrean unaccompanied asylum seekers. It explored the risks of child sexual maltreatment that they face and considered the effectiveness of preventive approaches and therapeutic and supportive interventions. In particular, it addressed issues of cultural competence. Fifty three young people were surveyed about their experiences of sexual maltreatment through questionnaires and interviews. Of those who responded to a question about the timing of their abuse, 39 reported that this had happened to them between 2000 and 2004 and eight that it had occurred in the 1990s. In addition, eight key professionals working or with an interest in this area were interviewed in order to obtain the views of service providers and policy makers.

It is a sad indictment on our society that this study found that many of the unaccompanied asylum seeking minors who had been sexually maltreated received less than satisfactory support. *Safer UK* explores why this was so.

The NSPCC is pleased to be associated with this important piece of research. We have a longstanding interest and involvement in responses to child sexual abuse. This goes back to the late 1970s and 1980s when we set up a specialist unit on child sexual abuse. Since then we have undertaken specialist investigations and assessments, provided therapeutic support to children and young people, and support to their families. We have also been involved in running preventive programmes and run public education campaigns aimed at both children and young people and also adults. We have carried out research and campaigned for law and social policy reforms. The NSPCC is currently establishing a national centre in north London that will provide a focus for a range of services and support to professionals working in the difficult and demanding area of child sexual abuse. We are keen to work in partnership with other organisations in this demanding area.

Today there is a much greater awareness of child sexual abuse among professionals and the general public than twenty years ago when cases from Cleveland hit the newspaper headlines and when ChildLine was set up to listen and advise children and young people. However, as the *Safer UK* study shows, many children and young people who are sexually abused and assaulted are reluctant to tell anyone. The NSPCC's study of the prevalence of child maltreatment found that 75 per cent of sexually abused children told no one at the time of the abuse. While the number of children placed on child protection registers represents a tip of an iceberg, it is at least a puzzle if not a major cause for concern that in recent years there has been a decline in the number of registrations for sexual abuse. We are also concerned that there is a significant shortage of treatment services for sexually abused children. Has child sexual maltreatment slipped off the agenda?

Responding to child sexual maltreatment is complex and challenging to professionals and policy makers but how much more so when the children and young people come from cultures very different from the dominant UK culture, as is the case with the young Ethiopian, Somalian, and Eritrean unaccompanied asylum seekers whose experiences are explored in this study. Given the lack of research that has been conducted in this area, *Safer UK – preventing sexual maltreatment of unaccompanied asylum seeking minors* provides useful insights for professional practice and policy development. It rightly encourages us to question our practice

and to challenge assumptions, particularly those grounded in an ethnocentric perspective.

The NSPCC's *Respect to Protect* programme (R2P), launched in 2003, is a modest attempt to meet the needs of children in black and minority ethnic communities. The aim of the programme is to develop and improve the safeguarding capacity of black and minority ethnic groups that provide services or advocate on behalf of children and young people. R2P is not seeking to impose solutions on BME community groups, but rather to support and improve their capacity to safeguard and protect children. R2P has worked with a number of groups in different communities and we are keen to share that experience and learning.

Safer UK makes a series of recommendations for improving professional practice and for preventing the sexual maltreatment of unaccompanied asylum seeking children and young people. Many of these proposals do not have significant resource implications but instead require improvements in practice and more joined up thinking between agencies. As the authors of this report point out, the experiences of the young people in this study took place before the recent raft of measures included in the *Every Child Matters* agenda were introduced and it is too soon to say what impact they will have had on unaccompanied asylum seeking children and young people. It is to be hoped that government, the Commissioners for Children, and local safeguarding children boards will keep their needs under the spotlight and that we shall see progress. If we are to safeguard and protect our children, an essential measure must be how we treat the most vulnerable. On anyone's reckoning, unaccompanied asylum seeking children are among the most vulnerable in our society and they deserve better. I urge practitioners and policy makers to take up the challenges outlined in this report. If we can succeed for this group of children we will succeed for all our children.

Christopher Cloke

Head of Child Protection Awareness and Diversity

NSPCC

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Contents

Publication Information	ii
Foreword	iii
Acknowledgements	vi
Contents	1
Chapter 1	1
Introduction and background	1
Background to the study	1
<u>Study Aims</u>	1
<u>Management of the project</u>	1
<u>Dissemination and information about the study</u>	2
Introduction	2
The vulnerabilities of UASM	3
Definitions of 'child', 'child sexual abuse' and 'sexual assault'	4
<u>Definitions of 'child'</u>	4
<u>Definitions of 'child sexual abuse'</u>	5
<u>Definitions of sexual assault</u>	6
<u>Terms used in the literature</u>	6
<u>The 'sexual maltreatment of minors': a working definition</u>	6
The study population	7
UASM and where they come from	8
<u>Asylum application procedures</u>	8
Legislation relating to unaccompanied asylum seeking children	9
International legislation	10
British legislation	11
<u>Immigration legislation</u>	11
<u>The Children Act 1989</u>	11
<u>The Sexual Offences Act 2003</u>	12
The ethno-history of the lay participants' countries of origin	13
Ethiopia	14
<i>The position of females in Ethiopia</i>	14
Eritrea	14
<i>The position of females in Eritrea</i>	15
Somalia	15
<i>The position of females in Somalia</i>	16
<u>Child refugees from areas of conflict</u>	16
Cultural norms	17
<u>Virgin brides</u>	17
<u>Marriage by abduction</u>	17
<u>Female circumcision</u>	18
Discussion	19
Structure of the report	20
Chapter 2	23
Methodology	23
Introduction	23
Theoretical approaches	23

<u>A constructivist approach</u>	23
<u>Culturally competent research</u>	24
<u>Transformative knowledge</u>	26
Methods	26
<u>Literature review</u>	26
<u>Ethical considerations</u>	27
<u>Considerations relating to sensitive topics</u>	27
Recruitment and training of interviewers	28
<u>Training</u>	28
<u>Sampling</u>	29
<u>Eligibility criteria</u>	29
<u>Exclusion criteria</u>	30
<u>Recruitment of eligible young people from the Horn of Africa</u>	30
<u>Information sought</u>	31
Key professionals	33
<u>Information sought from key professionals</u>	33
<u>Sampling key professionals</u>	33
<u>Data collection</u>	34
<u>Data analysis</u>	34
<u>Verification of findings</u>	35
Characteristics of the lay participants.....	35
<u>Sample size</u>	35
Socio-demographic characteristics.....	35
<u>Gender</u>	36
<u>Age</u>	36
<u>Ethnicity and religion</u>	36
<u>Age on arrival in the UK</u>	37
<u>Female genital mutilation</u>	38
Chapter 3.....	39
The 'anatomy' of the sexual maltreatment of minors.....	39
Introduction.....	39
The literature on sexual abuse and sexual assault.....	39
<u>Prevalence of Child Sexual Abuse</u>	39
Effects of sexual maltreatment	40
<u>Ethnocentricity in sexual maltreatment research</u>	41
FINDINGS: The incidents of sexual maltreatment.....	43
The nature of the incidents.....	43
<u>What happened</u>	43
<u>Where the incidences occurred</u>	43
<u>Frequency of the incidents</u>	44
<u>When the incidents occurred</u>	44
The literature on perpetrators of sexual maltreatment.....	46
Findings relating to perpetrators.....	47
<u>Number of perpetrators at each event</u>	47
Gender, age and ethnicity of perpetrators	48
Perpetrators' modus operandi.....	50
Perpetrator's behavioural profiles.....	51
<u>Paedophiles</u>	51
<u>Young male sexual 'predators'</u>	51
<u>The 'rescuer' or 'father figure' perpetrator</u>	52

<u>Case vignette</u>	52
<u>Use of collaborators to set up a victim</u>	53
Effects of sexual maltreatment.....	54
<u>Psychological effects</u>	54
<u>Physical health effects</u>	57
Professional help-seeking.....	58
Circumstances and support at the time of the incidents.....	59
<u>Support from social services</u>	59
<u>Support from community organisations</u>	59
<u>Contact with trusted adults</u>	59
Conclusions.....	60
Chapter 4.....	61
Attribution: theories and beliefs about causation.....	61
Introduction.....	61
Attributional theories.....	61
<u>The medico-legal model</u>	61
<u>Social and multi-factorial models</u>	62
<i>Feminist perspectives</i>	63
<u>Finkelhor's four preconditions model</u>	65
Common theories and beliefs about attribution.....	66
Beliefs about causation and their impact on effects.....	67
Lay participants' perceptions of their vulnerability.....	67
<u>Personal and cultural factors</u>	68
<u>Circumstantial factors</u>	69
<u>Factors related to the perpetrator</u>	71
<u>Factors relating to professional attitudes and beliefs</u>	72
Professionals' perceptions of vulnerability.....	73
<u>Psychological and behavioural factors</u>	74
<u>Socio-economic factors</u>	74
<u>Politico-legal factors</u>	75
<u>Professional beliefs</u>	76
Discussion.....	76
Conclusions.....	77
Chapter 5.....	79
The impact of fear on disclosure, health and integration.....	79
Introduction.....	79
Fear as protection from sexual maltreatment.....	79
Fear as a factor increasing vulnerability.....	80
Impact of fear on disclosure.....	81
<u>The literature</u>	81
Findings: lay participants.....	83
<u>Disclosure to friends</u>	83
<u>Factors associated with disclosure</u>	83
Reasons for non-disclosure.....	84
<u>Telling will not change anything</u>	85
<u>Telling is taboo</u>	85
<u>Nobody to tell</u>	86
<u>Lack of trust in authorities</u>	86
<u>Ethnic loyalty</u>	88
<u>Fear regarding victim status</u>	89

<u>Fear of being blamed and disbelieved</u>	89
<u>Fear of the consequences</u>	89
Impact of fear on the survivors' mental health	90
Impact of fear on social well-being and integration.....	91
Conclusions.....	92
Chapter 6	93
Prevention of sexual maltreatment.....	93
Introduction.....	93
Prevention: theory and practice.....	93
Approaches to prevention.....	94
<u>Finkelhor's Four Preconditions Model as a framework for prevention</u>	94
<u>Internal barriers of the perpetrators</u>	95
<u>Empowering children</u>	96
<u>Institutional approaches to preventing the abuse of power</u>	98
<u>Multi-faceted approaches</u>	99
Self protection strategies: findings.....	100
<u>Prior education about sexual abuse</u>	100
Primary prevention strategies.....	102
Secondary prevention strategies	103
<u>Avoiding the perpetrator</u>	103
<u>Strengthening personal resources</u>	104
<u>Political activism</u>	104
<u>Other preventive strategies</u>	105
Preventive interventions by professionals	105
Protection of minors	105
<u>Appropriate accommodation</u>	105
<u>Authorities to act and act more promptly</u>	106
Introduce to community organisations	107
<u>Education as prevention</u>	108
<u>Educating perpetrators</u>	109
<u>Greater openness about sexual maltreatment</u>	110
<u>Take action against the offenders</u>	110
Professionals' views on prevention	111
<u>Sentencing perpetrators</u>	111
<u>Retaining and sharing professional expertise</u>	111
<u>Training staff</u>	112
<u>Educating asylum seeking children about sexual maltreatment</u>	112
<u>Modifying the general education of UASM</u>	113
<u>Accessible services</u>	113
<u>Information provision</u>	114
Conclusions.....	115
Chapter 7	117
Perceptions and contradictions	117
Social denial and stigmatisation	117
Challenging assumptions	118
Professionals' definitions of child sexual abuse.....	119
Impact of media campaigns.....	121
Conclusions.....	122
Chapter 8	123
Professional practice.....	123

Introduction.....	123
Issues relating to the use of services by UASM	123
<u>Poor understanding or professionals' roles</u>	123
Racism and discrimination	125
<u>Cultural imposition</u>	125
Distrust.....	126
<u>Responsive interventions</u>	127
Institutional responses to sexual maltreatment of UASM	127
<u>Considerations for social services</u>	127
<u>Considerations for the medical professions</u>	128
Considerations for mental health professionals.....	128
Encouraging disclosure	130
<u>Direct questioning</u>	131
Conclusions.....	131
Chapter 9	133
Conclusions and recommendations	133
Conclusions.....	133
Recommendations for the prevention of sexual maltreatment	134
A model for child protection.....	135
Recommendations related to improving all relevant services.....	137
References	139

Tables:

Table 3.1: Frequency of occurrence of sexual maltreatment in the UK.....	44
Table 3.2: Approximate age group of perpetrators.....	48
Table 3.3: Relationship between the victim and the perpetrator	49
Table 3.4: Psychological effects of sexual maltreatment as a minor.....	54
Table 4.1: Personal factors perceived as contributing to vulnerability.....	69
Table 6.1: Sources of warning or education about sexual abuse.....	101

Figures:

Figure 2.1: Age on arrival in the UK.....	37
Figure 2.2: How long lived in the UK.....	38
Figure 3.1 Age at first sexual maltreatment in the UK.....	45
Figure 3.2: Duration between arrival and sexual maltreatment.....	46
Figure 6.1: Quality of sex education.....	101
Figure 9.1: The SAFER UK model for child protection.....	137

Boxes:

Box 4.1: Factors believed by professional participants to contribute to vulnerability of UASM to sexual maltreatment:	73
Box 6.1: Aims of cultural competence training	112

Appendices:

Appendix 1: Lay participants' self-completion questionnaire.....	149
Appendix 2: Lay participants' interview schedule.....	155
APPENDIX 3 : Professional participants' self-completion questionnaire.....	159
APPENDIX 4: Professional participants' interview schedule.....	161
APPENDIX 5: Dissemination activities.....	163

Chapter 1

Introduction and background

Background to the study

The SAFER UK study on which this report is based is the second collaborative research study undertaken by the authors relating to refugees from the Horn of Africa. The first study entitled EMBRACE UK (Papadopoulos and Gebrehiwot 2002) explored the health and social care needs, and settlement experiences of predominantly adult Ethiopian refugees in the United Kingdom (UK). It was during this study that the authors identified that young people from Ethiopia who arrive in the UK without a parent or responsible adult guardian, known as unaccompanied asylum seeking minors (UASM), may be at high risk of sexual maltreatment. This suspicion was supported by anecdotal evidence derived from the work of the Ethiopian Community Centre in the UK (ECCUK). Funding was sought to research this issue from the Big Lottery who awarded a grant to the ECCUK in 2004. The study, entitled 'SAFER UK', was undertaken in collaboration with the Research Centre for Transcultural Studies in Health at Middlesex University. Data collection started in December 2004 and was completed in November 2005.

Study Aims

The study aimed to explore the multifaceted risks of sexual maltreatment to Ethiopian UASM in England, to identify how it could be prevented and to ascertain how professional practice could be improved in relation to both prevention and therapeutic or supportive intervention, and in particular to cultural competence. The study group was expanded to include Somalis and Eritreans (also Horn of African countries) following difficulty recruiting young Ethiopians who fitted the selection criteria, a decision made by the study's Advisory Group.

Management of the project

The study was directed by two senior personnel from the ECCUK and Middlesex University and was overseen and guided by an Advisory Group. The group consisted of the above Directors, the main researcher, and relevant representatives

from the police service, social services, the National Society for the Prevention of Cruelty to Children (NSPCC), an academic / health care worker and lay representatives from the study group.

Dissemination and information about the study

A project Web page was developed within the Website of the Research Centre for Transcultural Studies in Health. This gave an overview of the project, provided progress bulletins and enabled participants to download questionnaires if they preferred to participate this way rather than by being interviewed. Appendix 5 details other dissemination activities undertaken during the course of the study.

Introduction

Concerns about the safety of unaccompanied asylum seeking minors (UASM) have been voiced by numerous children's charities, such as Barnardo's who expressed the view that the basic safety and fundamental needs of more than 5000 UASM in the UK are still not being met (Shepherd 2000). Human Rights Watch (2006) reports that refugee children are amongst the most vulnerable children in the world in terms of human rights violations in their countries of asylum. Whilst they acknowledge that many are well cared for by their foster families, others may be neglected and physically or sexually abused. They recommended that the care and delivery of assistance to these children must be carefully monitored.

A study by the Refugee Council and British Agencies for Adoption and Fostering (2001) found that there was no reliable system for recording the data required and that data about 16 and 17 year old UASM was often not collected separately from that of adults. However, recently the National Register for Unaccompanied Children was set up, operated by the London Asylum Seekers Consortium (LASC), a body that was established in 1999. LASC collates and distributes data on asylum seekers who are supported by the local authorities in London. The aims of the register include facilitating the efficient transfer of accurate information to statutory agencies to ensure safe and appropriate housing placements of UASM by ending 'age disputes' between asylum applicants and statutory agencies, and to facilitate more

co-ordinated provision of services to UASM thus reducing their vulnerability <http://www.nruc.gov.uk/objectives.html>. The consortium's other primary role is to commission accommodation and support services for various asylum-seeking groups. It is therefore in a position to make a significant contribution to the welfare of asylum seekers including children and young people. It has developed a strategy for the integration of refugees in London attending to the areas of education, training and employment, health, welfare, community cohesion and accommodation (LASC 2006).

The vulnerabilities of UASM

Previous research on the experiences of Ethiopian refugees and asylum seekers in the UK (Papadopoulos and Gebrehiwot 2002) indicated that being an asylum seeker creates a unique set of psychological and social challenges, particularly for children and young people. These challenges include living without the protection of their families, and initially at least, without a social network which makes them more isolated and vulnerable to exploitation and abuse. They are also in an alien culture that they do not understand and they often cannot speak the language. Those from African nations who are black may be more obvious as refugees and this makes them more vulnerable to exploitation, racism and discrimination. They may arrive in the UK suffering from the emotional and physical effects of war and conflict in their homelands, and in most cases they will be unaware of the support systems available to them; their case therefore deserves special attention.

A report for Barnardo's (Shepherd 2000) on the needs of UASM found that the majority of local authorities they surveyed had no specific policies to work with these children. Many had not included them in their management action plans under the *Quality Protects* initiative. The UNHCR (2003) reported that the protection of 'separated refugee children' in the UK is not always adequately integrated into national legislation or into local practices. The vulnerability of UASM to sexual maltreatment in the UK is likely to have been worsened by attitudinal, structural and procedural weaknesses within our institutions.

It is important to acknowledge that recently there has been considerable effort spent on improving the protection of children in the UK, particularly since Lord Laming's (2003) report on the inquiry into the horrific abuse and death of Victoria Climbié. *Every Child Matters* (2003) started as a Green Paper devised in response to this. It is now a ten year programme of reform for children's services that aim to ensure each child achieves the right to: be healthy; stay safe; enjoy and achieve; make a positive contribution; and achieve economic well-being. *Every Child Matters* seeks to encourage and support the more closely integrated frontline delivery of children's services and closer working between professionals; early intervention and greater emphasis on prevention of problems; more coherent planning and commissioning of services and the establishment of Children's Trusts (or similar) to support this; and greater involvement of children and their parents and carers in service development. The National Service Framework for Children Young People and Maternity Services (DoH and DfES 2004) is another significant recent initiative; however the experiences of sexual maltreatment of the young people who contributed to the SAFER UK study largely predate these developments.

The Save the Children's (2003) policy on protecting children from sexual abuse and exploitation highlighted the need for more knowledge on the economic, political, cultural and social factors that underlie child sexual abuse and exploitation. They also stated that children's as well as adults' views regarding this are needed. We hope that this report goes some way to contributing to this knowledge base.

Definitions of 'child', 'child sexual abuse' and 'sexual assault'

Definitions of 'child'

The Convention on the Rights of the Child (CRC 1990) defines a child as anyone under the age of eighteen years '*unless under the law applicable to the child, majority is attained earlier*' (Art. 1). The CRC equates child with 'minor' whereas the dictionary defines 'child', as a person who is not yet sexually mature (pre-pubescent). The United Nations High Commissioner for Refugees policy on refugee children (UNHCR 2003) uses the CRC definition. The British legal system takes account of differences in sexual and emotional maturity between children who are

pre-pubescent and those who are sexually mature. The age of sexual consent in England is 16 years for heterosexuals and homosexuals except in cases of position of trust (e.g teacher/pupil) when it is 18 years.

Definitions of 'child sexual abuse'

There is no consensus on the definition of child sexual abuse (CSA) and they tend to vary in depth of description. For example, the World Health Organisation's (WHO 1999) definition does not focus so much on the nature of the sexual activity but more on the cognitive and relational aspects of it. They define it as:

'...the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or that violate the laws or social taboos of society. Child sexual abuse is evidenced by this activity between a child and an adult, or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the perpetrator. This may include but is not limited to:

- *The inducement or coercion of a child to engage in any unlawful sexual activity.*
- *The exploitative use of a child in prostitution or other unlawful sexual practices.*
- *The exploitative use of children in pornographic performances and materials.'* <http://www.yesican.org/definitions/WHO.html>

Another definition gives more detail of the types of sexual activity that may occur:

'...sexual abuse involves forcing or enticing a child or young person to take part in sexual activities including prostitution, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative (e.g. rape, buggery or oral sex) or non-penetrative acts. They may include non-contact activities, such as involving children in looking at, or in the production of, pornographic material or watching sexual activities, or encouraging children to behave in sexually inappropriate ways'

<http://www.teachernet.gov.uk/wholeschool/familyandcommunity/childprotection/usefulinformation/definitionsabuse/>

Definitions of sexual assault

There is little in the literature that clearly distinguishes 'sexual assault' from 'sexual abuse'. However, 'assault' implies the use of physical force whereas 'abuse' does not. In sexual abuse compliance with a sexual act is gained through the *abuse* of the perpetrator's greater position of power be it physical, psychological or social. When compliance is obtained physical force is not needed. Sexual assault on the other hand can occur without the abuse of power other than physical force or the threat of force, such as in the act of rape.

Terms used in the literature

A review of 'Medline' and 'PsychINFO' databases for 1986 to 2006 revealed a plethora of articles about 'child sexual abuse' (n=4301), many fewer on 'child sexual assault' (n=93), fewer still on 'child sexual maltreatment' (n= 7) and none on the 'sexual maltreatment of minors'. Sometimes these terms are used interchangeably but that there is a need for clarity. The latter may receive more attention in future since the implementation of the Sexual Offences Act 2003. This Act recognises that young people aged 16 and 17 who although able to give their consent to sexual activity are vulnerable to sexual maltreatment perpetrated by people in a *position of trust*.

The higher level of interest in CSA (as indicated by the above figures) may reflect the high moral imperative to understand adults' abuse of power over children and young people.

The 'sexual maltreatment of minors': a working definition

We have adopted the term '*sexual maltreatment of minors*' for this study and have given it a working definition of: any sexual offence against a minor (someone aged under 18) perpetrated by adults, adolescents or peers without their consent, or when aged under 13 years irrespective of consent. This we take to include rape, sexual assault involving actual physical contact, acts of a sexual nature not involving sexual contact (e.g. voyeurism and flashing) and verbal or other taunts of a sexual nature

intended to be intimidating to the victim, sub-categorised in this study as 'harassment'. Activities we describe under the term '*sexual maltreatment of minors*' are covered by the Sexual Offences Act (2003).

The study population

The Home Office Immigration and Nationality Directorate (2006) defines an unaccompanied asylum seeking child as,

'A person who, at the time of making the asylum application is, or (if there is no proof) appears to be, under eighteen; is applying for asylum in his or her own right; and has no adult relative or guardian to turn to in this country'
<http://www.ind.homeoffice.gov.uk/applying/asylumapplications/10902>

This makes it a more narrowly defined term than 'separated child'. For example, the *Separated Children in Europe Programme* uses this term and defines it as:

'...children under 18 years of age who are outside their country of origin and separated from both parents, or their previous legal/customary primary caregiver. Some children are totally alone while others may be living with extended family members' (Save the Children 2004).

We use the term 'unaccompanied asylum seeking minor' (UASM) in this report as it is more commonly used by public services in the UK and because arriving in the UK unaccompanied by a responsible adult or guardian was a selection criteria.

Fifty three (N=53) young people took part in this study. Of the forty-seven (n=47) lay participants who gave information on their age at the time of their experiences of sexual maltreatment (or 'near misses') the majority (n=39) were describing events that happened between 2000 and 2004 and eight (n=8) were describing events that occurred during the 1990s.

UASM and where they come from

A report (Metropolitan Police 2004) was produced following *Operation Paladin Child*, a project that explored the number and circumstances of unaccompanied minors entering via Heathrow airport from non-European Union countries during three months between August and November 2003. The Metropolitan Police in collaboration with the immigration services, social services and the NSPCC led the project. They identified 1,904 unaccompanied minors of whom only 166 (8.7%) of them had claimed asylum on arrival at the airport. These mainly came from South Asia (n=84) and sub-Saharan Africa (n=54); the majority of the latter came from the Horn of Africa (n=29): Eritrea (n=12), Somalia (n=10) and Ethiopia (n=7) (ibid: 58). However, most UASM since 1997 are reported to have originated in Kosovo, Afghanistan, Sri-Lanka, Somalia, Iraq and Turkey (<http://www.qca.org.uk/9983.html>). Some UASM arrive through British seaports and other airports having travelled via Europe and therefore were not included in Operation Paladin Child.

Asylum application procedures

There are three Asylum Screening Units in England located in Croydon, Liverpool and Leeds. All children who arrive as UASM aged over five are taken to one of these centres. Since 2002 all new asylum seekers aged over 5 have been issued with an Application Registration Card containing their photograph and fingerprints, their name, date of birth, nationality, the place and date of issue, information regarding dependants, the languages spoken, whether the holder is entitled to work, and a secure updateable chip for additional information about the holder, such as their address.

At the time of this study each separated child coming to the attention of the authorities and seeking asylum was referred within 24 hours of the claim being lodged to the Refugee Council Panel of Advisers for Unaccompanied Children (a Home Office funded body administered by the Refugee Council, initiated in 1994). The Children's panel consists of three teams of Panel Advisers - a drop-in team who work in London assisting separated children who are newly arrived, or in crisis. The other two teams undertake more intensive casework both within London and outside of the southeast.

<http://www.refugeecouncil.org.uk/howwehelp/directly/children/team.htm>. The adviser's role historically has been to provide independent guidance and support to ensure that the child is aware of their rights and the services to which they were entitled during the asylum process. Although they did not themselves offer legal advice they referred them on to legal representation. They also supported the child in relation to any aspect of their situation, including welfare issues. According to a study commissioned by Save the Children and the Refugee Council (Ayotte and Williamson 2001) the service was reported to be under severe pressure because of increased demands and inadequate funding.

Ayotte and Williamson's study (2001) found that although the treatment of UASM (termed 'separated children' by them) in the UK was good in comparison to many other countries, some problems and weaknesses still remained, these were: high levels of racism; detention of young people whose ages are disputed by immigration or local authorities; and uncertainties related to their limited immigration status. They found that few unaccompanied minors applying for asylum were awarded refugee status and they tended to be given temporary leave to remain (Exceptional Leave to Remain) until they were 18 years of age.

Legislation relating to unaccompanied asylum seeking children

UASM in Britain are protected by legislation drawn up by international bodies, such as the United Nations as well as by the British legislative system. Here we provide an outline of some of the main pieces of legislation and policies appertaining to our study participants as they existed around the time the majority experienced sexual maltreatment as UASM i.e. prior to 2004.

International legislation

The most significant piece of international child protection legislation is the *United Nations Convention on the Rights of the Child* (CRC 1990). Article 34 of the CRC states that,

'States Parties undertake to protect the child from all forms of sexual exploitation and sexual abuse. For these purposes, States Parties shall in particular take all appropriate national, bilateral and multilateral measures to prevent:

(a) The inducement or coercion of a child to engage in any unlawful sexual activity;

(b) The exploitative use of children in prostitution or other unlawful sexual practices;

(c) The exploitative use of children in pornographic performances and materials' <http://www.unhchr.ch/html/menu3/b/k2crc.htm>.

Article 39 decrees that,

'States Parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of: any form of neglect, exploitation, or abuse; torture or any other form of cruel, inhuman or degrading treatment or punishment; or armed conflicts. Such recovery and reintegration shall take place in an environment which fosters the health, self-respect and dignity of the child.'

The provision of a social context where recovery can take place and no further harm is caused to the child (or young person) appears to be particularly pertinent to UASM, particularly those who are aged 16 and 17 who are often placed under Section 17 of the Children Act (1989) in accommodation with little supervision (Wade *et al* 2005).

British legislation

Immigration legislation

Applications for asylum in the UK are considered in accordance with the obligations of the 1951 UN Convention relating to the Status of Refugees and the 1967 Protocol. Unaccompanied asylum seeking minors like others that are recognised as refugees are granted Indefinite Leave to Remain. Minors whose application for asylum fails are not deported to their home countries, but *'...are granted Discretionary Leave for 3 years or 1 year (depending on their country of origin) or until their 18th birthday, whichever is the shorter. At the age of 18 they could then apply for further leave to remain'* <http://www.homeoffice.gov.uk/about-us/freedom-of-information/released-information/foi-archive-immigration/4984-child-trafficking?view=Binary>. Discretionary Leave (DL) and Humanitarian Protection (HP) replaced Exceptional Leave to Remain (ELR) from 1 April 2003.

The Children Act 1989

The Children Act (1989) is the primary piece of English legislation covering the care of UASM and all other children in England. According to the law UASM in the UK have equal legal and welfare entitlements as children who are British citizens, including the right to free education and healthcare and the rights enshrined in the Human Rights Act (1998). Local authorities are accorded responsibility for all UASM defined as 'in need' and the Children Act (1989) stipulates that they are obliged to provide a range and level of services appropriate to their needs. The Children Act 2004 has since been introduced detailing additional methods to enhance the protection of children. These include the promotion of cooperation between children's services; safeguarding and promoting the welfare of children; the establishment of databases; the establishment of Local Safeguarding Children Boards, and the appointment of Director of Children's Services by each children's services authority.

The lay participants in our study were cared for under Section 17 or Section 20 of the Children Act (1989). Children aged below 16 years receive services and accommodation under Section 20. They are usually placed with foster families, or

put in residential or semi-independent care and are termed 'looked after' children. The Home Office reports that these children are entitled to continuing support after age 18 up to the age of 21 and sometimes beyond.

(<http://www.asylumsupport.info/publications/homeoffice/children.htm>). Wade *et al's* study (2005) of the social services provided to UASM during 2004 found that the majority of 16 and 17 year old UASM who were provided for under Section 17 received variable care which often consisted of a 'rudimentary assessment' followed by placement in unsupported shared housing with limited social work support, such as bed and breakfast accommodation. Children cared for under Section 17 were deemed to do less well in terms of education and developing social networks (ibid). Children aged 16 or 17 therefore may be particularly at risk of finding themselves in situations which compromise their safety and well-being.

It has been asserted that councils have been 'under assessing' the needs of UASM as the law enabled a degree of discretion regarding the level of support they provided. Following complaints by a group of some former UASM a high court judgement in August 2003 (the Hillingdon Judgement) ruled that the support offered to 16 and 17-year-old UASM '*should be equal with that afforded British children in care. This means they must be assigned a social worker to regularly review their health and education needs.*' (<http://www.asylumsupport.info/castadrfit.htm>). The lay participants in the SAFER UK study would not have benefited from the recommendations of the Hillingdon Judgement.

The Sexual Offences Act 2003

The British *Sexual Offences Act* (2003) came into force in 2004 and therefore was not in effect at the time our lay participants were the victims of sexual offences. It supersedes the *Sexual Offences Act* 1956 and makes the following additions from earlier legislation relevant to our study population:

- '*consent*' now has a legal definition - this makes it easier for juries to make fair and balanced decisions on the question of consent, and sends a clear signal to men that they can't make assumptions
- the meaning of rape has been expanded to include oral penetration
- children under 13 can now never legally consent to sexual activity

- a new law 'protecting children from exposure to indecent text messages, and online and offline 'grooming' (communication with a child with an intention to meet and commit a sex offence)
- all sexual offences now apply equally to males and females of any sexual orientation

<http://www.homeoffice.gov.uk/crime-victims/reducing-crime/sexual-offences/>

As mentioned above, the Sexual Offences Act 2003 also legislates directly against sexual activity with young people aged 16 and 17 (i.e. above the age of sexual consent) when perpetrated by someone aged over 18 years who is in a position of trust.

Despite improvements in the law relating to sexual offences, convictions for rape and other sexual offences remain disturbingly low with less than 6% of reported rapes resulting in a conviction and fewer than 20% of rapes being reported to the police.

<http://politics.guardian.co.uk/women/story/0,,1311939,00.html>.

The ethno-history of the lay participants' countries of origin

The young people who were interviewed for the SAFER UK study originated from Ethiopia, Eritrea and Somalia, a group of neighbouring countries that lie geographically within what is termed the *Horn of Africa*, located in the northeast of the continent. These countries have much in common with one another including ethnic conflicts, human rights abuses, high mortality rates, poverty and gross gender inequalities. However, there are variations between regions and between different cultural and socio-economic groups in the Horn of African nations. A brief synopsis of the ethno- histories of these countries is given here, as well as relevant cultural information to help contextualise the young study participants' accounts of their experiences of sexual maltreatment in the UK.

Ethiopia

The federal republic of Ethiopia is bordered by Eritrea and Djibouti to the north, Somalia to the east, Kenya to the south and Sudan to the west. It is the third most populous country in Africa with a population estimate in 2004 of nearly 68 million (CIA World Fact book) divided between over 80 different ethnic groups. The predominant religions are Christianity (mainly orthodox), Islam (Sunni Muslims) and Judaism. The majority of the people are deeply religious.

The position of females in Ethiopia

According to *Womankind Worldwide* (2006), which provides a summary of the political and socio-economic situation for women around the world, Ethiopian women are discriminated against on all levels and they have low social status in a strongly patriarchal regime. Their maternal mortality rates are the highest in the world and girls have the worst rates of school enrolment of any country in Africa. Consequently their literacy rate is only 35% compared to over 50% for men. Lack of education condemns many Ethiopian women to a lifetime of poverty and exclusion. Of the small number that does paid work (40%) few are in positions of responsibility or involved in decision-making.

According to *Womankind Worldwide*, Ethiopian women are still regarded as second-class citizens because of cultural influences and educational barriers. Over 85% of Ethiopian women are reported to have undergone circumcision, or female genital mutilation (FGM). The Ethiopian Government banned the practice in 2004. Many women are also reported to endure early forced marriage or marriage by abduction depending on the region. Abduction often involves rape by the abductor.

<http://www.womankind.org.uk/global%20reach/East%20Africa/ethiopia.html#society>

Marriage through abduction of the bride in Ethiopia is a traditional practice that has been retained to a greater or lesser degree throughout the country.

Eritrea

Eritrea borders the Red Sea, between Djibouti and Sudan and it shares a border with Ethiopia. It has a population of a little fewer than 5 million who follow a number of religions including Islam and Christianity (Coptic Christian, Roman Catholic and

Protestant). It gained independence from Ethiopia in 1993 following a thirty-year struggle. The estimated literacy rate in 2003 was higher for males (69.9%) than females (47.6%). Since independence from Ethiopia in 1993, Eritrea has faced the economic problems of a small, desperately poor country. The economy is largely based on subsistence agriculture and was badly damaged by further war with Ethiopia in 1998-2000 (ibid).

The position of females in Eritrea

A report by the 'OMCT' (2003) states that Eritrea has several different cultures with differing perspectives towards women, however customary (traditional) views tend to dominate in many areas of society which often discriminate against females who are subordinate in this strongly patriarchal country. Like other Horn of African countries girls receive less education and their roles are primarily geared toward child rearing and domestic chores. Girls are subjected to several harmful practices, including circumcision (about 90%), early marriage, dowry payments, and polygamous marriages. Although the age of majority in Eritrea is 18, customary law enables children to marry younger and they are often married between 13 and 15 years of age. Early marriage and circumcision helps to ensure the bride's virginity. The 'OMCT' (2003) report cites a study that claims that unmarried pregnant girls are vulnerable to violence. In the Gash-Barka region of Eritrea it is seen as a crime and unmarried pregnant girls may be 'kicked out of the home, beaten, stoned, or even killed' (p.206).

Somalia

Somalia borders Kenya to the southwest, Ethiopia to the northwest and Djibouti to the north. Somalia was reported to have a population of around nine million in 1976 (CIA World Fact book). Counting the population is complicated due to nomadism and large migrations of refugees fleeing from clan conflict and famine. Years of political turmoil and insecurity have led to substantial economic under-development, widespread poverty and deprivation, and human and civil rights violations. The country has one of the highest mortality rates in the world. The main religion is Sunni Muslim.

The position of females in Somalia

Womankind Worldwide (2006) states that many Somali women are denied access to health, education and full participation in decision-making at any level because of local tradition and custom. It is reported that female's needs and concerns are not addressed, and their voices are not heard. The preferred gender of new babies is male.

Women are reported to have experienced isolation, displacement, violence, rape and discrimination. Violence against women is widespread and socially accepted. Almost all (over 98%) Somali women have undergone circumcision (FGM), usually infibulation, which is the severest form (described in more detail later). Early and forced marriage is typical and part of traditional Somali society (ibid).

Many of the country's women and children are considered 'stateless' and lack even basic protection and freedom. Females are further disadvantaged by pastoral agriculture, nomadism, conservatism and patriarchy. Their role in many parts of the country is child rearing and providing the labour necessary to ensure the daily survival of the family (ibid).

Child refugees from areas of conflict

The problem of child soldiers is reported to be most critical in Africa where an estimated 100,000 children in 2004 were involved in armed conflict, some of whom were reported to be as young as nine (Teach Kids Peace 2005). Male child asylum seekers who were child soldiers may have been forced to commit sexual outrages, such as rape against women and girls during ethnic conflicts. Girl soldiers are reported to be used for the sexual gratification of male soldiers, as well as being active in combat (ibid). Rape of women and girls by militia has been, and is being used as a weapon of war (Griffiths 2002).

Cultural norms

Virgin brides

In the Horn of Africa girls who are known not to be virgins are perceived as being unsuitable as wives therefore early marriage helps ensure their virginity. Female virginity at marriage is perceived as a sign of their families' as well as their own respectability (UNICEF n.d).

There are conflicting pressures within the Horn of African nations between what is seen to be acceptable cultural practice relating to the treatment of women and girls and their desire to comply with both national and international Conventions, as pointed out by a women's activist group:

'Articles 558 and 599 of the 1957 Ethiopian Penal Code allowing abductors and rapists to escape punishment through marriage contravene both the Constitution of Ethiopia and the international conventions to which Ethiopia is a party' (Equality Now 2002).

The international conventions referred to above include the Convention on the Rights of the Child.

Marriage by abduction

An example of the process of marriage by abduction reported to occur in some parts of Ethiopia whereby the girl is abducted by a group of young men, she is then raped by the man who wants to marry her (who may be a total stranger or someone she knows). An elder from the man's village then asks the family of the girl if they will consent to him marrying her. The girl herself has no choice in this. As not being a virgin bride is considered socially unacceptable, marrying the rapist or the man who took her virginity appears to be the only solution. The Bible (Deuteronomy 22:28-29) seems to suggest this as a means of ensuring the female's economic protection, as her husband is not permitted ever to divorce her:

'If a man happens to meet a virgin who is not pledged to be married and rapes her and they are discovered, he shall pay the girl's father fifty shekels of silver. He must marry the girl, for he has violated her. He can never divorce her as long as he lives'.

(http://en.wikipedia.org/wiki/User:Myst%C3%ACc/Morality_of_Bible).

Female circumcision

As discussed above, the majority of females from Somalia, Eritrea and Ethiopia undergo 'circumcision', a term more acceptable to African communities than **female genital mutilation** (Morison *et al* 2004). According to UNICEF (2005) it is mainly performed on children and adolescents between four and 14 years of age. In some countries, however, up to half of the girls having this operation are infants under one year old, including 44 % in Eritrea. A number of ethnic groups do not practice any female circumcision.

The World Health Organisation (WHO 2000) classifies female circumcision (FGM) into four types:

- Type I. Excision of the prepuce, with or without excision of part or all of the clitoris.*
- Type II. Excision of the clitoris with partial or total excision of the labia minora.*
- Type III. Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation).*
- Type IV. Unclassified: this includes pricking, piercing or incising of the clitoris and/or labia; stretching of the clitoris and/or labia cauterisation by burning of the clitoris and surrounding tissue.*

UNICEF (n.d) reports that circumcision decreases or eradicates the circumcised female's sexual pleasure and may lead to irreversible lifelong health risks including:

'...failure to heal; abscess formation; cysts; excessive growth of scar tissue; urinary tract infection; painful sexual intercourse; increased susceptibility to HIV/AIDS, hepatitis and other blood-borne diseases; reproductive tract infection; pelvic inflammatory diseases; infertility; painful menstruation; chronic

urinary tract obstruction/ bladder stones; urinary incontinence; obstructed labour; increased risk of bleeding and infection during childbirth’.

(http://www.unicef.org/protection/index_genitalmutilation.html).

Female circumcision is often erroneously associated with Islam, but it is a social practice not a religious one and in fact predated Islam. The practice originated in Africa and remains a mainly African cultural practice today. Control of female sexuality has been reported to be the reason for circumcising them (Morison *et al* 2004).

(http://www.religioustolerance.org/fem_cirm.htm).

Discussion

The cultural traditions of asylum seekers from Horn of African countries, such as their subservience to males in their home countries are likely to have a profound effect on their lives as UASM in the UK. For example, they may have low expectations regarding their rights to autonomy and self-determination and this is likely to impact on their responses to situations of sexual maltreatment. Such effects may include fear of unwanted sexual encounters resulting in social avoidance behaviours, or increased compliance with sexual advances and abuse through a sense of learned helplessness. Female asylum seekers' lower social status preconditions them to sexual maltreatment both in their homelands and in countries in which they seek refuge. Although there is little or no evidence of African girls being openly exploited for sexual purposes in London unlike some other parts of Europe (Metropolitan Police 2004), there is little known about their experiences of sexual maltreatment during their day- to- day personal encounters.

Male UASM from the Horn of Africa will also retain their cultural norms and expectations in terms of gender roles and relationships. They may also be unaware of British law regarding sexual offences. These cultural norms and expectations will be referred back to during the course of this report to help enhance readers' understanding of the accounts of the former UASM who contributed to this study.

Structure of the report

A number of overarching themes emerged from the data from the lay participants (young adult Ethiopians, Eritreans and Somalis who had been UASM) and the key professionals. These themes have been used to organise the presentation of the findings in the report. Each chapter has its own introduction and conclusions and is designed to stand-alone. The quantitative and qualitative data are presented in an integrated way where relevant and possible based on these themes to enable a more comprehensive and contextualised picture to be presented. Findings relating to the lay participants are generally presented separately from the key professionals within each chapter; links are made in the discussion and conclusions.

Extracts from the interview transcripts are presented periodically to illustrate key points. Each extract is followed by a unique identifying code denoting the interviewer, the number of their interview and a 'f' or 'm' indicating whether the interviewee was female or male e.g. C2f. Key professionals' extracts are denoted with 'KP' followed by a unique identifying number. Where relevant, their professional field or role is also given.

Chapter 1 provides an introduction to the project with definitions of the main concepts; a review of the literature relating to the sexual maltreatment of minors; a synopsis of the primary legislation relating to this group, and the policies and procedures that impact on their safety and well-being in the UK; and a summary of the socio-cultural context of their countries of origin, such as their ethno-history, gender relations and cultural beliefs and practices relevant to the issues under study. Chapter 2 describes the theoretical approaches used in the study and the methodology, and describes the main demographic and other relevant characteristics of the study participants. Chapter 3 describes and discusses the findings relating to the lay participants' sexual maltreatment, such as the type of incident they experienced, its frequency, and when and where it happened; the victim's circumstances at the time; the physical, emotional and social effects of the sexual maltreatment; and their professional help-seeking behaviour. Chapter 4 explores theories of attribution, and the lay and professional participants' views

about why UASM may be vulnerable to sexual maltreatment. Chapter 5 explores the role fear played in protecting the lay participants from sexual maltreatment, as well as being a risk factor for it and an after-effect, and the impact of fear on disclosure. Chapter 6 explores the theories behind preventive interventions and describes and discusses the participants' views as to how it could best be prevented from happening to UASM. Chapter 7 discussed the various perceptions of the study participants that appear to be contradictory or contentious to help illuminate where caution may be needed in developing more appropriate services and support for these young people. Chapter 8 presents and discusses the findings relating to participants' perceptions and experiences of professionals and their service provision. It particularly seeks to provide insights into how they could be developed to become more culturally competent. The final chapter (9) outlines the conclusions of the study and the recommendations.

Chapter 2

Methodology

Introduction

This chapter summarises the theoretical approaches that underpin the methods chosen to fulfil the aims of the SAFER UK study (outlined in chapter 1); it then goes on to describe the details of these methods. The socio-demographic characteristics of the lay participants are described at the end of the chapter.

Theoretical approaches

As the focus of the study was on people from cultures vastly different from our own (western European) it presented us with many methodological and ethical challenges. Firstly there were the challenges that stemmed from the fact that we are 'First World' academics researching 'Third World' people and we needed to avoid ethnocentrism and what might be construed as 'academic imperialism'. Secondly we were also researching the highly sensitive issue of the sexual maltreatment of minors. Clearly we needed to select theoretical approaches that would enable us to navigate this rocky and somewhat treacherous terrain in ways that would do minimal harm to participants and researchers in the process, as well as reach a destination of worth to those we set out on the journey to benefit.

A constructivist approach

A positivist approach to researching this topic would demand an objective stance whereby the position of the researcher would be outside the sphere of the subject to be investigated in an attempt to place a distance between them. The justification for such objectivity being that the researcher needs to ascertain as closely as possible what is 'really' going on and avoid subjective opinions about what is being observed; or unduly influencing what is being observed. This is contrary to the constructivist approach that posits that there is no objective reality, just human constructions and

interpretations of that reality. This is, as Patton (2002) puts it, '*...because language creates a screen between human beings and physical reality*' (p.101). Understanding complex social relationships and phenomenon is in our view best approached by adopting a constructivist, relativistic epistemological stance. Relativism means '*...that knowledge is viewed as relative to time and place*' (ibid: 100). In this study of the sexual maltreatment of minors we challenge the taken for granted constructions of child sexual abuse. We conceive it to be a historically and culturally derived construct that carries little (or variable) meaning outside of its historical and cultural context. Even within the so-called developed world there is no consensus on its definition.

In taking a constructivist epistemology we perceive refugee children as being active constructors of the meaning they place on their sexual maltreatment events. Their responses to them are dependent upon these subjective meanings that are also shaped by the actual and imagined reactions of others. The sense they make out of being sexually maltreated and their responses to it will be influenced by their social position as new aliens in a foreign world, and are likely to differ from those who are not so positioned. Constructivist approaches to researching these children's lives are said to '*provide a means of integrating psychological, social and broader cultural dimensions of refugee children's experiences*' (Ahern *et al* in Ager 1999: 218). Such approaches also facilitate the construction of more complex models for understanding the varying constructions of it in different cultural contexts, and at different times in history within any given cultural group.

The cultural construction of the phenomenon of *child sexual abuse* as we have come to understand it in the UK differs widely from how it is constructed in Ethiopia or other Horn of Africa countries where the concepts of 'child', 'sexual' and 'abuse' may carry different meanings.

Culturally competent research

Of particular importance to us as researchers exploring the experiences of people from cultures other than our own was the need to ensure we undertook *culturally competent research*. This has been defined by Papadopoulos in relation to health care as, '*research that both utilizes and develops knowledge and skills which*

promotes the delivery of health care that is sensitive and appropriate to individuals' needs, whatever their cultural background' (Papadopoulos 2006: 85). The Papadopoulos model of cultural competence consists of four concepts: cultural awareness, cultural knowledge, and cultural sensitivity culminating in a synthesis of all three: cultural competence. This model proposes that researchers should use an epistemological stance that raises their consciousness of their own positions in the research process and that they make their position explicit to others. This means that researchers should adopt a '*reflexive*' approach whereby they consider how their culturally distinct values and beliefs may influence their perceptions of the social phenomenon they are investigating, the methods they choose and conclusions they make. A reflexive approach involves ongoing review and evaluation of the research processes and ensuring flexible responses to new knowledge and events that arise during the research process. Reflexivity is also a hallmark of feminist research approaches, which also seek not to objectify and disempower participants (Roberts 1981).

Another characteristic of culturally competent research is inclusivity, which adopts the ideology of participatory research. Participatory research is people orientated as it promotes the use of anti-oppressive research practices, for example by providing people-friendly ways of participating and of giving their accounts, an approach advocated by Durham (2002). The production of relevant and accessible knowledge to ordinary people is another essential characteristic of culturally competent research. Anderson (2002) supports this by proposing that [research] '*...must treat as legitimate the voices of those who have been marginalised and bring these voices forward in the social production of knowledge*' (p.22). The participatory research approach embraces the principles of empowerment of ordinary people as partners, rather than simply informants. Participation should be a two-way process whereby as Maynard puts it,

'Research becomes a means of sharing information and, rather than being seen as a source of bias, the personal involvement of the interviewer is an important element in establishing trust and thus obtaining good quality information' (Maynard 1994: 16).

However, in order to be empowered to participate on a level of relative equality in relation to the professional researchers and other stakeholders, lay participants (as co-researchers) need to be given relevant skills and knowledge (Guba and Lincoln 1989).

Transformative knowledge

Another theoretical principle that informed the methodology of this study is the production of *transformative knowledge*. This is endorsed by the proponents of culturally competent research as well as post-colonial feminist researchers, such as Anderson *et al* (2002) who described it as being research that is,

'...under-girded by critical consciousness... and that unmasks unequal relations of power and issues of domination and subordination, based on assumptions about race, gender and class relations... [it] is knowledge... that acknowledges the "wisdom of the people"' (pp.21-22).

Therefore for transformative knowledge to be produced the researcher must take account not only of dominant discourses but also the discourses of marginalised and less powerful groups. Anderson (2002) argues that transformative knowledge is, *'...knowledge that is constructed from the social location of those who have been marginalised...'* (p.23), clearly this calls for a participatory and constructivist approach.

Methods

Literature review

The literature relating to the following issues and theories were reviewed: 'child sexual abuse' and 'sexual assault' including rape; social, psychological and cultural theories relating to the attribution of the sexual maltreatment of children; disclosure of child sexual abuse; after effects of sexual maltreatment in childhood; the ethno-history of the countries of origin of the former UASM participating in the study; international, national and local policy and legislation relating to asylum seeking

children, sexual offences and child protection; resources for survivors of child sexual maltreatment such as websites, leaflets and guidelines for users; and resources for professionals interested in child sexual abuse and sexual assault. The data collection tools were devised following a review of relevant literature.

Ethical considerations

Due to the extreme sensitivity of the topic under study it was felt that those under the age of 18 should not be included as study participants and to use a retrospective study design with young adults instead. Care was needed to ensure confidentiality both during recruitment and participation (and beyond) and interviewers were given careful instruction on how to ensure this in practice. Participant information sheets for both lay and professional participants were carefully worded to ensure minimal upset and to instil trust in the project's integrity and sensitivity. Written consent was obtained from the participants. The project was granted ethical approval by the University's School of Health and Social Sciences Research Ethics Committee.

Considerations relating to sensitive topics

A primary consideration of the research team when designing the methodology for this study was how to deal with the sensitivity of the subject matter and the fact that we wished to seek first-hand accounts of sexual maltreatment from survivors of it. Some researchers argue that the *life story* method is ideal as it allows the participants to speak for themselves and is non-oppressive (Durham 2002). However, we felt that such a lack of structure during the interview may feel threatening to the lay participants, as they may never have discussed the issue before. A less structured approach would also have required great skill on the part of the lay interviewers who were mostly young adults inexperienced in research interviewing. Consequently we decided that it would be best to collect data from lay participants using both a self-completion questionnaire and a personal interview using a semi-structured schedule; an approach suited to the constructivist approach and the culturally competent research paradigm. As sexual abuse and sexual assault are highly stigmatised in the participants' countries of origin, those who did not wish to have a personal interview were offered the options of a telephone interview or to complete a self-completion questionnaire only. These alternative

methods included the questions from the interview schedule as well as the self-completion questionnaire.

Recruitment and training of interviewers

The project needed to employ lay interviewers to recruit the lay participants to the study, to interview them and translate and transcribe the interview transcripts. The selection criteria were that the interviewers should be young natives from the countries of origin of the lay participants, as we believed they would talk more openly with a peer. They also needed to be able to speak and write in English as well as the languages of the proposed interviewees to give them the choice of being interviewed in their native language. Both males and females were to be recruited as interviewers, again to give interviewees a choice. The project co-director (Executive Director of the Ethiopian Community Centre in the UK) recruited six young Ethiopian interviewers. A second mixed sex group of five Somali young people were recruited as interviewers some months later. In addition, two older interviewers were recruited and trained, one a female Eritrean and the other an Ethiopian male. Interviewers were paid a fee per interview performed with an additional sum if it was conducted in an African language and needed translating.

Training

A training day was developed and delivered to all the interviewers as a condition of their employment which included the following learning objectives:

- To know the background and aims of the study and to understand their role as interviewers.
- To acquire skills in recruiting eligible young adults as study participants.
- Have an understanding of the sexual maltreatment of minors and its potential impact on them.
- To be able to sensitively interview young people who have experienced sexual maltreatment or a 'near miss' as a minor.
- To give relevant information regarding seeking counselling or support for psychological trauma resulting from sexual maltreatment in a sensitive manner.

We felt it was important to include young people who had experienced a 'near miss' as this might illuminate some effective strategies for prevention.

The minimum age for participation was lowered to seventeen if the interviewer felt they were suitable, and if they believed that they were living independently of a guardian and consent could therefore not be sought from them. The maximum age limit for age at the time of abuse was extended from under 16 to 17 years since they were considered to be vulnerable due to their immigration status and living conditions, despite being above the legal age of consent for sex. Additionally, according to our professional contacts and other sources (Wade *et al* 2005) most unaccompanied minors do not arrive in the UK until their mid teens.

Exclusion criteria

The only exclusion criterion was that participants should not currently be in the process of legal procedures relating to sexual abuse, sexual assault, or a related crime.

Recruitment of eligible young people from the Horn of Africa

A variety of strategies were needed to target potential lay participants, these included: a poster advertising the study detailing the aims of the study, eligibility criteria for participation, and contact details for potential participants. These were posted by the interviewers in locations known to be frequented by the target groups, such as hostels, refugee community organisations, self-help groups, churches, mosques, Ethiopian restaurants and internet cafes. A recruitment leaflet was also produced in English (most young adults from the Horn of Africa countries can read English) and small piles of these were left in the locations where the posters were situated. The leaflets were also given to potential participants during face-to-face recruitment activities.

Participant information sheets were also produced which gave full details of the study and assurances about confidentiality. Participants were to read this prior to signing the study participation consent form. In addition to the above recruitment methods, a pre-recorded radio broadcast was transmitted by the Ethiopian 'Negat' radio station run by ECCUK. The broadcast was an interview of the Executive

- Be able to give relevant information on sources of advice for physical trauma or disease resulting from sexual maltreatment in a sensitive manner.

As the young interviewers were likely to have been unaccustomed to bearing witness to stories of sexual maltreatment it was important to provide them with some preparation for this. Their training therefore included open discussion about sexual maltreatment to help make them feel more comfortable with the subject matter. The interviewers were also requested to meet with the researcher throughout the data collection period to encourage them to discuss any personal feelings or difficulties they might be having in relation to the work, as well as to provide ongoing practical guidance and support. All interviewers were made aware that they could attend for professional counselling if they wanted it to help them deal with any emotional impact of their work and that this would be paid for by the project funds.

Sampling

For the lay participants a purposive sampling method was chosen with the following eligibility criteria for participation:

Eligibility criteria

- Ethiopian, Somali or Eritrean ethnicity (or a mix of these)
- Aged now between 18* and 25 years
- Arrived in the UK aged under 16 years**
- Arrived in the UK unaccompanied by a parent or adult guardian
- Had been sexually abused or sexually assaulted in the UK whilst under the age of 16**, or believed they had been at risk of this, or had a 'near miss'
- Living in the UK as an asylum seeker or refugee at the time of the event(s)
- The event(s), or near event(s) happened within the last 10 years

* This was later reduced to 17 years old.

** These criteria were later increased to less than 18 years old.

demographic information; details of their experiences of sexual assault/ sexual abuse in the UK, such as the type and frequency of the events; their knowledge of sexual abuse and the sources of this; their levels of adult support at the time of the incidents; and whether they sought professional help for it and if so who from (Appendix 1). The participants were asked to indicate the specific sexual activities they had engaged in by ticking against a comprehensive list of sexual acts on the self-completion questionnaire. This approach was felt to be a more sensitive way of prompting them to reveal the true nature of their sexual maltreatment, bearing in mind their young age and the high levels of stigma and shame attached to the issue in their home countries.

The aims of the interviews with the lay participants were to obtain detailed information about their experiences of and views about sexual maltreatment including:

- what happened, where and when;
- their social circumstances at the time including their level of formal and informal support;
- details about the perpetrators, such as their age, ethnicity and relationship to the lay participant;
- what they felt made them vulnerable to sexual abuse / sexual assault;
- whether they told anyone and whom, and how they responded compared with how they would like them to have responded;
- whether they reported the incident to the police and the outcome, or why they did not report it to the police;
- how the events had affected them at the time and what they feel about it currently;
- what they feel could help prevent sexual maltreatment of UASM;
- what professional support they have obtained since the events/ near events in relation to them;
- and how support services for UASM could be made more culturally sensitive and appropriate.

The interview schedule for lay participants is in Appendix 2.

Director of ECCUK in which she informed the Ethiopian community about the study and how they could participate. Finally an email was sent to 24,000 students at Middlesex University requesting Ethiopians to identify themselves with the view to possibly taking part in a study, which at this stage was not specified. Only twenty students responded to this first email request and all of them were then given full details of the study, however none fitted the eligibility criteria for inclusion.

Recruitment was found to be very difficult and the first interview was not undertaken until December 2004. By early March 2005 only two interviewers had interviewed participants (3 in total). The four interviewers that had not interviewed anyone were withdrawn from the team because their knowledge had not been consolidated in practice and they were deemed no longer competent to interview. The sensitivity of the subject required interviewers to be skilled and reasonably confident in this role. Despite much effort, nobody else came forward for interview. The reasons for this included expressed fears that providing information to the study might affect potential participants' immigration cases. An Advisory Group meeting was called to address the problem of lay participant recruitment in April 2005 when it was decided to extend the scope of the project to include Somalis and Eritreans. As it was recognised that participants may be reluctant to share sensitive information with strangers, it was also decided to widen the data collection methods to include the alternatives of a telephone interview, postal questionnaire, or a downloadable questionnaire. These changes were activated in May 2005. Shortly after this the two new interviewers were recruited and trained. The new male interviewer had significant prior experience of interviewing in depth. He managed to recruit interviewees rapidly through previous professional contacts who were currently working with the target groups. This yielded many more participants than other recruitment methods. Lay participants who were interviewed were offered a £20 cash 'participation fee' and a £10 fee offered to those who completed a questionnaire only.

Information sought

The majority (50/53) of the lay participants opted for a personal interview and they were all requested to complete the self-completion questionnaire in the presence of the interviewer prior to the interview. This sought information on: socio-

As the subject matter was extremely sensitive and liable to cause both immediate and potentially long-term distress all interviewees and those approached for an interview in person were given a leaflet detailing a number of counselling and support organisations and their contact details. These organisations had been researched to ensure they were accessible in terms of the languages spoken, hours of service, accessibility by public transport, their fees and their appropriateness. The Big Lottery Fund had provided funding to pay for the costs of counselling should there be a fee. Additionally lay participants were provided with an information sheet on how to report the incident to the police should they wish to do so and an overview of the procedures that they would need to follow. They were assured that any decision to pursue legal action was entirely their own.

Key professionals

Information sought from key professionals

It was considered essential to the aims of the study that the views of service providers and policy makers were sought. We were particularly interested in their views regarding the vulnerability of UASM to sexual maltreatment and how it could be prevented; their views of legislation and policies relating to this group; and what their organisation could do to improve services for this group.

Sampling key professionals

A purposive sampling method was employed to recruit key professionals to the study. The selection criteria were that the professional was to have a policy-making role or responsibilities for providing direct services to UASM and / or survivors of sexual maltreatment and as such to hold a position that influences outcomes for them. We also wanted to ensure a mix of professionals from across the spectrum of organisations that serve the needs of UASM.

Eight key professionals (one from each field) were interviewed; all worked in London and were as follows:

- Police officer from Project Sapphire (a special Metropolitan Police service for investigating sexual assault)
- Social services child asylum seekers' support team manager
- 'Designated teacher' in a secondary school with a high refugee population
- Senior member of staff from the NSPCC (a child protection charity)
- Private counsellor who had experience with male and female sexual abuse victims
- Senior member of staff from the National Asylum Support Service (NASS)
- Nursing academic and primary care nurse practitioner
- Former employee of refugee support organisations

Data collection

Data was collected during personal interviews using a semi-structured interview schedule (Appendix 4). Details of their professional roles and functions in relation to working with the study group and sexual maltreatment survivors were obtained via a self-completion questionnaire (Appendix 3).

Data analysis

The quantitative data from the lay participants was entered onto and analysed using SPSS for Windows. The interviews were transcribed and analysed using the NUDIST qualitative data analysis package. Analysis of the quantitative data involved obtaining frequencies of categories within variables and statistics to describe numerical data distributions. Correlation and cross-tabulation were used to explore relationships between variables. We did not have a large enough sample to undertake more sophisticated multivariate analysis.

Qualitative data were explored to answer the questions we had predetermined as central to the concerns articulated in the research project. These were developed in collaboration with the multi-disciplinary and user-participant Advisory Group. We also analysed the qualitative data to identify themes that were not predetermined by the research questions, but which arose spontaneously from the enquiry.

Verification of findings

The lay participant transcripts were checked for accuracy of translation, such as conceptual equivalence. This was done by translating the English versions back into the original languages (known as back-translation) used in the interviews and having a researcher fluent in these languages check for differences between the original and the back-translated versions. A randomly selected number of transcripts from each interviewer were selected for this procedure.

Further verification was performed when the transcripts from both the lay participants and the key professionals were read and analysed separately by two researchers; the resultant themes were then compared for similarities and differences and consensus reached. These were then discussed with a third research team member who had interviewed the majority of the lay participants. Emerging themes were then compared with and elaborated through the available relevant literature.

Finally, drafts of this report were read and commented on by members of the Advisory Group. This helped to achieve maximum clarity in the presentation and discussion of the findings as well as the formulation of recommendations.

Characteristics of the lay participants

Sample size

Fifty three (N=53) lay participants (young Ethiopians, Somalis and Eritreans) participated in the SAFER UK study. Fifty (n=50) agreed to be interviewed and three (n=3) agreed to complete a questionnaire only which was designed to capture the data otherwise obtained by interview and the self-completed questionnaire.

Socio-demographic characteristics

The socio-demographic characteristics of the lay participants were ascertained through the self-completion questionnaire.

Gender

The vast majority of lay participants were female (n=51/53) but as this was not a randomly selected sample it cannot be interpreted as representing the true ratio of female to male UASM from the Horn of Africa who suffer sexual maltreatment in the UK. However, it is well documented that perpetrators far more often target females than males.

Age

The age of the lay participants at the time of interview ranged from 17 to 25. A total of eight (n=8) were aged 17. All of these participants were living independently of adult guardians and were considered to be capable of giving their own informed consent to participate.

Ethnicity and religion

Most of the fifty two (n=52/53) participants who responded to the question regarding their ethnicity reported that they were Ethiopian (n=35: 82%). The others were Eritrean (n=10: 19%), Somalian (n=4: 8%) and three (n=3: 6%) were of mixed Ethiopian and Eritrean ethnicity. These ratios reflect the greater success of the Ethiopian interviewers (one in particular) in recruiting their country-folk to participate in the study.

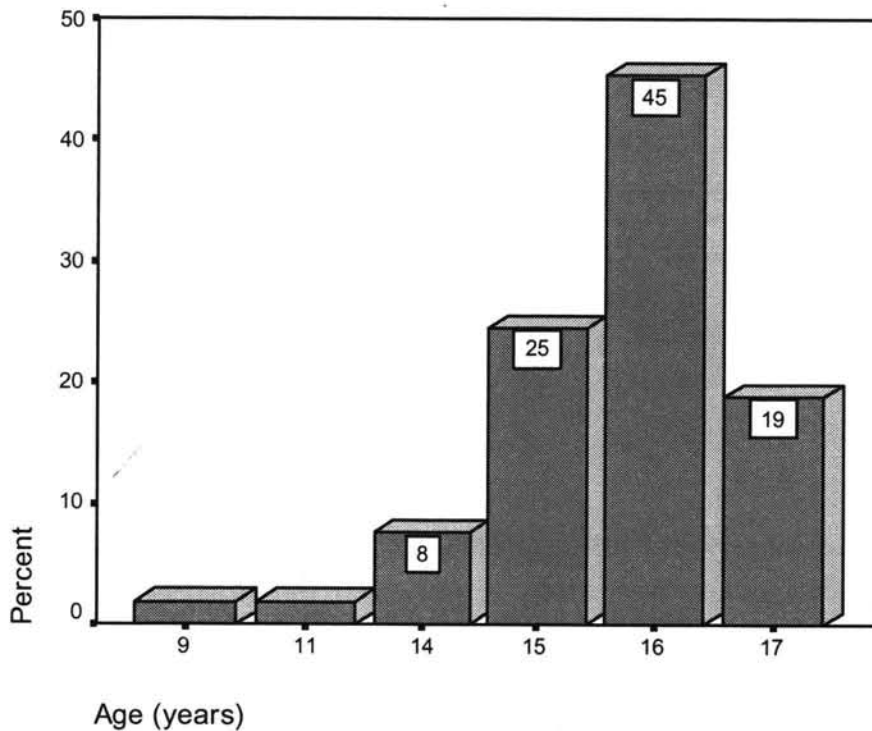
Participants were asked which country they had spent most of their lives in; six of the ten Eritreans (n=6/10) reported that they had spent most of their lives in Ethiopia and four (n=4/10) in Eritrea. Two (n=2/4) of the Somalis had spent most of their lives in Somalia, and two (n=2/4) did not respond. Most Ethiopians had spent most of their lives in Ethiopia (n=31/35), one (n=1) in Eritrea and three (3/35) did not respond.

The majority of the lay participants who answered the question regarding their religion (n=52), most were Christian (n=43:83 %) and nine were Muslim (n=9: 17%). All but three of them were currently residing in London Boroughs at the time of the interview – again a consequence of recruitment activities that focused on London where most UASM from the Horn of Africa live.

Age on arrival in the UK

The age that the participants arrived in the UK ranged from nine years of age to seventeen years with the majority arriving between 15 and 17 years (Figure 2.1). Almost half were aged 16 years on arrival and the average age was fifteen and a half years.

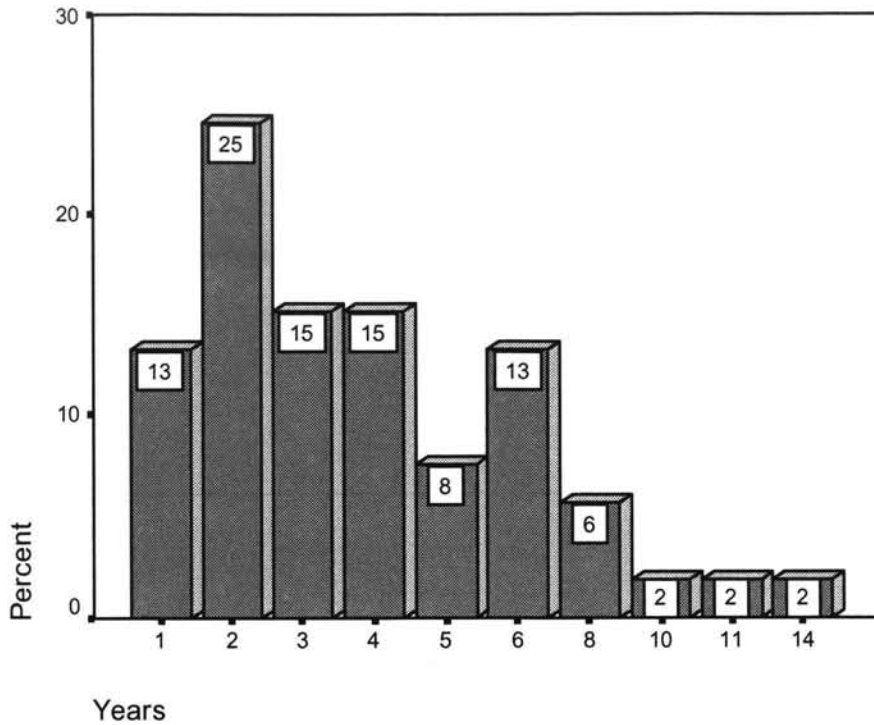
Figure 2.1: Age on arrival in the UK



Although the age that young people can officially marry in their homelands is 18, traditionally girls reach marriageable age at 15, although some are married younger than this (Chapter 1). According to our informants most unaccompanied female minors from the Horn of Africa seek asylum in the UK around the age of fifteen and our participants reflect this.

Many of the lay participants were fairly recent arrivals in the UK (Figure 2.2) and their experiences of sexual maltreatment and the circumstances in which it occurred were therefore related to relatively recent policy. In some cases the incidents occurred during the mid to late 1990s.

Figure 2.2: How long lived in the UK



Female genital mutilation

Most of the female participants who answered the question in the self-completion questionnaire as to whether they had been 'circumcised' said they had been (31/50: 62%). This is a lower proportion than is found in their countries of origin, which is nearer to 90% (see Chapter 1). A study by Morison et al (2004) of the circumcision of Somali girls living in London aged 16-22 years found that in their sample (N=94) seventy percent (70%) had been circumcised with two-thirds of these having been infibulated.

We did not seek to ascertain the socio-demographic characteristics of the key professionals as this was not thought to be relevant.

Chapter 3

The 'anatomy' of the sexual maltreatment of minors

Introduction

This chapter describes the unaccompanied asylum seeking minors' experiences of sexual maltreatment in the UK. It specifically describes their circumstances around the time of the incident, such as their accommodation and level of support; what happened, where it happened, when it happened and how frequently; the socio-demographic characteristics of the perpetrators and their modus operandi; the emotional and physical effects; and the survivors' help seeking behaviour subsequent to the events. Disclosure is discussed more fully in chapter 5.

The literature on sexual abuse and sexual assault

Prevalence of Child Sexual Abuse

Finkelhor (1984) made a plea not to place too much emphasis on researching the prevalence and incidence of child sexual abuse (CSA) and distracting attention from identifying and preventing it. He asserted that identifying that CSA is 'widespread' is 'accurate enough' (p.229). We would concur with this view, however it may be important to note here that the prevalence of CSA depends on which population is studied and how it is defined (we have given some definitions for CSA in chapter 1). Finkelhor (1984) found that when CSA is defined as,

*'...sexual contact, ranging from fondling to intercourse, between a child in mid-adolescence or younger and a person at least five years older, the sexual victimization rate is generally considered to be around 20-30% for females...
...and around 10-15% for males' (p. 4).*

These figures suggest that CSA is a relatively common occurrence. Briere (1992) notes that more recent studies place the male rate as rising to as much as 20% in non-clinical samples; clinical samples have much higher rates of reported child abuse of varying types. Clearly if the five year age difference rule is relaxed, a significantly larger proportion of children and young people will count as victims and perpetrators. However, our study did not seek to identify the prevalence or incidence of sexual maltreatment amongst UASM, nor can an estimate be made from this study. However we would speculate that it is likely to be disturbingly high because of the extreme vulnerability of this group.

Although we sought to explore the effects of sexual maltreatment on our group of UASM this was mainly to ascertain how the effects correlate with help-seeking behaviour and their adjustment to life in the UK, rather than to add to the knowledge base on effects *per se*.

Effects of sexual maltreatment

The effects of child sexual abuse have been researched in depth for several decades, particularly in Britain and America, and much evidence has now been accrued to conclude that it can cause both short and long term effects. Briere (1992) cites a number of studies that indicate that the long term effects include distorted self perceptions, such as low self-esteem, guilt, self-blame; a heightened sense of danger; altered emotionality, such as depression and anxiety; dissociation, such as amnesia for the events and emotional detachment; disturbed relatedness, including distrust of others; avoidance behaviours through substance abuse; sexual dysfunction; and suicide. Although post-traumatic stress disorder (PTSD) is a somewhat contested syndrome, particularly in relation to non-western people, (Bracken *et al* 1995), Petrak (Petrak and Hedge 2002) cites studies that indicate that it is particularly common in people who have been raped. It tends to occur within three months of an acutely stressful event (Doyle and Thornton in Petrak and Hedge 2002). In PTSD there are persistent intrusive symptoms with re-experiencing of the event and general hyper-arousal; avoidance of things that evoke thoughts or

feelings of the associated trauma; and the disturbance causes impairment in functioning or 'clinically significant distress' (ibid: 117).

Many studies have sought to identify the factors that are associated with psychological harm and why it is that some survivors appear to be less affected by sexual maltreatment in childhood than others. Briere (1992) suggests that there is evidence that certain factors, either singly or in combination, are '*...frequently associated with greater trauma than abuse without such characteristics*', these were outlined as:

- *'Greater duration and frequency of the abuse (e.g. Elliot and Briere, 1992)*
- *Multiple perpetrators (e.g. Peters, 1988)*
- *Presence of penetration or intercourse (e.g. Finkelhor et al, 1989)*
- *Physically forced sexual contact (e.g. Fromouth, 1986)*
- *Abuse at an earlier age (e.g. Zivney, Nash, & Hulsey, 1988)*
- *Molestation by a perpetrator substantially older than the victim (e.g. Finkelhor, 1979)*
- *Concurrent physical abuse (e.g. Briere & Runtz, 1989a)*
- *Abuse involving more bizarre features (e.g. Briere, 1988)*
- *The victim's immediate sense of personal responsibility for the molestation (e.g. Wyatt & Newcomb, 1991)*
- *Victim feeling powerlessness, betrayal, and/or stigma at the time of the abuse (e.g. Henschel et al., 1990)'*

(Briere 1992: 3-4).

However, Briere when writing about the lasting effects of child sexual abuse (CSA) concurred with Berliner's (1991) assertion that, '*...it is likely that, if untreated, any form of sexual maltreatment in childhood increases the risk of later mental health problems*' (Briere 1992: 5).

Ethnocentricity in sexual maltreatment research

There is now considerable knowledge about child sexual abuse, its nature, causes and effects, and a growing body of knowledge about those who perpetrate it. However, there is a dearth of studies explicating the relationship of culture, ethnicity

or refugeedom to it. Variables that are highly correlated with the most severe impacts, for example a greater age differential between perpetrator and victim, and abuse by family members have attained a high degree of acceptance as significant independent variables. These are often used either as victim selection criteria or as independent variables in further studies of CSA. Whilst this may be justifiable in studies of people normally resident in 'Western' countries, we would argue that it is ethnocentric to do so in studies involving people from non-Western cultures. It certainly would not be ethical to generalise findings based on Western participants living in the west to people of other cultures living in the west, or in their homelands or vice-versa. It seems probable therefore that the factors that have been identified as impacting most negatively on survivors of sexual maltreatment (outlined above) may not have the same significance for other groups, such as black African asylum seeking children in Western countries. For example, it seems feasible that a black UASM who is new to the UK who cannot speak the language may suffer greater trauma from being abused by an English person nearer their own age (or even younger) than an English child would. It is the meanings placed on events that are important and these are very subjective and often culturally and socially mediated. Crucially, studies of sexual maltreatment which exclude individuals whose trauma or experiences do not fit the criteria for being included as a 'case' causes that case to be marginalized and renders the individual's experiences invisible. As well as marginalising individuals from minority groups, failure to be inclusive can result in obscuring from view the 'true' nature of sexual maltreatment and how widespread, persistent and pervasive it is. Save the Children (2003) asserted that, '*Child sexual exploitation is unlikely to be efficiently prevented unless the diversity of the people who sexually abuse and exploit children is fully taken into account*' (p.5). A culturally competent discourse on sexual abuse and assault should, we argue, fully acknowledge and take account of all power differentials, including those based on ethnicity, citizenship and sexuality, factors which may interact with age, gender and social role in an abusive situation.

FINDINGS: The incidents of sexual maltreatment

The lay participants were asked in the self-completion questionnaire (Appendix 1) to indicate the type of sexual maltreatment they had experienced as an UASM in the UK. This was both to prepare them psychologically to discuss their experiences in detail in the interview and to encourage them to report the nature of the incidents as honestly as possible.

The nature of the incidents

What happened

Both of the male lay participants reported experiencing hand to genital fondling, as did a quarter of the forty nine females who responded (n=13:26%). 'Other types of fondling' were reported by half of the females (n=25:51%). Four (n=4: 8%) females reported that they had been raped and a further five (n=5:10%) described attempted rape. A participant who was sexually assaulted described being 'intimidated' by the perpetrator who had threatened her with a knife and threatened to kill her boyfriend. Ten (n=10:20%) of the females had experienced some other type of sexual maltreatment or a near miss. Although only five (n=5: 10%) of the females indicated in their self-completion questionnaire that they had experienced sexual harassment, many more of the fifty one females described this in their interview (n=29: 57%). Several reported two or more types of incidents of sexual maltreatment. Some had only felt at risk or afraid for their safety sexually (n=5:10%) but had not experienced actual events or near misses. These fears were often significant and related to living in conditions where they felt exposed to people they perceived to be sexually threatening. Some attributed their fear to learning via the media about women being sexually abused and assaulted in the UK.

Where the incidences occurred

The lay participants were asked in their interview where the incident had occurred; the majority (n=19) of the participants in our study reported that the incidents had happened where they were living at the time, which included hostels, shared houses

and flats, care homes, and foster homes. The second most commonly reported location was in the perpetrator's home (n=6). This is a similar pattern to the findings of other studies, such as that by the NSPCC (2002-2006) that concluded that most sexual abuse occurs in the home of either the 'respondent' or the home of the other person involved and rarely in other locations, except for indecent exposure. Some of our participants reported that the incidents occurred in a friend's house or a friend of the perpetrator's house, in the perpetrator's a car, outside, in the workplace, and over the telephone. Incidents that happened in their own homes seem to have been particularly difficult as it created a fear of being there when home should be a place of safety.

Frequency of the incidents

Of the forty five (n=45) participants who answered the question as to the frequency of sexual maltreatment, three-quarters said they had more than one experience (Table 3.1); the most common frequency was two to three times; and a disturbingly high proportion reported four or more incidents.

Table 3.1: Frequency of occurrence of sexual maltreatment in the UK

Frequency	N	(%)
Once	12	(26.7)
2-3 times	19	(42.2)
4-6 times	8	(17.8)
10+ times	6	(13.3)
Total	45	(100%)

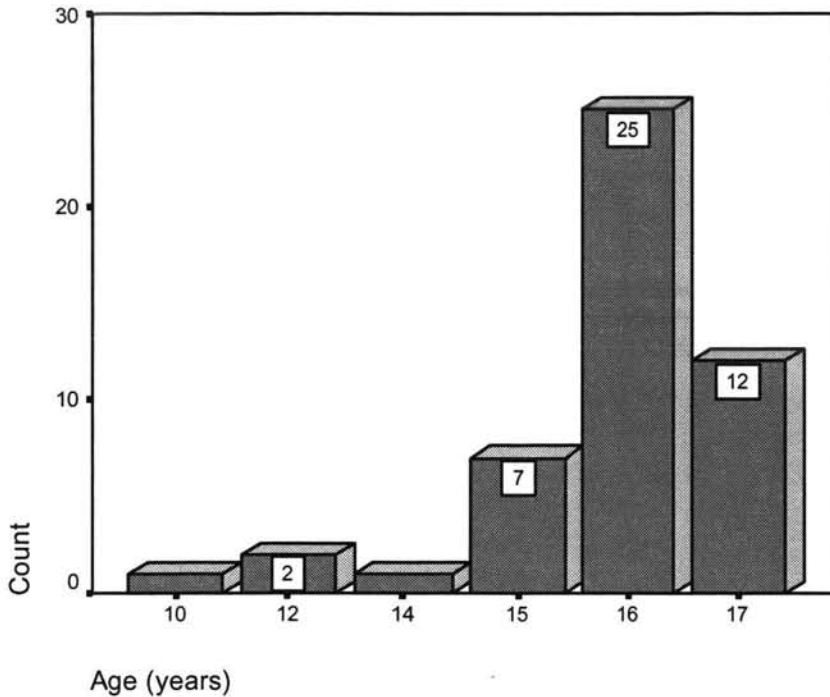
In the interviews twenty eight (n=28:53%) lay participants reported that they had been abused or sexually harassed by the same person on more than one occasion over a period of weeks, months or years.

When the incidents occurred

Of forty eight (n=48) participants who gave their age at the time they were first sexually maltreated in the UK (Figure 3.1) three (n=3: 6%) were aged under thirteen; one (n=1: 2%) was fourteen; seven (n=7: 15%) were aged 15 years; twenty five (n=25:52%) were aged 16 years and twelve (n=12: 25%) were aged seventeen

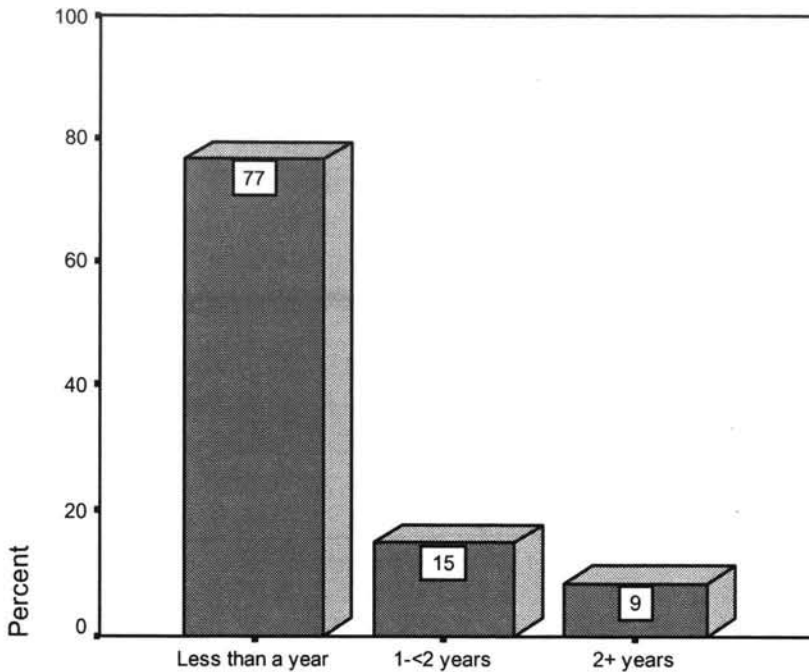
years (figure 3.1) Both the males had been sexually abused before the age of sixteen; one was 10 years old and one was 12.

Figure 3.1 Age at first sexual maltreatment in the UK



The age of the incident /near miss is related to the age they arrived in the UK seeking asylum, 90% of our participants had arrived age 15, 16 or 17 years, and more than three-quarters of them reported being sexually maltreated / experiencing a near miss within twelve months of their arrival (Figure 3.2).

Figure 3.2: Duration between arrival and sexual maltreatment



The literature on perpetrators of sexual maltreatment

Contrary to popular belief, most child sexual abuse is committed by people known to the victim. A report by the NSPCC (2002-2006) on their study of the prevalence of child abuse found that, '*...much larger numbers had experienced sexual acts by non-relatives, predominantly by people known to them and by age peers: boy or girlfriends, friends of brothers or sisters, fellow pupils or students*' (<http://tinyurl.com/kfuf1>). However, the perpetrator's relationship with their victim tended to vary according to the age of the victim. They noted for example that among older children, neighbours and parent's friends were the most common perpetrators. Very few said that the perpetrator was a professional. The NSPCC also found that indecent exposure was the only category of abuse committed to any great extent by strangers (ibid). The profile of perpetrators is likely to vary according to the profile of the victims and the social conditions and contexts they find themselves in, as well as their personal histories. A study by Fehon *et al* (2005) concluded that exposure to violence and childhood maltreatment can predispose males to behave in impulsively violent ways. This suggests that particularly young male asylum seekers who have fled conflict-rife communities where they may have

witnessed or been party to extreme violence may be more prone to impulsive violent behaviour than those without such a history. This has serious implications for those who may become their victims, such as the UASM who are likely to live within close proximity to them.

Seymour (1998) cites studies that indicate that that between 90% and 99% of the perpetrators of child sexual abuse are male and that 90% to 99.7% of their victims are female (p.415). Most perpetrators are reported to be in their mid twenties or older (Briere 1992). Paedophiles are perpetrators defined as people whose sexual desire is directed towards pre-pubescent children. It is important to note that most people who sexually abuse children are not paedophiles and they have sexual relationships with other adults, homosexual or heterosexual (Child and Women's Abuse Studies Unit 2006). Several types of perpetrators of sexual maltreatment have been described in the literature including six types of female sexual offender (Vandiver and Kercher 2004). Chapter 4 discusses the theories of sexual maltreatment in more detail.

Findings relating to perpetrators

In our study we sought information about the characteristics of the perpetrator, such as their relationship to the victim, their age, gender, and ethnicity. The nature of their behaviour was also elicited, such as whether they had acted singly or in groups and the methods they had used to access their victim (their *modus operandi*). Whether the perpetrator had used rewards for sexual favours was a direct question asked on the self-completion questionnaire to enable statistical analysis of this with variables relating to the psychological impact of the events. There is some evidence to suggest that the adjustment following sexual abuse is not simply associated with the nature of the sexual maltreatment, but that it is mediated by the survivor's level of shame and 'attributional style' (Feiring *et al* 2002).

Number of perpetrators at each event

Of the forty lay participants who were asked in the interview how many perpetrators took part in each event, seventeen (n=17: 42%) reported that there had only been

one perpetrator at each event whilst twenty-three (n=23: 58%) reported that there had been more than one perpetrator present, at least at one of the incidents. Typically the perpetrators in these cases were groups of young men. Others reported that they had only felt in danger for their sexual safety, so there had not been a specific perpetrator as such.

Gender, age and ethnicity of perpetrators

Of forty four (n=44) lay participants who gave the sex of perpetrators, forty two (n=42/44: 95%) reported that the perpetrators were male; only two said the perpetrator was female (one of whom was a foster parent and the other a residential care worker). The participants were asked to give the approximate age of the perpetrators. Table 3.2 shows their responses:

Table 3.2. Approximate age group of perpetrators

Approximate age group	N	(%)
Teenager	12	(24)
20s	21	(42)
30s	12	(24)
40s	5	(10)
Total	50	(100)

Numbers relate to the number of lay participants reporting single and groups of perpetrators

Most (42%) participants believed the perpetrators were in their twenties whereas only ten percent (10%) believed the perpetrators were in their forties. This may be in part due to the relative lack of 'natural' contact the lay participants had with this age group due to the absence of their family, whereas children within families can be expected to have parents, uncles and aunts, and friends of the family in this age group.

Most of the groups of males consisted of a mix of ethnic groups including Arabs, 'white' males, eastern Europeans, Africans, 'blacks' and Afghans. There was one group believed to have been white British. A large majority of perpetrators who were

reported to have acted alone were said to be 'black' of various ethnic backgrounds including black African (from Ethiopia, Somalia, Eritrea, Nigeria, Ghana, Cameroon, Sierra Leon), black African-Caribbean, and black British. Those described as 'Black', or who were not described as 'white' or 'white British' outnumbered 'white' or 'white British' by a ratio of about four to one according to the interview data. Of the four women who reported being raped, three perpetrators were Ethiopian (the same as the survivor) and one rapist was described as a 'black African'. This data should not be used as evidence to reinforce any negative racial stereotypes, but simply be interpreted as being circumstantial.

Relationship of the victims to the perpetrators

The participants were asked what their relationship was to the perpetrator(s) of their sexual maltreatment (Table 3.3). The table lists their responses in order of frequency. Although these findings are not generalisable they suggest the ratios that may exist for African UASM. However, the proportions in each relationship category may indicate that the participants were more willing to participate and discuss their sexual maltreatment if the perpetrator was a stranger, as had been found in other studies. Myhill and Allen (2002) for example, in reporting on the British Crime Survey found that stranger rapes were more likely to be reported to the police.

Table 3.3: Relationship between the victim and the perpetrator

Relationship	Number
Neighbours/cohabitees	17
Strangers	14
Friend of friend	8
Acquaintance	4
Home/hostel staff	3
Foster parent	1
Manager/ employer	2
Classmates	2
Others	6
Total	57*

* Some reported on two or more perpetrators.

Those who were neighbours and cohabittees were in many cases young men who lived in the same hostel or other type of shared accommodation, or who lived in close proximity to the participants but who were otherwise strangers. Some were reported to be visitors of those living in the accommodation, or people who had gained unauthorised entry as a young woman reported,

'The front door (common door) to our flat was not working and these people used to come to our room and knock on the doors. They used to smoke drugs in front of my room. They drank alcohol in front of my room. Sometimes they brought cassettes and asked us to listen to them together' (T31f).

Perpetrators' modus operandi

Perpetrators of CSA are known to use a number of methods to gain access to their victims including care-taking, using bribes, gifts or games, using force or threats, and systematically desensitising children through physical contact, talk about sex, and persuasion. In our study nearly two thirds (n=31) of the lay participants reported in the self-completion questionnaire that the perpetrator had given them 'rewards for sexual favours'; this was often elaborated on in the interviews. One young woman described how the perpetrator had used threats against her after attempts at grooming her had failed:

'I was abused by another Ethiopian while I was living in another hostel. He was very supportive. He used to bring gifts for me. We used to go out together and he used to buy me things. Since I had no family here he was just like a brother and I trusted him. When I denied him what he wanted, he started to threaten me. He used to write me a threatening letter. He was blackmailing me with letter' (T11f).

Some perpetrators were said to use flattery to gain access to their victim, for example a female participant said a man had told her that she could become a model if she let him take her photograph. Others described the perpetrator's modus operandi in terms of having abused their trust (n=8), exploited their weaknesses (n=7), or simply as having seized an opportunity (n=7).

Perpetrator's behavioural profiles

Paedophiles

Paedophilic perpetrators were the least common type among the cases studied. Paedophiles by definition are sexually attracted to pre-pubescent children. Most of our lay participants came to this country at the age of 15 or over and therefore were sexually mature taking them outside the paedophile's sphere of interest. However both the male participants in our study suffered paedophilic abuse: one boy was abused by his English foster mother when he was aged twelve, the second was fondled by his 'uncle's friend' when he was ten. A female participant reported that a female care worker had kissed her inappropriately when she was twelve and living in residential care.

Young male sexual 'predators'

Many female participants described being sexually harassed by young males who lived in the same accommodation or nearby. They were often reported to operate in mixed ethnicity groups (described above) and some were thought to be asylum seekers themselves:

'These people were asylum seekers. Since we were living in the same locality, we used to see each other quite often. As a result they focused their attention on us for sexual abuse' (T36f).

In some instances what appeared to be normal courtship behaviour, such as being persuaded to have a date developed into a situation of sexual assault. Group dynamics had a part to play in several cases, such as described by a Somali woman who recounted how a group of young men had goaded one of their members to rape her when she was sixteen. She did not disclose this until three years later when she confided in a friend:

'... there were boys that lived in the hostel with me and these boys always touch my ass but I used to tell them to leave me alone. And one day I went out to meet my friend and as usual they were standing in the front of one their rooms, so they stopped me and said, "You look sexy" and started touching my

body, so I told them to get lost. So one of them said, "Show her what we are about." He pushed me into the room and the bed and he stood over me trying to unbutton my jeans. I was shouting. At that point his friend said, "I think someone is coming." So they stopped and said, "If you tell anyone I will kill you". So I left and went to my friend's' (B1f).

This incident graphically illustrates how males may use rape to assert their dominance and control over females; it may also give the perpetrator an enhanced sense of personal power and higher status within his group. The perpetrators in this case were reported to be adolescent males thought to be aged between 16 and 18 years and all were believed to be British, although this seems unlikely as hostels designated for asylum seekers are normally allocated exclusively for them (LASC 2006). This case illustrates the degree to which mixed sex accommodation poses serious threats to the safety of girls and young women.

The 'rescuer' or 'father figure' perpetrator

A third type of sexual abuser identified in this study was the older male who was often settled in the UK with British citizenship and the concomitant credentials of being knowledgeable about the British way of life, relatively affluent, and probably married. He was often of African or non-white extraction and frequently of the same ethnic group as the young girls he targeted for sex. His modus operandi was generally found to be one of 'grooming' or befriending and exploiting the girl's vulnerabilities and lack of contact with her fellow country people in the UK. This type of perpetrator seems to particularly exploit her absence of male protectors, such as older brothers, father and uncles whose role he seeks to emulate until he gains then abuses her trust.

Case vignette

An example of the 'rescuer' type of abuser and his modus operandi was described by an Ethiopian girl who had arrived in the UK aged 16, was granted temporary leave to remain for two years and was housed by the local authority in a mixed-sex hostel in south London. The hostel was shared by a number of different nationalities including Jamaicans, Kosovans and Albanians, but only one other Ethiopian. She reported that she had difficulties speaking or understanding English and said she felt

very afraid living in the hostel where men, with whom she had to share facilities, would roam around in their underwear. Feeling afraid in her accommodation and lonely, she took up a friendship with an Ethiopian male aged about 30 who lived outside the hostel and who had British citizenship. He helped her cope with the stresses of her situation and gave her 'presents'. She trusted him because he was also Ethiopian. Hungry for freedom from the restrictions of the hostel she went to his house with him and his other friends and they began smoking and drinking. That evening she reported that he raped her. She identified several aspects of her life that had made her vulnerable to this which were consequential to her situation as an UASM:

'He knew that I was alone or had no one around. I had a language problem and he was helping me in interpreting. Whenever I wanted to go somewhere he used to show me the way, as I was new. He understood my weaknesses and this was how he exploited and caused problem to me. I did not know anything at that time. This was how the problem happened' (T13f).

Use of collaborators to set up a victim

In some instances participants suspected that the incident of sexual maltreatment had been a deliberate premeditated plan contrived between the perpetrator and a third party (usually known to the victim) to facilitate a serious sexual assault. In these cases the person collaborating with the perpetrators often portrayed themselves as friendly and concerned for the victim's welfare. Survivors usually describe having trusted the collaborator and/or perpetrator because they were of their nationality, were older, or because they were female (the collaborator). An Ethiopian refugee who was raped when she was sixteen years old by a man of about forty described her experience thus:

'I think it was my friend who exposed me to the problem. Had I not been left alone by my friend I would not have been raped, she might have discussed about the process with her brother [the perpetrator] in advance' (T8f).

Another participant recounted a similar story of sexual abuse occurring following a friendship with the perpetrator of a few months:

'...there were 3-4 people who were his friends, there were also two women with them and that's why I trusted them. I knew one of the men who introduced me with the rest of them. They left me with him and went home. I thought he would drop me home because he knows where I lived, but the story became different' (C5f).

Although this girl narrowly averted being raped she suffered severe psychological effects afterwards including an inability to trust and form relationships with others.

Effects of sexual maltreatment

Psychological effects

To identify how sexual maltreatment had affected the lay participants the self-completion questionnaire asked, *'Have you experienced any of the following problems since your experiences of childhood sexual abuse or sexual assault, or a near miss?'* The results are listed in Table 3.4 in order of frequency.

Table 3.4: Psychological effects of sexual maltreatment as a minor

Symptoms /effects	N	(%)	Total
Symptoms of mental distress	39	(76)	51
Lack of self-esteem/ confidence	33	(67)	49
Persistent nightmares	28	(56)	50
Difficulties finding/ keeping friendships or sexual relationships	28	(55)	51
Amnesia for event or the time around the event	26	(52)	50
Feeling life was not worth living	26	(52)	50
Problems concentrating leading to under achievement	26	(52)	50
Lack of interest in sex, fear of intimacy	20	(41)	49
Eating disorder – anorexia or bulimia	17	(34)	50
Psychiatric symptoms requiring medication or hospitalisation	12	(24)	50
Difficulties integrating	11	(22)	49
Self-harm/ attempted suicide	9	(17)	52
Drug or alcohol abuse	1	(2)	50

These findings confirm that a large number of these young people suffered significant mental health problems. Three quarters of them admitted to having suffered symptoms of 'mental distress' such as anxiety, depression, sleeplessness and phobias. Other more specific symptoms or difficulties were also common. Worryingly over half reported having felt life was not worth living and almost one in five had harmed themselves or attempted suicide. A large proportion reported a lack of concentration leading to under achievement. A third reported eating disorders, thought to be unusual in non-western cultures (Walker 2005). A quarter reported receiving medication or hospitalisation for their mental health symptoms suggesting their symptoms must have been severe. Half (51%) reported having five or more psychological symptoms or difficulties. However it is possible that these were experienced at different times.

Correlation analysis was performed which showed (unsurprisingly) that many symptoms were correlated with one another (and were statistically significant, $p < .05$). However, some symptoms were more strongly correlated with all or the vast majority of others, these were: eating disorders, amnesia for the event or the time around the event, and a lack of interest in sex. Many studies of the effects of CSA have shown a positive association between a history of CSA or sexual assault in childhood with drug and alcohol dependency (Briere 1992). However, this association was not revealed here which illustrates the significance of cultural factors in mediating effects.

Further exploration of the quantitative data was done to identify which factors were associated with psychological symptoms. Correlations were found between the perpetrator giving 'rewards for sexual favours' and the survivor having difficulties finding or keeping friendships or sexual relationships, lack of interest in sex, and a lack of self-esteem or self-confidence. Some survivor's may have had a sense of self-blame having accepted some kind of 'reward', and this may have led to avoidance of relationships. The types of reward were revealed in the interviews to be things like 'gifts', being treated well, help with interpretation and other types of supportive behaviour. Sadly their difficulties in relationships and poor self-esteem and confidence often led to increased isolation and further mental distress. A

participant who had been raped by the brother of a new Ethiopian female friend that she had trusted described the impact this incident had on her capacity to trust men:

'I cannot trust men. I have a negative feeling for romance when men try to approach me, I feel as if people are trying to cheat me, or trying to do something bad to me when they approach me for romance. I have a bad feeling' (T8f).

This young woman also described feeling 'humiliated' by the incident and consequently did not tell anyone.

The number of mental health symptoms and problems they had as listed in Table 3.4 were counted and dichotomised at the median ($n=5$); this new variable was then used in cross tabulations to identify what factors were related to this. A correlation was found between having five or more mental health symptoms and there having been multiple perpetrators involved in their sexual maltreatment; 73% of those who had multiple perpetrators had five or more symptoms compared with 24% of those who did not ($p<.01$). Those who were given 'rewards for sexual favours' (which included treats and support) were also more likely to have five or more mental health symptoms (68% versus 26%; $p<.01$). Those who had five or more mental health symptoms were more likely to report having suffered physical health problems as a consequence of the abuse (44% versus 11%; $p<.01$).

Self-harm was mainly associated with eating disorders, amnesia, psychiatric symptoms requiring hospitalisation or medication, feeling life was not worth living, lack of interest in sex, lack of self-esteem or self-confidence, and problems concentrating. Many of these symptoms when found together constitute a picture of depression. However, Ethiopians tend not to separate health into physical, mental and spiritual realms but have a holistic understanding of it. For example, they believe '*...health is happiness and happiness is healthiness*' (Papadopoulos *et al* 2004: p.65). Mental illness, or 'madness' as it is often perceived to be in its severest forms, is highly stigmatised in Ethiopian culture. The stigma exists because mental illness is not seen as a sickness inflicting an innocent victim, but as punishment to the victim's family or community for moral transgression, and as such it is perceived

as casting a shadow of shame upon them all. This is why symptoms of mental illness, such as depression are hidden and not talked about in their culture. Their '*punishment for sin*' understanding of mental illness helps explain why many from the Horn of Africa do not believe individual psychological treatment, such as counselling or psychotherapy is appropriate whereas drinking holy water, or being anointed with it and praying is.

Physical health effects

The lay participants were asked if they had suffered any physical health problems as a consequence of their sexual maltreatment as an UASM. Just over a quarter (n=15: 28%) reported that they had. They were then asked to specify what the physical health problems were; of fifteen (n=15) participants who responded the most common symptom was 'headache' reported by thirteen (n=13) of them. Other symptoms or problems were sleeping problems (n=4) and appetite or stomach disorders (n=3); seven (n=7) reported two or three symptoms. Taken together the collection of symptoms in some cases suggests that stress was the underlying problem. Kimerling and Calhoun (1994) found that survivors of sexual assault tended to more frequently report physical symptoms during the first twelve months after the assault and to perceive their health as worse than non-survivors. They speculated that either they did indeed have worse physical health due to the immunological effects of stress, or they found it more socially acceptable to seek medical rather than psychological treatment. Another finding was that even though symptoms declined, their medical service use did not decline indicating that they used medical services for reasons other than physical health problems.

The physical impacts of sexual maltreatment included one reported case of pregnancy followed by a termination of pregnancy. None reported that they had suffered a sexually transmitted disease subsequent to their sexual maltreatment, or to having sought advice from a genito-urinary medicine clinic.

Professional help-seeking

Of fifty lay participants (n=50) who responded to the question in the self-completion questionnaire, 'Did you seek professional advice about what happened to you or its consequences from anyone?' just under half (n=23) reported that they had. Thirty one lay participants said they had a social worker; fourteen (n=14) indicated that they had disclosed it to a social worker. Few had sought help from their GP (n=7). However, in their interviews several revealed that although they went to their GP after the event they did not actually disclose their sexual maltreatment. Generally they consulted their GP regarding somatic complaints, sleeplessness and depression, which they believed were related to the incidents. Such complaints are common among those with post-traumatic stress disorder and Herman (1992) describes the commonness of '*disguised presentations*' among patients with post-traumatic stress disorder. This is in part because dissociation with partial forgetting is common among survivors and in part because survivors frequently prefer to conceal such a history because of fears of the consequences of disclosure (chapter 5). Other studies have also shown an association between sexual abuse and somatic complaints (Dickinson *et al* 1999; Kimerling and Calhoun 1994; Nickel and Egle 2006). Summerfield (in Ingleby 2005) notes that somatic symptoms are the most frequent manifestations of distress across the globe.

Two participants sought help from two different professional sources and one from three (GP, a social worker and a civic centre). However, most of those who sought help (n=19/23) had sought it from a single professional source. Only one participant sought help from each of the following: a therapist, a psychiatrist, a teacher, a 'befriender' and someone at a 'community centre'. This indicates that, despite a high degree of psychological disturbance and some physical and social consequences of their sexual maltreatment, many of these young people attempted to cope with it without professional support.

Circumstances and support at the time of the incidents

The lay participants were asked what support they had around the time of the incidents of sexual maltreatment to ascertain whether this was related to their vulnerability.

Support from social services

In their review of studies on UASM, Ayotte and Williamson (2001) reported that not all UASM in the UK are allocated a social worker. This finding was replicated in our study where only thirty-one (n=31; 60%) of the lay participants reported that they had a social worker at the time of their sexual maltreatment / near miss. However, as a direct question as to whether they had been allocated a social worker was not always asked more may have had one. Some of those who lived independently in flats and hostels described having had a 'key worker'. This finding suggests that many of the UASM in our study at the time of their sexual maltreatment were being cared for under Section 17 of the Children Act (1986) under which a social worker does not always have to be allocated.

Support from community organisations

A majority of lay participants also reported that they had not been in contact at the time with any community organisations that are run specifically for their country people in the UK, such as the Eritrean Community in the UK or the Ethiopian Community Centre in the UK. The overwhelming reason for not having contact with these organisations was ignorance about their existence, as one of them said, 'I asked no one to tell me about these organisations. No one had told me either. I had no friend or anyone to tell me at that time' (T16f). Some felt embittered that they had not been introduced to them as they felt such contact would have helped protect them from sexual maltreatment.

Contact with trusted adults

When asked how many good adult relationships with family or friends they had in the UK around the time they were first sexually maltreated, just over a quarter of those who responded (n=14/51) reported that they did not have any trusting relationship with any such adults. Half (n=26/51) had one or two relationships with

trusted adults and six (n=6/51) had three or four relationships. Of those who had contact with a trusted adult (n=37), most were in contact daily (n=15) or weekly (n=18), and the rest had contact with them monthly or less frequently. We did not ask them to specify who these adults were.

Conclusions

We can conclude that the young people who contributed to the SAFER UK study were often leading very isolated, under-supported and unhappy lives. We have no reason to believe that their stories and experiences are in any way peculiar to them as youngsters from the Horn of Africa; it seems likely that UASM from other countries may suffer similarly. The lay participants painted a picture of desperation in which their isolation and loneliness led them to fall victim to predatory abusers many of which seem to have honed their predatory skills to deliberately target these children and young people. Their stories also highlight how restricted some of their lives had become after their experiences of sexual maltreatment. This appears to have limited their opportunities for development at a time when they should have been venturing into the rich and varied social terrain open to most adolescents as they move toward adulthood. More needs to be done to ensure that UASM are protected and given the opportunity to develop into healthy and happy individuals. In particular UASM need to be provided with safe and secure accommodation with high levels of supervision and monitoring in their first year in the UK when they appear to be most vulnerable, irrespective of age.

Chapter 4

Attribution: theories and beliefs about causation

Introduction

Academics in several disciplines have been involved in researching child sexual maltreatment and developing attributional theories for it, including psychologists, psychotherapists, sociologists and anthropologists. In this chapter we outline the main attributional theories derived from a review of the academic literature. We then present and discuss the study participants' views regarding what they see as the vulnerabilities of unaccompanied asylum seeking minors to sexual maltreatment in the UK. Understanding the underlying causes of child sexual maltreatment is crucial for developing effective measures to prevent it from occurring and recurring, and for shaping appropriate and effective therapeutic and supportive interventions for survivors.

Attributional theories

Historically there have been two broad models of CSA attribution developed over the past three decades or so by academics in Europe and America; these are the medico-legal model and the social model. Another way of organising the numerous attributional theories has been to classify them as 'single' or 'multi-factorial'.

The medico-legal model

Theories within this model locate the causes of CSA either within the individual family, which is labelled as 'dysfunctional', or in the psychology of the individual perpetrator, who is labelled as 'deviant', 'sick' or 'perverted', as described by a Royal College of Psychiatrists' report:

'In common with all other perversions, the observable behaviour is a result of a particular constellation of unconscious forces in the individual's mind. The act

is the individual's own way of dealing with particular anxieties and conflicts. Paedophilic abuse and incestuous sexual abuse can serve defensive functions by providing momentary relief from the perpetrator's overwhelming fears and anxieties' (1994: 7-8).

The individual and family dysfunction- based theories are criticised as being unable to explain why it is that men sexually abuse children far more than women do; why children and predominantly girls are the chosen target for relieving the abuser's fears and anxieties through sexual acts; why it is that rape and sexual abuse are shrouded in victim shame and secrecy; and why it is that victims are often blamed (Finkelhor 1984). Failure to adequately explain why it happens, according to Finkelhor, is due partly to the tendency for research to focus either on the victims or the perpetrators, and rarely to examine both simultaneously, and due to a lack of research on the sociological contexts in which it occurs. He remarked that '*few theories have tried to address the full complexity of the behaviour*' (p.36).

There has also been research to identify biological determinants and predisposing factors to paedophilia, such as hormonal 'alterations', and organic brain disease and intoxication both of which may impact on inhibition. The Royal College of Psychiatrists concluded however that there is, '*a consensus that aetiology is likely to be multifactorial*' (1994: 10).

Social and multi-factorial models

There has been a shift away from what are often construed as simplistic single factor attributional theories of sexual maltreatment towards models that include multiple factors located in personal, interpersonal and socio-political dimensions (Hooper and McClusky, 2000). These authors make a case for an interdisciplinary approach that recognises the complex nature of the problem and the need for a synthesis of the personal and political dimensions of the issue. They cite Orbach's (1998) argument that political and emotional literacy, rather than being seen as alternatives should be viewed as being mutually enhancing and complementary in nature.

We would argue that for a theory of sexual maltreatment to be useful, it should not only have explanatory power but also the capacity to be applied to the development of prevention and therapeutic strategies. Such a theoretical model therefore needs to be able to explain perpetrator motives, choice of 'sexual' object (where sexual drive is the motivator), the contexts in which it tends to occur and the social reinforcement of behaviour. Attributional theories based on social models attempt to explain why it is that males commit about 95% of all sexual offences against children (Finkelhor and Russell 1984; Grayston and DeLuca 1999). These theories postulate that CSA should be perceived '*...as a social ill relating to the position of women and children in society and male sexual socialization, not as individual pathology*' (Browne 1996: 42-3).

Feminist perspectives

The radical feminist perspective on rape and CSA is that they are ways of subordinating women, power being the dynamic rather than sexual gratification. Brownmiller (1975) asserts that '*...[rape] is nothing more or less than a conscious process of intimidation by which all men keep all women in a state of fear*' (p.15). She likens the rape of women to the lynching of blacks as a means of '*psychological intimidation*' (p.254) with the purpose of maintaining their subjugation. Stigma, shame and victim-blaming silences the victims (usually women and children) which is reinforced by their fear of rejection and social ostracisation, a frequent consequence of disclosure. An online commentary locates the roots of shame in patriarchal gender relations where women are viewed as the property of males. It attempts to explain the silencing of victims thus:

'Rape stigma is a direct result of male privilege. As long as women are assumed to be the property of men, a woman's rape is a defeat to whoever "owns" her. According to this warped worldview, a rape victim who speaks out about her ordeal shames not only herself, but everyone who was supposed to have been controlling her (her husband, her male relatives, her community, and even her nation)' .

<http://bamber.blogspot.com/2005/06/rape-and-male-hegemony.html>

This article concludes that what may seem to be irrational reactions to rape seem rational if understood as being reactions to a threat to male privilege.

Seymour (1998) presents 'an extended feminist perspective' on CSA that explains why males constitute the vast majority of perpetrators and why it is often children who are targeted. She draws on the work of Chodorow (1978) amongst others who posit that it is predicated on the development of masculine sexual identity during which male children seek differentiation and individuation from the primary carer (usually female). To support this argument Seymour cites Margaret Mead's (1963) study of the Arapesh – a society in which males were expected to care for children equally and where society was generally non-violent, and rape was unknown.

According to a study by Hite (1981: 60) masculinity (in most societies) means being '*...in control, autonomous, not dependent and dominant*'; males are taught not to express their emotions, needs or weaknesses in so doing they become what Seymour describes as '*emotional illiterates*' (1998: 420). Consequently males have to get their emotional needs met indirectly, which is often, Seymour argues through '*the exertion of power over others*' (ibid: 421). Seymour cites Hite (1981) whose study found that '*One of the reasons male respondents... gave for liking and wanting sex, was the sense it gave them of being accepted*' (Seymour 1998: 423). For many males she argues, sex is the only socially legitimate means of expressing their feelings and of satisfying their emotional needs. Fine, but the question remains as to what makes some men feel justified in using another person for their own gratification without the other's explicit consent. The fact that some men get pleasure from a non-consensual sexual act whilst inflicting pain and emotional distress upon the other suggests either sexual sadism or a need for gratification through power and domination. Although these psychological traits are located within individuals, their development occurs within socio-cultural contexts where male dominance and aggression has been legitimated, and in which punishment for sexual transgression is frequently avoided by perpetrators.

In reviewing the research on child sexual abuse, Seymour (1998) found a number of studies that indicated that sexual abuse offenders lack empathy. Poor empathy removes or weakens an internal restraint from abusive behaviour – one of

Finkelhor's four preconditions to sexual abuse that have to be met before abuse can occur (see below). Also men, unlike women, are socialised into wanting sexual partners who are smaller and younger than them, and also '*...to take the initiative in sex, be dominant and to overcome resistance*' (p.425), all features of CSA.

Seymour also cites Abbey (1982) whose study appears to support the argument that males have more difficulties in differentiating between friendly behaviour and seduction. Seymour picks up on Howells (1981) point that males may misinterpret positive behaviours towards them as sexual, described by Howells as 'attributional error'. Attributional error is supported by a female lay participant in our study who said, '*In our country we approach men as friends not in a sexual context, but men misunderstand this relationship*' (T11f).

Panton's (1978) study on the personality profiles of offenders was thought by Seymour to '*support the argument that their primary motivation is to service their needs for a sense of self-worth*' (1998: 419). Another study she reviewed (Peters 1976) '*indicated a feeling of inferiority among these men along with strong dependency needs and inadequacy*' (p.419). Seymour states that, '*Males are socialized into believing that power, dominance, and control are measures of their success and worth as men*' (p.420). Therefore males who have poor self-esteem and insecurities about their masculinity may seek to dominate and exploit others through their sexuality.

Finkelhor's four preconditions model

Finkelhor's model posits that there are four preconditions the perpetrator of child sexual abuse must meet if sexual abuse is to occur. They are that a potential offender needs 1) to be motivated to engage in sexual activity with a child; 2) be able to overcome internal inhibitions against acting on the motivation 3) be able to overcome external barriers to acting on the motivation; and 4) must be able to overcome or undermine the child's potential resistance to it. The main limitation of this model is that it is essentially a descriptive framework which incorporates a range of dissonant theories and observed clinical data. However, it provides a useful schema for preventative work and we have adopted it for this study.

Common theories and beliefs about attribution

The general public's beliefs and attitudes toward CSA and sexual assault, such as rape, are shaped by myth and the media and have been demonstrated to impact on the nature and frequency of its occurrence and the responses to it by victims, perpetrators and society as a whole (Finkelhor 1986). They are therefore important to consider. The two main myths are that men cannot control their sexual urges and that females are to blame for their own sexual victimisation. These two myths are interdependent: if males cannot control their sexuality then they cannot be blamed for sexual misdemeanours, if they are not to blame then it must be the fault of the females for luring them into such acts and this then puts the onus on females to prevent unwanted sexual attention (Fontes 2005). A poll by ICN for Amnesty International (2005) which interviewed over a thousand UK adults by telephone confirmed the tendency to blame the victim. Its findings revealed that a considerable proportion of respondents felt that victims are at least partially to blame because of their clothing, their alcohol consumption, their perceived promiscuity, personal safety and whether the victim had clearly said "no" to the man. Attitudes to this varied between age groups and social classes with older age groups and lower social classes being more likely to apportion some blame on the female victim. However, they reported few gender differences in attitudes, the main difference relating to men's opinion was that dressing in certain ways makes women responsible for being raped, a belief often demonstrated by those she discloses it to, such as a judge or parent.

A study by Finkelhor (1984) of Boston parents' beliefs and knowledge about CSA revealed that parents were most likely to attribute CSA to 'mental illness' in the perpetrators – an example of the medical model. He conjectures that this is because they cannot explain it any other way and because they were seen to be in need of treatment (p.100). Such a belief distances 'normal' people from abhorrent behaviour but contradicts the reality of sexual maltreatment which is mostly perpetrated by otherwise 'normal' men and women. Clearly there will be different myths and beliefs in different cultures therefore practitioners need to ascertain what these are in each individual case.

Beliefs about causation and their impact on effects

Perceptions and beliefs about sexual assault and sexual abuse impact on victims' and professionals' responses to them. A clear example of this is described by Fontes in citing Feiring *et al's* (2002) study findings, '*The degree of shame and attributional style (cognitive appraisal of the event) were found to be even more important than the severity of the abuse in determining how children fared*' (Fontes 2005:137). This study was of 147 child and adolescent victims of CSA assessed on discovery of the abuse and again a year later. Feiring *et al* (2002) found in their study of the impact of shame and attributional style on the symptoms of CSA victims that girls were more likely than boys to have experienced severe abuse and were more likely to feel shame.

<http://www.yorku.ca/ycom/gazette/past/archive/2000/112900/issue.htm>.

This supports the hypothesis that patriarchal cultures socialise females to be submissive and are consequently more likely to take the blame (and be blamed) for their sexual victimisation.

Fonte's (2005) analysis explains why the family of the rape victim may feel ashamed if the culture interprets negative events occurring to a family member as punishment for another family member's, or even an ancestor's earlier moral transgression. This interpretation of bad events is common in cultures, such as those in the Horn of Africa with a collective rather than an individualistic social structure. It seems probable that such common attributional theories will have a major influence on the type of corrective action or intervention people affected by sexual maltreatment from these two divergent cultural types will seek or accept.

Lay participants' perceptions of their vulnerability

Lay (and professional participants) were asked to describe the factors they believe contribute to the vulnerability of UASM to sexual maltreatment. This data should be useful in further developing culturally sensitive and appropriate sexual maltreatment

preventive programmes and therapeutic interventions. They described factors relating to the personal, interpersonal and socio-cultural domains.

Personal and cultural factors

Several females believed that their socialisation into submissive roles in their home country was an important factor in their vulnerability to sexual maltreatment:

'We came here with our culture. We are shy and this could make us vulnerable. ...from our cultural point of view we are not open. We are scared to express ourselves. Inability to speak openly has affected us and made us vulnerable to sexual abuse' (T11f).

A lack of knowledge as to their human rights in the UK was also reported to lead to crimes against them going unreported:

'There are crimes committed and ignored without action taken against perpetrators. We just want to ignore things and struggle with day-to-day life. We do not know about our rights. We should not compromise with our rights. We ignore when crime is committed on us' (T23f).

Many were sexually maltreated soon after their arrival in the UK when they were at their most vulnerable (chapter 3). Acquiring knowledge about human and social rights in the UK and developing personal power requires access to appropriate learning experiences and resources.

The personal factors mentioned were predominantly aspects of themselves or their circumstance that were outside their own sphere of control, things they could not change, such as being a female and young (Table 4.1). Many recognised the significance of their lack of knowledge about their rights and ignorance about the dangers of being sexually manipulated or abused. Some blamed themselves for their maltreatment, as described by a young Ethiopian woman:

'The other reason why it happened to me could be because of the way we dress up. It could be because of the way we talk, smile or laugh. It could be because of the way we approach men' (T11f).

Table 4.1: Personal factors perceived as contributing to vulnerability

Personal factors	N
Ignorance (of sexual abuse/ rights)	22
Being without a family in the UK	19
Loneliness and isolation	18
Being female	15
Young age	14
Being a foreigner	9
Cultural reasons	5

**Participants may have given two or more reasons for their vulnerability*

Circumstantial factors

A previous study of 16 and 17 year old UASM (Munoz 2002: cited by Lees and Lovett (n.d) had found that a lack of central government funding often led to the use of emergency accommodation and the allocation of the landlords as unofficial guardians. The risk of sexual maltreatment due to the lack of monitoring and support highlighted in Munoz's study was echoed by our own study. Indeed, the most common circumstantial factor (mentioned by 19 participants) thought by our lay participants to have made them vulnerable to sexual maltreatment was their housing situation. Several described the dangers of living as an 'underage person' among adults in mixed sex, mixed ethnicity hostels and hotels. Others felt that their vulnerability was enhanced by a lack of professional supervision. Open access to shared accommodation was also a problem. An Ethiopian female described being repeatedly sexually harassed by a cohabitee's boyfriend who was allowed into their female-only house:

'Yes, I got very angry because if my key worker was doing her job properly, if she followed up the case and if she was listening to me and asked me about my problems, if she was making sure that no male should be allowed to our house I wouldn't have suffered like this' (C22f).

However, the children who lived in foster care were not exempt from sexual danger. A male Somali participant reported lack of monitoring as contributing to his

vulnerability to being repeatedly sexually abused by his white British foster mother when he was twelve. He said, *'Sometimes I was on my own and my social worker was not visiting me a lot and there was hardly any monitoring'* (L2m).

Being lonely and without their family was also seen as a contributory factor by many lay participants. They felt it made them more vulnerable to being enticed into potentially sexually dangerous situations because of unmet social and emotional needs, particularly when they first arrived when they had no social networks:

'The thing that led up to the incident was that I was not living with my family. Loneliness could lead to sexual abuse. This man was observing my movements when I was going in and out of the house. He knew that I was a refugee. He knew that no one would help me if something happened to me. It seems the person was experienced in this sort of thing i.e. abusing women. I was disturbed at the beginning. I think loneliness and living alone without a family was the factor that led up to the incident' (T15f).

Another issue raised by this participant is that of not having the protection of other family members, particularly perhaps their father, brothers and uncles. The wish to replace such male relatives may be a factor underlying their tendency to get involved with older male perpetrators, as an Eritrean girl described:

'He [the perpetrator] knew that I was alone or had no one around. I had language problem and he was helping me in interpreting. Whenever I wanted to go somewhere he used to show me the way, as I was new. He understood my weaknesses and this was how he exploited and caused problem to me' (T13f).

Loneliness and isolation was identified in our previous study of Ethiopian refugees to be one of the greatest problems they had to contend with (Papadopoulos *et al* 2004).

Other social circumstances that were thought by the lay participants to increase their vulnerability included having poor English language skills (n=9), being a refugee

(n=2), and being an illegal worker (n=1). Again most of these factors were outside of their control or could not be altered immediately. Two young women reported being abused by men who were either their employer or supervisor, one of whom took advantage of her illegal working status to abuse her:

'When I went to him to collect the money I worked for he was not paying me right away; I had to go there repeatedly. He used to say something which I did not want to hear from him. He used to say that I was pretty and so on and used to touch me. I was against these deeds and did not like it. His action was a nuisance to me and it was disturbing me. I left the job because he did this repeatedly to me' (T19f).

Factors related to the perpetrator

Very few lay participants mentioned aspects of the perpetrators that they felt contributed to their sexual maltreatment. However, those that did do so mentioned the perpetrator's youth, their poor upbringing, lack of respect for others, lack of access to other females, the sexual proclivity of other girls, and the perpetrator's belief that the victim would not tell anyone. A participant suggested that the perpetrators may be unaware that sexual abuse and sexual assault are crimes in the UK, and that it has a bad effect on victims.

Many lay participants identified a number of factors that combined together to contribute to their vulnerability to sexual maltreatment:

'The main thing that led up to the abuse was that all the asylum seekers living in the hotel were adult. ...I was 16 when I arrived in this country. I did not bring my birth certificate. I did not know that I should have brought it with me. Therefore, it was decided that I should live with adults. The perpetrator was aware that I was underage. I think the reason why he wanted to abuse me was that he thought I was young and easily manipulated. The other reason was that he felt I would be scared to tell anyone about it. I think these were the reasons why he tried to rape me' (T23f).

This case illustrates the dangers of wrongly assessing someone's age when it is disputed.

Sometimes other asylum seekers were sources of information about sexual abuse, for example a lay participant was told by a fellow asylum seeker that young men target Ethiopian female residences like hostels in search of 'dates', and that they '*attract young women by giving treats*' (T15f). The stories recounted by the lay participants certainly suggest that they were being deliberately targeted in many instances, as there appeared to be considerable premeditation.

Factors relating to professional attitudes and beliefs

Some lay participants felt more vulnerable to sexual maltreatment when their social worker or key worker did not take action when they told them they were being abused, or were in fear of an attack, as illustrated by an Ethiopian female participant:

'A man was following me. He used to watch my movements when I was going in and out of the house. The social worker was a Habesha [Ethiopian] and she was not supportive when I told her about this problem. ... I cannot understand why she was reluctant to help me' (T15f).

The Royal College of Psychiatrists (1994) reported that when professionals are confronted with suspicions or accusations of abuse they may experience '*...disbelief, shock and inability to process the unbearable information [this] may lead some professionals to close their minds to the possibility of sexual abuse*'. They also suggested that the powerful dynamics inherent in CSA highlight the need for '*...skilled support, both technical and emotional, for professionals working in this field*' (ibid: 18).

The reported failure of some social workers to take appropriate action on behalf of our lay participants in relation to other issues sometimes had the serious consequence of creating a lack of trust resulting in the participant not reporting sexual maltreatment:

'Yes, I had a social worker, but I did not tell about the sexual abuse I experienced. Since my question for foster parent was unsuccessful, I thought they would do nothing regarding sexual abuse. Therefore I did not tell my social worker about the abuse. I had a notion that my complaints would not be heard by these people' (T33f).

This illustrates the importance of social workers being seen to be effective and taking their concerns seriously if they are to gain the trust of the child. They should also give the child opportunities to talk in private irrespective of the wishes of foster carers with whom the child/young person may have a problem. A young woman explained that, *'I did not tell her [the social worker] that I was at risk of sexual abuse because the foster parents were always there when I told her my problems' (T27f).*

Professionals' perceptions of vulnerability

The key professionals identified a variety of factors that they thought contributed to the vulnerability of UASM to sexual maltreatment, some of which were similar to the lay participant's (Box 4.1). However, few had much professional contact with UASM and these participants found it difficult to consider what their specific vulnerabilities might be. Many gave examples of vulnerability to sexual maltreatment within the family and social contexts of settled British people.

Box 4.1: Factors believed by professional participants to contribute to vulnerability of UASM to sexual maltreatment:

- Psychological and behavioural factors: loneliness, fear, timidity, submissiveness, previous sexual abuse, promiscuity, peer pressure
- Lack of appropriate knowledge about human rights and the help available etc; underdeveloped social skills
- Politico-legal factors: immigration issues, policies on employment etc
- Socio-economic factors: being a refugee, social isolation, poverty
- Historical factors: previous traumatic experiences
- Cultural factors: stigma, taboo, protocol etc

Psychological and behavioural factors

Designated teachers are responsible for the co-ordination of child protection procedures within each school and for liaison with social services and other agencies. A designated teacher described a very sad case in her school that she used as an example of how traumatic events back home can impact on refugee children's vulnerability to sexual maltreatment:

'We had one girl who was the only survivor of a primary school massacre in Angola and so what they bring in terms of disturbed behaviour, all that presents to people is very angry disturbed behaviour which then in school can lead them to being seen as difficult, but can out of school and at home lead to physical abuse if they're not conforming in a way. And sometimes as well very early sexualised behaviour which is difficult because you come into the fourteen, fifteen year olds as to where the abuse sits' (KP8).

Sexualised behaviour was seen to be a response to earlier abuse and as a way of gaining adult attention.

Differences in sexual taboos between the country of origin and the UK were thought to impact on the vulnerability of males to homosexual abuse, as described by an Ethiopian professional participant:

'I think the culture in my country [Ethiopia] is that nothing happens to young men because in my country homosexuality is a taboo. No one would rape them.... So in my country they are free. When they come to this country... they are aware that they could be raped, or that people may try to have sex with them' (KP4).

Socio-economic factors

Poverty, poor housing, and being needy were seen as lowering resistance to abuse, as described by a designated teacher, *'...and so it's worth putting up with because you are warm, fed and dry kind of stuff. That's what it seems, so there seems to be a lower resistance' (KP8).* Finkelhor's fourth precondition was the need to overcome

the child's resistance to sexual abuse; clearly if this is diminished they are more vulnerable. Therefore it is important that UASM know they have the right to have their physical and emotional needs met without needing to trade sex for this. Clearly they need access to safe, supportive, adult attention which over time some obtained. However, their vulnerability to sexual exploitation and abuse is at its height on their arrival and during the early months, as explained by an asylum support team manager:

'It is easier if you like, for a potential abuser to groom somebody who is not from this country, doesn't speak the language, who doesn't really understand what the authorities are about etcetera because they can instil a certain level of fear in them that they maybe wouldn't be able to... Where the indigenous population will have contacts with lots of adults that they can talk to that will protect them, whereas these young people, unaccompanied children particularly, particularly upon arrival into this country and before they've established networks they are very isolated. So an adult who pretends to take interest in their welfare could very easily win over their trust and their time, which could then of course lead onto something much more concerning' (KP7).

Racism and discrimination against asylum seekers whipped up by the media was also thought by two of the eight key professionals to contribute to their vulnerability.

Politico-legal factors

Delays in UASM's asylum application decision was also thought to increase their vulnerability, as many of the UASM applications fail, or they are only given temporary leave to remain until they are aged eighteen (chapter 1). Rather than risk waiting until they are eighteen and being deported, some UASM were reported to seek a longer- term future in the UK by planning to stay as an illegal immigrant. Illegal immigrants are very vulnerable to exploitation (<http://tinyurl.com/24zxxg>). Being given an early decision on their asylum application was felt to be less likely to lead to this outcome.

Professional beliefs

There was some suggestion that sexually maltreated UASM would be likely to inform those who cared for them in the UK of any maltreatment, as a professional participant explained:

'Certainly I would be surprised if any of them [UASM] had been withholding information which they hadn't disclosed. It may well be that you find something different, but I know for example that after a year or so most of them had a relationship with their foster carers which allowed really quite intimate disclosures and there was quite a lot of life story work being done with the social workers with them in which they were quite forthcoming' (KP1).

Clearly this is not a view that would be shared by many of our lay participants who were survivors of sexual maltreatment for whom fear and other factors often prevented disclosure to the professionals or others who cared for them.

Discussion

It could be argued that male asylum seekers may be more prone than settled males to commit sexual assault and sexual abuse if, as some theorise, *'Men tend to have sex as a form of reconfirmation when their ego has encountered any kind of rebuff'* (South Eastern Centre against Sexual Assault 2003). Papadopoulos and Gebrehiwot's (2002) study of Ethiopian refugees lends some support to this hypothesis. This study found that male Ethiopian refugees' egos appeared to be particularly severely damaged by the experience of being an asylum seeker in the UK. Asylum seekers at the time of this study were not allowed to work whilst waiting for a decision on their claim for asylum, they usually had little money for recreation, and many were without a sexual partner. These deprivations are likely to block many of the normal channels for expressing personal power and for gaining self-esteem. It is possible therefore, and in line with feminist attributional theories, that these men may seek to fulfil their unmet emotional needs through sexual activity. This would not be a problem were it not for difficulties finding suitable partners consequent to their poverty, living conditions, and lack of social outlets. Additionally, Papadopoulos and Gebrehiwot (2002) found that female refugees from Ethiopia

preferred not to date men from their own country as they perceived them as wanting to maintain traditional gender roles and power differentials which they often welcomed the opportunity to escape. These factors taken together may have contributed to the vulnerability of our female lay participants to forcible or unwanted sexual attention, particularly from African asylum seeking males. If these young women and girls were the only ones available, some of these young males may have been tempted to have sexual contact with them irrespective of their wishes. This behaviour may be reinforced by the fact that rape and forced marriage were customary behaviours in their homelands (although now without legal sanction) as are gross gender inequalities (see Chapter 1).

Conclusions

The insights of young victims of sexual maltreatment into the factors that they believe made them vulnerable to sexual maltreatment are rarely obtained in studies of this issue our participants' accounts therefore are particularly valuable in helping further the theories of sexual maltreatment. They have for example, reaffirmed the importance of a holistic approach and of linking the personal, interpersonal and socio-political dimensions of sexual maltreatment. Their accounts also highlight the dangers of ignoring factors related to ethnicity, culture and immigration status which they demonstrate as having a clear impact on sexual maltreatment incidents, including causative factors; its disclosure; its after-effects; and on help-seeking behaviours. Their accounts also indicate the importance of not adhering to white Eurocentric norms relating to sexual maltreatment. For example, when assessing the significance of age differentials between the perpetrator and their victim consideration needs to be given to power differentials based on ethnicity, culture and immigration status.

Chapter 5

The impact of fear on disclosure, health and integration

Introduction

Fear is one of the most powerful emotions experienced by mankind; it stimulates a flight or fight response aimed at protecting the person from something perceived to be threatening. It is an adaptive response providing that flight is towards a safer situation, or that the fight is against a threat that the person has the capacity to overpower. If not, fear is liable to increase an individual's vulnerability to further fear and anxiety-inducing experiences. Parents or other caretakers who send a child to another country for asylum do so in the belief that the child will be safer from harm and will have a better future than in their homeland. The unfortunate reality is that many UASM have to face life in a strange country where customs and beliefs are often diametrically opposed to their own, with difficulties in communicating and understanding the social system; a situation often endured with little support. They also are forced to face an uncertain future with little power or control over their circumstances. The whole experience for UASM therefore is likely to induce intense fear and chronic anxiety. Our lay participants illustrated the complexity of the various functions that fear played in their lives as UASM; functions that ranged from protecting them from sexual maltreatment (and other adversity) to making them vulnerable to it, preventing them from disclosing it, and as a damaging after-effect of sexual maltreatment.

Fear as protection from sexual maltreatment

As stated above, fear is an adaptive response aimed to protect the individual from harm. Some of the lay participants described how their fear had helped them protect themselves from being sexually maltreated:

'The other thing that helped it from happening was that I was a child and scared of sexual relationships. Lack of experience in sexual relationships and being frightened of the unknown made me prevent the incident from happening' (T15f).

Another female described how she responded when threatened by men intending to sexually assault her:

'And when the men opened my door and entered the room, I was shocked. I screamed and said that I will dial 999. Then one of them said that he liked me. When I continue shouting at him, they both left the room' (C4f).

Others described putting up a physical fight with their assailant and escaping to safety. Several said how their fear of sexual assault made them avoid places, people and situations they perceived to be dangerous.

Fear as a factor increasing vulnerability

Anxiety caused by living in a strange country, alone without the support and protection of their family and friends was common among our lay participants and often contributed to their vulnerability to sexual victimisation. As a participant explained, *'I used to feel frightened before. I was sleepless when I realised about it. I felt that it was because of loneliness that I was scared of things'* (T19f). Another young woman was even more specific as to the anxieties her situation exposed her to:

'... as a girl when I came here I was worried and I was scared. The environment was new to me and I have not lived by myself alone. It was my first time to be in such a situation alone. I was worried that someone would come and attack me. They might even rape me. That was my worry' (T9f).

Loneliness in many of these young people's lives therefore created a state of fearful isolation and vulnerability. In response to this many described seeking out their fellow country people, as they expected they would offer them protection.

'You know, I totally lost hope. I had no family or relative and no one I know. I couldn't discuss it with anyone. I was only praying to God. I have asked them if there is Ethiopian church. ...Later, I told my social worker that I missed Ethiopian food and wanted him to take me to an Ethiopian Restaurant. On this occasion I met so many Ethiopians. When I started eating Ethiopian food and thinking about the love of my country and missing it, I wanted to change my foster family, you know; have an Ethiopian family' (C1F).

However, as described in Chapter 3, some of their fellow country people exploited these children's emotional needs for their own sexual gratification.

Impact of fear on disclosure

The literature

ChildLine, a charity that provides a telephone help-line for children in the UK, reported that children's reluctance to talk about their abuse experiences was common. They reported that the victims may be afraid to disclose it because of shame and guilt as they feel in some way to blame, or fear they will be blamed by others. They also reported that children fear they will not be believed by those they tell, and are afraid of the consequences if the police or social services were to become involved. Some children were said to report being intimidated and often seriously threatened by their abuser. A study by Jensen *et al* (2005) found that some children did not disclose CSA not only because they felt that they would not be believed, but also that their motives for disclosure might be 'misinterpreted'. None of our participants had used a telephone help-line such as ChildLine to talk about their experiences of sexual maltreatment.

A similar picture relating to disclosure of CSA has been found in other countries. An Italian study on the sexual abuse of adolescents (Crisma *et al* 2004) reported that the victims' reasons for not seeking professional services included their lack of

knowledge about protective agencies and their functions; being unaware that their experience was abuse; not trusting adults and professionals; and fear of the consequences of disclosure.

Different reasons for non-disclosure of CSA have been reported between males and females (Allagia 2005) whereby males tended not to disclose it due to fear of being thought homosexual or a 'victim'; and female's reasons were due to feeling 'conflicted' about it. Allagia also reported that females predicted more strongly than males that they may be blamed or not believed.

A review of child sexual abuse for the NSPCC (Cawson *et al* 2000) found that disclosure by those who had experienced sexual abuse by someone five or more years older around the time of sexual maltreatment was unusual. If they did tell, the person they told was usually a friend and less frequently a family member. Very rarely were the police or other professionals informed. Fear may have been a factor that prevented such disclosure.

A Home Office survey report on the rape and sexual assault of women (Myhill and Allen 2002) found that many women in Britain never report sexual assault or rape, particularly rape:

"Fewer victims of rape than sexual assault told somebody about their experience at the time and rape victims were more likely never to have told anybody about their experience. Approximately a third of rape victims (34%) told somebody about their ordeal at the time, compared to over a half (52%) of sexual assault victims" (p.46)

However the above study (data derived from the British Crime Survey) did not collect data on race or ethnicity, so differences that might be attributable to these factors or culture could not be explored. Disclosure of sexual maltreatment by child victims is likely to be confounded by other variables such as their awareness of it being wrong, fear of upsetting caretakers upon whom they are dependent, and other contextual and relational issues.

Few rapes are reported to the police as doing so often involves further traumatising (Herman 1992). Additionally Herman argues that women,

'...learn that rape is a crime only in theory; in practice the standard for what constitutes rape is set not at the level of women's experience of violation but just above the level of coercion acceptable to men. That level turns out to be very high indeed' (p.72).

This might help explain why victims of rape are more likely to report it when the perpetrator is a stranger; they may feel that their story is more likely to be believed, as their lack of complicity is more evident. Kelly (2005) found that stranger rapes are also more likely to be investigated and prosecuted.

Caro Hollander (2000) points out that in authoritarian societies (such as the countries of origin of our lay participants) social bonds between people are targeted in acts of 'state terror' that aim to depoliticise them (p.86). (The term 'authoritarian regimes' includes '*...totalitarian states, dictatorships, and regimes in which opposition is suppressed*' <http://tinyurl.com/27q2ay>). People in exile from such countries consequently tend to distrust and not confide in others. It seems likely that this culture of silence and fear isolates people and exposes them to danger, such as sexual abuse and may render them less likely to report it.

Findings: lay participants

Disclosure to friends

Just over half of the lay participants (n=29/53) said they had told a friend or peer who lived with them in shared accommodation about their experience of sexual abuse or sexual assault in the UK. Findings regarding disclosure to professionals are presented in chapter 3.

Factors associated with disclosure

We found that there was a complex relationship between seriousness of the sexual maltreatment and the likelihood that the victim would disclose; more of those who experienced genital fondling reported the incident than those who experienced non-

genital fondling (92% versus 67%). However this association did not quite meet statistical significance ($p=0.068$). In contrast, only one of the four females who said they had been raped reported it. Fear was often behind this decision, as a girl who had become pregnant after being raped by a male acquaintance explained, '*I knew no one and I was in a difficult situation. I was scared to inform the social worker*' (T13f).

There were no statistically significant relationships between the frequency of sexual maltreatment and the tendency to report it; neither was sexual abuse by multiple perpetrators, or being given 'rewards for sexual favours' associated with whether they told anyone. However, those who were warned as a child that adults might sexually abuse them were far more likely to disclose their sexual maltreatment (81% versus 41%, $p<.01$). They were also more likely to seek professional help or advice for the consequences of it (56% versus 21%; $p<.05$). This may be because the subject was discussed openly and in so being it had been stripped of its stigma. The quality of their sex education in school (described as 'good', 'fairly good', 'not good', or 'non-existent') did not impact on their likelihood of disclosing sexual maltreatment or on seeking professional help or advice for it. However, a significant number had reported that they had been taught or warned at school in England and / or at home that adults might sexually abuse them (Table 6.1).

Reasons for non-disclosure

Lay participants were asked in their interview if they had not told anyone or not told their social worker or a police office about their sexual maltreatment why they had not done so. The reasons given mainly related to a lack of access to people they felt they could tell ($n=11$); 'cultural' reasons, such as the stigma attached to it ($n=10$); being afraid to tell, for example because of a fear of retaliation or eviction ($n=9$); feelings of shame, embarrassment or humiliation ($n=5$); not knowing how to complain ($n=4$); and believing nothing would be done about it anyway ($n=3$), amongst other less common reasons. Fear of being stigmatised was described by a young woman, '*The reason why I did not tell anyone was that it would have*

some reflection on me. In my country we would not tell this sort of thing to anyone' (T16f).

Several commented that telling a friend of roughly the same age and ethnicity had not been helpful because they had the same cultural background and current circumstances and therefore tended to advise them not to tell anyone.

'My friend was shocked, but her situation was similar with mine and therefore she could not help. She told me to talk to the person who abused me therefore I could not do anything' (T13f).

Poor advice given by friends and other peers can therefore be very damaging to the outcome for the victim as it is likely to lead to them not disclosing the event to professionals, thus maintaining their vulnerability to re-victimisation.

Some lay participants indicated that fear was often a reason for non-disclosure but described how over time they had grown more confident regarding their rights and would now report it to the police if the same thing happened again:

'No, I did not report because I didn't know that the incident should be reported to the police and I was scared since I was new to the country. If I face similar problem this time I would report to the police. No one would touch me without my consent now I know about my rights' (T10f).

Telling will not change anything

The reasons for not telling their social workers included their belief that nothing would be done by them anyway as they felt they had failed to take appropriate action to resolve earlier problems.

Telling is taboo

The stigma attached to sexual abuse in their culture of origin prevented many from disclosing it to anyone as a participant explained, *'I was scared. It does not go with my culture therefore I cannot report, I cannot talk openly about this thing'*

(T2f). A culture of silence was described by most of our lay participants in relation to sexual abuse and assault,

'Yes I kept it to myself. It is the way we are raised up and also our culture when we encounter such things. I believe there are a lot of others who came across the same thing, but the way we were raised and the culture protects us not to tell others because it embarrasses us. We believe it causes isolation from friends and the public. I had this kind of thinking at the time and that was one of my reasons for not telling anyone' (J1f).

Nobody to tell

Who the participants told was often dependent on who was available to tell. UASM aged 16 and over are frequently cared for under Section 17 of the Children Act, this provides them with accommodation but as they are not 'looked after children' they receive minimal supervision and frequently have no contact with a trained social worker. A female lay participant described how isolated she felt and in need of a social worker:

Well, I would have told anyone at that time if at all there was one who could have told me they would help me, but I didn't know anyone, I was all alone. I had no social worker. It was the agency (I mean the landlord) who brought me and kept me and ever since I had never met anyone. I never had any communication or connection with social services except when I went to collect my money' (C3f).

None of the lay participants reported telling a member of their family back home although it is likely in some cases that their close family members may have been deceased, imprisoned or unable to be contacted for other reasons. However, some of them may have feared causing anxiety to their family who had sent them to the UK for their protection.

Lack of trust in authorities

Several lay participants described a lack of trust as underlying their non-disclosure of sexual maltreatment. This often manifested as fear of disclosure because of

uncertain outcomes, or how they would be treated following disclosure. An example of this was related to an assumption of police corruption, as described by the police sergeant participant:

'There are cultural conflicts and barriers to people from other cultures reporting these crimes because they have a lack of confidence in the police. They think we are like the police in their country, corrupt, and that we would rape them too' (KP5).

Only four of our lay participants reported their sexual maltreatment to the police. Some of those who did not report it were asked why they had not. The reasons included fear of doing so (n=13); not knowing they should report sexual maltreatment to the police (n=9); not knowing how to (n=8); poor English language skills (n=4). Lack of trust or fear of the police was also reported:

'I didn't even know how to report it to police. I didn't even want to see any police and never wanted to go wherever they are' (C5f).

Another lay participant reported that the police failed to pursue her case because of a lack of evidence, but she perceived it to be more to do with discrimination:

'They [the police] did not do anything for me. My case had a problem regarding evidence. This person tried to rape me in a dark corner. My friends helped me to explain this to the police in better English. I think they thought I was the cause of the problem, as they cannot trust refugees. They thought I was there to deceive them about the abuse' (T41f).

UASM were also thought by a social work professional to lack trust in social workers and to have erroneous perceptions of their roles:

'You have to get past that initial difference in public perception of what our responsibilities are because they do see us as people in authority, maybe people who have some determination of their asylum application and therefore the trust and rapport takes a bit longer to build up' (KP7).

Another professional participant highlighted how victims of sexual assault or abuse are responded to in their homelands will impact on their willingness to disclose it in the UK.

Some female lay participants felt they could not tell their social worker or other support worker if they were male. Fear that the disclosed material would not be kept confidential was also apparent, as one of them explained regarding not telling:

'I had no confidence. I was suspicious because of our upbringing. If you tell this sort of thing (sexual abuse) to anyone they would tell another person, which you do not want. Therefore, I did not tell anyone' (T11f).

Ethnic loyalty

The young people we interviewed came from countries where ethnic loyalty is strong and this was reflected in the accounts they gave regarding disclosure of sexual maltreatment. For example, a female participant said, *'The people [girls] who I was living with were from another country. I would not tell about sexual abuse to them'* (T18f). That disclosing sexual maltreatment by people from their homeland to people from another country was thought to be unacceptable suggests that the survivor feels it would reflect badly on their country. In this case the need to protect her country's honour seems to have been more important than satisfying her own need to tell. The expectation that others would also be loyal to their ethnic group was also implied and this impacted negatively on disclosure:

'The only person I knew was my social worker and I didn't want to tell him because he was from their [the foster parent's] country, Jamaica, and didn't expect he could help me and thought telling him doesn't make any difference. On top of this, I was too shy to tell the story' (C1f).

This account illustrates how telling is very difficult anyway, but it may be made to feel impossible by perceptions that the helping agent would not be sympathetic because of perceived ethnic or other allegiances. In another case a girl who had a

white social worker reported not disclosing her sexual abuse to them because they were white and the perpetrator was black. They were afraid that this would add to what the victim believed were the worker's preconceptions and prejudices regarding 'the black sex attacker'. Another female did not want to disclose because the perpetrator was of the same nationality as her:

'I thought the person who abused me loved me and wanted a serious relationship. The other thing was that he was a fellow Ethiopian and I did not want to betray him. I did not think he would do something bad to me' (T24f)

Fear regarding victim status

Males were thought by some of our professional participants to fear reporting sexual maltreatment as they would not want to be seen as victims; victimisation being perceived as an indicator of personal weakness and a lack of masculinity.

Fear of being blamed and disbelieved

Other studies have identified a fear of not being believed or being thought to blame for their sexual maltreatment as reasons for non-disclosure, these reasons were also given by some of our participants. *'I did not tell anyone except the police and the reception. The reason was that I felt ashamed of the incident. I felt like I was the cause of the problem and hesitated to tell anyone'* (D20f). Others indicated that it was due to their personal attributes, such as being a young female or the way they dress, as a lay participant explained, *'I think sometimes it is because of the clothes we wear. It could be because of short skirts we wear. When we wear short skirts boys would follow us and cause problems to us. We cannot wear what we want to'* (T2f). However, there were few overt reports of survivors not reporting being sexually maltreated because felt they would not be believed.

Fear of the consequences

Feeling at the mercy of the authorities and insecure in their capacity as asylum seekers contributes to fears of disclosing sexual maltreatment to them, as a female participant indicated:

'I wanted to inform my social worker and consulted my friend about it and she was not supportive of the idea. She felt that I would be evicted if I had informed them about it. I was frightened by her remarks and scared to inform them' (T13f).

Impact of fear on the survivors' mental health

Fear was a primary emotion during their experiences of sexual maltreatment. Many also described fear and anxiety as being the predominant effect, including fear of men, fear of being in their accommodation, fear of HIV and pregnancy, and fear of attack and retaliation. A female participant described her life during the abuse thus:

'Sometimes I could not sleep because of them. I could not eat and drink as result of their abuse. I had headache. I was restless. I start to be worried when it starts to be late in the day. Since they were abusing me everyday I was restless and depressed. ...They were knocking on my door everyday. I was frightened when it was dark and late in the evening. Sometimes I was not sleeping in my room. Instead I used to sleep with my friends somewhere else' (T31f).

It has been argued that forgetting and denial are psychological defence mechanisms employed not only by victims of distressing events but also by whole communities. Herman (1992) notes for example, that the study of psychological trauma has been one of ebb and flow whereby *'it has been periodically forgotten and has to be periodically reclaimed'* (p.7). One of the strongest points made by our study's lay participants is that telling an adult about their experiences of sexual maltreatment was often felt to be impossible; telling their peers was often easier but sometimes led to negative outcomes. Given this and the absence of mature ways of coping with the effects of abuse, young survivors may conclude that forgetting what happened is the only option. Dissociation, according to a study by Kelly (2005) was the most commonly employed coping strategy used both at the time of the assault and in dealing with the aftermath. Such a response is bound up with the event

being unspeakable. Herman (1992) suggests this is because women and girls' reality is not socially validated as they are devalued in society.

Our own participants at times indicated that their aim was eventually to be able to forget the incident(s), to put it behind them and get on with their lives. Although forgetting can bring relief in the immediate term, generally the traumatic memories seek expression in some disguised form or another and may manifest in somatic complaints. Some studies, such as that by Nickel and Egle (2006) have shown a direct relationship between CSA and somatisation. Many of our participants described having physical complaints that they attributed to their sexual maltreatment, such as problems with headaches.

Impact of fear on social well-being and integration

Fear not only impacted on participants' psychological well-being directly but also indirectly by restricting their physical movements and use of public space. This had the effect of limiting their access to shelter, protection, food, friendship, and on their motivation and ability to integrate socially. A girl, assaulted and abused by two separate males in her hostel (including an employee) at the age of 16, illustrated this when she recounted the impact of the fear one of these men had caused her and how her subsequent social isolation increased her vulnerability further:

'He was disturbing me. I was not able to stay freely in the premises. I was scared of him. I was not able to have my meal without fear of this person. I was always keeping my room closed to avoid him. I was not eating the food he cooked because of fear. I was very much tormented. He used to knock on my door at night. Because of this I was sleeping in the same room with the Chinese girl. ...I went down stairs to eat dinner and no one was there. This person tried to rape me in the kitchen' (SG12f).

In this instance the social worker that had allocated the accommodation had been told that only girls lived there, when in fact two males did also. When they were informed about the incident the girl was relocated.

Having trusting connection with others is essential to a healthy human existence and those who have been traumatised (such as by being raped or sexually abused) according to Herman (1992) '*...feel utterly abandoned, utterly alone, cast out of the human and divine systems of care and protection.... Thereafter, a sense of alienation, of disconnection, pervades every relationship....*' (p.52). This situation is difficult and disturbing for a child living within a family context; it is unimaginable for those without such a potential source of protection and support.

In the absence of a protective family, young people are forced to develop their own protective strategies. These strategies are often lifestyle adaptations, which although protective can have a serious impact on their ability to integrate, as a young female lay participant explained:

'The main thing that helped prevent serious abuse from happening was that I kept my relationship with everybody at a distance. I had no contact or firm relationship with anyone. I used to stay in my room and did not go around for any reason. I think this was one of the reasons why the abuse stopped' (T28f).

Clearly such disconnection caused by trauma and the fear of re-victimisation is likely to seriously impede young people's capacity to integrate into an alien society; more especially perhaps when this society was previously perceived as a haven from the political and personal terror they had witnessed in their homelands.

Conclusions

Fear and anxiety was a common experience for our lay participants as young UASM in the UK in relation to their sexual maltreatment. Their social isolation and lack of knowledge of the British social and welfare system and the vast cultural differences made them particularly vulnerable to sexual maltreatment. To avoid the negative impacts of anxiety and fear on their mental, physical and social well-being, support and protection has to be made available to them possibly at a greater level than that afforded to indigenous children who at least have the benefit of knowing the language and the culture.

Chapter 6

Prevention of sexual maltreatment

Introduction

A review of the literature on the prevention of sexual maltreatment in childhood indicates that there has been much more research on preventing the sexual abuse of children (CSA) than on preventing their sexual assault. This may be because CSA is primarily perpetrated by adult males, and as adult males in patriarchal societies occupy positions of power in the family and the wider society CSA therefore represents a greater moral challenge to society than sexual assault, such as child rape. Also CSA tends to be committed repeatedly by the same person and often over a long period of time whereas sexual assaults tend to be one-off incidents. However, the prevention of CSA has received less attention than its causes and effects (Daro1994). Finkelhor (1984) argued research was still needed into how *'...power inequities create offenders, make children vulnerable, increase the trauma and inhibit reporting'* (p.225). This chapter presents the lay and professional participants' views of how the sexual maltreatment of unaccompanied asylum seeking minors can be prevented after first outlining some of the current theories.

Prevention: theory and practice

Preventive and therapeutic work relating to child sexual maltreatment is usually based on an attributional theory derived from either a medico-legal perspective, which tends to view causation in terms of individual pathological processes within the perpetrator, or on social theories which locate the pathology or aetiology within the socio-cultural context and influences surrounding the individual (see Chapter 4). Browne (1996) cites Gabarino's (1986) dual classification regarding the type of interventions as those which ignore the socio-cultural context of CSA as leading to

'patchwork prevention' and those which postulate the need for total social reform as 'total reform prevention.'

Browne (1996) argues that there are marked differences in responses to the problem of CSA between charities involved in child protection and survivor's groups. The charities tending to operate patchwork prevention and the latter aspire to total reform prevention. Charities, she argues, whilst recognising the need for social reform may be stymied by their need for funding and therefore may not wish to challenge existing power structures. However, there appears to have been some recent shift in this; the Save the Children policy on protecting children from sexual abuse and exploitation for example recognises that, '*Sexual abuse and exploitation of children reflects deep inadequacies and structural power imbalances between generations, sexes, classes, ethnic groups and races*' (2003: p.4). Professionals involved in the difficult field of the prevention of sexual maltreatment of minors need to acknowledge and address all of these power imbalances.

Approaches to prevention

Finkelhor's Four Preconditions Model as a framework for prevention

We believe Finkelhor's model (outlined above) provides a robust and useful framework for approaching the problem of preventing the sexual maltreatment of minors. Clearly if Finkelhor's model is correct, action on prevention only needs to be successful in removing one precondition. In the past, interventions have been targeted both at perpetrators by attempting to reduce their motivation to commit offences and increasing their internal barriers; and at increasing children's awareness and ability to avert sexual maltreatment through educational programmes. However, there is evidence from evaluations of such programmes that they were often ineffective (Daro 1994). It seems necessary therefore to address all four preconditions so that external barriers to commit sexual offences against children and young people are also strengthened. Multi-faceted approaches appear to be needed to achieve this. Save the Children's (2003) policy on CSA prevention advocates that children should participate in developing the means of doing this and we would endorse this principle.

Internal barriers of the perpetrators

Interventions targeted at perpetrators seek either to deter them from repeating their behaviour through punishment, or aim to reform them through some kind of therapeutic intervention. A review of the literature by Lehne *et al* (2000) ascertained that there is some evidence to suggest that anti-androgen and cognitive behavioural therapy (CBT) may have most beneficial effects on recidivism. It has been asserted following a review of the research on perpetrator interventions that,

'...effective intervention must be focused on the offender taking full responsibility for the feelings, thoughts and behaviour that support his offending predicated on the premise that male sexual arousal is controllable. ...In the longer term the prevention of sexual offences needs to address the gender role expectations of males in society' (Erooga 2002).

The Royal College of Psychiatrists reports that around fifty percent of adult offenders coming before the courts began their sexual deviancy in adolescence and a third are reported to be adolescents (Royal College of Psychiatrists 1994). They make the case for prevention through the assessment, treatment and management of adolescent child sexual abusers as well as adults.

Measures aimed at strengthening the perpetrator's *internal inhibitions* to commit abusive acts, such as encouraging empathy are also addressed through offender treatment programmes. However, these measures only impact on secondary prevention and are available to those who either voluntarily seek treatment, or who are given treatment as part of their offender rehabilitation package. With conviction rates being very low for sexual offences, such programmes do not reach the majority of offenders, or those who will go on to offend in the future. Neither do such programmes change the underlying patriarchal structures and processes in society that foster the sexual maltreatment of children and young people.

Little action has been taken to address male gender role expectations, or other aspects of male psychological development that may contribute towards male sexual violence and abuse. In the UK, there have been some changes in social policy to assist men to play a greater part in the upbringing of their children, such as

extended paternity leave. However, granting such opportunities is not always enough to motivate fathers to engage more with the care of their children. Action is needed to encourage change in what is perceived as acceptable and desirable paternal roles, as there is some evidence that increasing the male nurturing role impacts favourably on rates of sexual violence (Mead 1963 cited in Seymour 1998).

Strengthening external barriers

Current preventive strategies aimed at strengthening external (social) barriers to sexual maltreatment in the UK include: enabling and empowering adults to help protect children from sexual abuse; encouraging people to join or support campaigning groups; and squashing the myths that perpetuate harmful social norms, i.e. that it is acceptable to sexualise a relationship with a child, or that victims are to blame for sexual abuse.

An American multi-agency group spearheads the 'Stop it Now' campaign aims to help abusers and potential abusers and their families, and other members of the public. It communicates with them to '*...give people information about the nature and extent of child sexual abuse and about the ways abusers manipulate children and other adults, whilst often deluding themselves that they are doing little or no harm.*'

<http://www.stopitnow.org.uk/Helpline%20Report.pdf>.

Empowering children

Strengthening children's resistance to sexual maltreatment includes the education of children about abuse so they are better equipped to resist it and encouragement and support to disclose it, such as is provided by ChildLine (<http://www.ChildLine.org.uk/>). Other campaigns, such as the 'Don't hide it' campaign targeted at 11 to 16 year olds led by the NSPCC also encourage disclosure (<http://www.donthideit.com>). Improved reporting and investigation procedures are thought to be 'most promising' in protecting children from sexual abuse in the community (Trocme and Schumaker 1999).

Daro (1994) highlights an anomaly in CSA prevention in which, unlike physical abuse and neglect prevention, children are taught how to increase their resistance

to it. It would seem ludicrous to expect children to be taught how to fend off the slaps and punches of a physically abusive parent, or to be expected to learn how to overcome parental neglect. It seems illogical and morally wrong therefore to expect children to learn how to thwart the intentions of adults to involve them in a sexual act. Tharinger *et al* (1988) recommend that CSA prevention programmes for children should not convey concepts of assertiveness and empowerment for children, but they do accept that such concepts may be applicable to adolescents. Daro points to studies that suggest that educating young children how to protect themselves from sexual abuse may even harm them by making them unable to trust any affection from an adult. Other authors promote the idea that children have a right to grow up free of fears and anxieties that educating them about the dangers of sexual abuse and assault would engender.

Although many studies emphasise the need to empower children and to *change the social conditions associated with CSA* (e.g. Miller-Perrin *et al* 1988), most CSA prevention programs neglect the latter in favour of the former. A reason given for this is that empowering children to resist sexual maltreatment is seen as cost-effective (Daro 1994). However, Daro's review of evaluations of this leads her to conclude that,

'To date, no rigorous, scientific work has been completed on the degree to which the accomplishment of these changes leads to a real decrease in the rate of child sexual abuse' (p.203).

MacMillan *et al* (1994) also argue that although there is evidence that educational programmes can improve children's safety skills and knowledge, no studies have produced evidence that it actually reduces the occurrence of CSA. Daro argues that as the power imbalance between adults and children means adults normally would be able to assert their will over most children, so empowering and educating children to resist CSA *as an isolated strategy* is futile (my italics). She does however concede that it could be an important component in prevention. It has been argued that there is more to be gained from targeting the perpetrators or other adults who can intervene with the abuser (CDCP 2001).

Institutional approaches to preventing the abuse of power

Daro (1994) points out that most studies concur with the view that preventive strategies tend to have limited options and she identifies some of the factors that she believes have played a part in this. Significantly she points out that many have challenged '*...the wisdom of its inherent questioning of the balance of power between males and females, children and parents*' (ibid: 200). Some studies she states, suggest that the problem of CSA may be 'resistant' to any preventive initiative. However, resistance does not mean immunity. Although power imbalances will always prevail between generations, accepting this assertion does not legitimate the abuse of that power. Children should not need to protect themselves against their supposed protectors. It is the responsibility of adults to use their greater power to protect children, and to ensure that other adults also do so.

Currently in the UK many agencies are involved in the prevention of the sexual maltreatment of minors either directly, such as social services, the police and teachers, or indirectly, such as those who develop policies and law. These agencies however have different roles and goals with the police seeking to prosecute the offender, and social services seeking to support those with social needs (Moran-Ellis and Fielding 1996). Also where there is a lack of congruence and consensus between agencies as to the underlying causes of CSA and sexual assault impacts on what they see as the most appropriate interventions. This can lead to them pulling in different directions which may increase the risk to victims. Erooga (2002) highlights the need for co-ordination between agencies and a comprehensive approach:

'Effective approaches require the development of comprehensive packages of policy, procedures and treatment, derived from co-operation and partnership between the various professionals and agencies involved, from Area Child Protection Committee level down.'

We would argue that the partnership should include the child.

Multi-faceted approaches

Conte *et al* (1986) recommended that professionals involved in child protection should view measures aimed at helping children resist sexual abuse as 'temporary' and that they should continue to be active in their attempts to alter the factors that cause and maintain it. Daro (1994) promotes 'multifaceted prevention systems' as they would address conditions that lead adults to consider using children for 'sexual gratification', the need to strengthen the environmental factors that discourage abuse, in addition to improving children's resistance to it. This argument mirrors Finkelhor's four preconditions model.

An example of a multi-faceted programme of CSA prevention is a campaign undertaken in Vermont, USA that employed three strategies:

- 1) *A media campaign targeting all Vermont residents to increase residents' awareness of abuse and its signs (strengthening external barriers);*
- 2) *an outreach campaign targeting high-risk families that provides a helpline for adults with questions about or experience of sexual abuse and provides information to agencies working with these families;*
- 3) *a strategy to explore partnerships with Vermont decision-makers and leaders and develop approaches to prevent child sexual abuse. (Center for Disease Control and Prevention [CDC] 2001: 78)*

This report notes how '*...community factors may be critical to the success of these programs*' (p.78) and goes on to point out that Vermont can guarantee treatment to anyone who enters the legal system; offers '*accessible media markets*'; and has a '*...coalition of victim and abuser treatment organizations that supported the introduction of this approach to prevention*' (ibid: 78). The strength of this campaign is in its focus on perpetrators rather than victims. However, considering that most perpetrators never reach the courts let alone get convicted, it is unlikely that their campaign will be successful on its own. Those who have never been convicted of a sexual offence with children need to be able to access therapeutic programmes, but this will be an admission of guilt and they would fear prosecution. Another problem with this approach is that targeting 'high risk families' deflects attention away from

the normative processes in the construction of masculinities and the power differentials central to CSA. These differentials are located in the 'normal' patriarchal relations between men and women, and children and adults. Because of this it is impossible to identify those at risk of perpetrating CSA or their potential victims. Attempts to do so may create stereotypes and be likely to protect perpetrators who do not fit the stereotype. Focusing and targeting high-risk families may also further stigmatise the offence for survivors and perpetrators alike. This may result in an increase in survivor shame and reduce disclosures, thus perpetuating the problem of CSA.

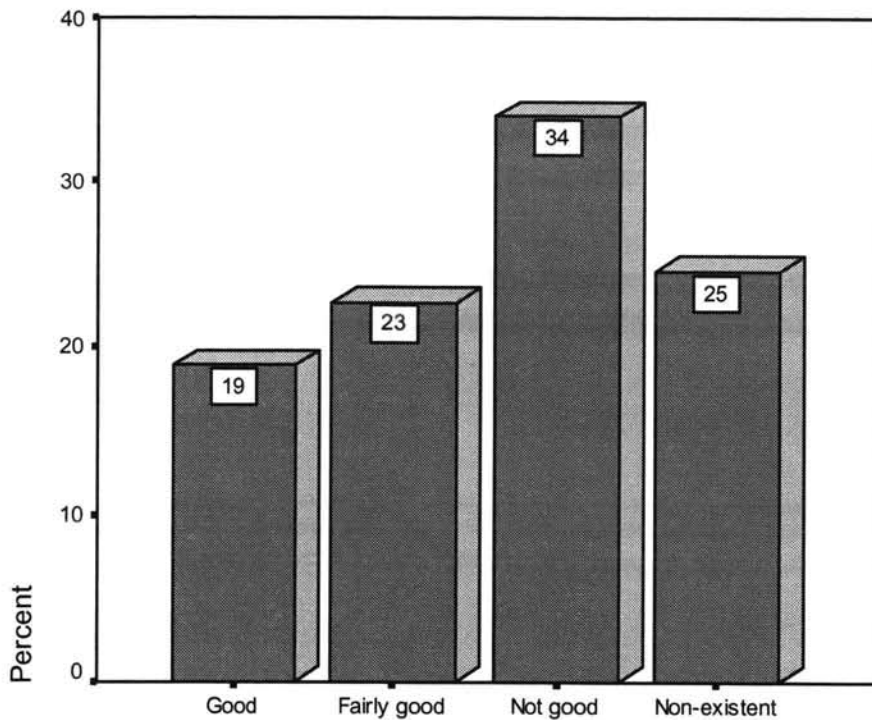
Self protection strategies: findings

The lay participants were asked a series of questions to elicit the CSA prevention strategies they had been exposed to, such as sex education, and the strategies they had used to prevent their victimisation and re-victimisation.

Prior education about sexual abuse

We wished to ascertain the lay participants' level of knowledge of sexual abuse and sex education generally that they had accrued as a child. To this end they were asked in the self-completion questionnaire how they would 'describe their education about sexual matters'. Around fifty-nine percent (59%) indicated that it had either been 'not good' or 'non-existent' (Figure 6.1).

Figure 6.1: Quality of sex education



They were also asked if they recalled being taught as a child to be aware that adults might sexually abuse them, most (n=36: 68%) indicated that they had been taught. When these were asked who had warned them or taught them about this the majority (n=24/35: 69%) indicated that it had been a 'parent or other adult' (Table 6.1). Schools at home and in England were equally reported to have been the source of such information.

Table 6.1: Sources of warning or education about sexual abuse

Who warned /taught?	N	(%)
Parent or other adult	24/35	(69)
School in homeland	23/35	(66)
School in England	23/35	(66)
Sibling	5/35	(14)
Another source	10/36	(28)

*Percentages have been rounded.
More than one response could be given.*

The 'other' sources of information about sexual abuse by adults included foster parents (n=2), the media (n=3), peers (n=1) and a social worker (n=1). Some lay participants may have put their social workers under the category of 'parent or other adult'.

'My mother had told me about sexual abuse when I was in Ethiopia. She advised me to look after myself. There is sexual abuse/assault in Ethiopia. Many children were being abused in Ethiopia. The government had taken action to overcome the problem, now the problem is decreasing' (T02f).

Primary prevention strategies

The lay participants who experienced a 'near miss' and who managed to extricate themselves from a situation in which they felt sexually threatened were asked what they believed stopped it from actually happening. Some said they avoided the attack by screaming, crying or pleading with the perpetrator and threatening to alert others, or to report them to the police.

'He tried to have sex with me, wanted to rape me. I told him to stop his action and I also told him that I was going to cry. It was possible to directly call the reception from my room and I told him that I was going to call. When I was set to call the reception he was frightened and left me alone' (T23f).

This was a successful strategy for another girl:

'The other thing was that I used to threaten them by saying I would report their action to concerned people. I think this had frightened them not to do anything to me' (T28f).

Sometimes an incidental passer-by would cause the perpetrator to stop his attack.

Being aware of the modus operandi of perpetrators, such as their use of treats and favours and not accepting them was a strategy used by at least one participant,

'...when we were walking we used to see a person apparently from Ethiopia or Eritrea. He used to greet us. He used to come to our area quite often and he was offering us lifts and wanted to take us to different places. We were scared

of him. We were not accepting his offer. When we turned down his offer he disappeared after three or four attempts' (T6f).

Secondary prevention strategies

Those who had been victims of sexual abuse or sexual assault described using a number of strategies to protect themselves from re-victimisation, these included:

Avoiding the perpetrator

Participants described isolating themselves; changing their route of travel; moving accommodation; leaving their job; and changing their foster family. Another avoidance tactic was avoiding male attention by reducing their attractiveness to males by wearing less flattering clothing. Avoidance of the perpetrator had a very negative impact on their personal freedom and social well-being, as a female participant described:

'... I used to leave early in the morning before anyone woke up and in the evening I got home late after everyone got home. ...I was living on the ground floor and I used to enter my house quietly. I used to sit in my room with the light off and I was trying hard not to see them. ... I used to cover my hair and used to change the way I dressed up. I used to wear a bigger dress, bigger trousers, and a bigger jumper. I started wearing [clothes] differently to make them think in a different way, even if they see me' (C3f).

A young woman who was working illegally described how avoiding the perpetrator who was her manager affected her:

'I used to be with other people. When we finished work I used to leave with other people. I did not want him to see me alone. Whenever I was assigned to work alone I used to be absent from work' (T29f).

Strengthening personal resources

Developing personal resources, such as by educating themselves to increase their understanding and awareness of abuse issues and improving their English language skills were quite common strategies.

'Yes, I have learnt enough. I know that men try to attract women through different things such as giving treats and buying food. I know that loneliness would make young people vulnerable to sexual abuse' (T15f).

Another young woman described how becoming more integrated with a better support network and greater knowledge about sexual abuse had reduced her vulnerability to it over time:

'Now, yes; I can look after myself, I am not scared of sexual abuse this time. I know the country. I have friends. I have enough information on this issue. I am not worried that I would encounter sexual abuse. I can protect myself from sexual abuse' (T19f).

Others described being more vigilant or using chaperones, such as a male friend who would pretend to be their partner. Recognising their rights not to be abused was felt to strengthen their sense of empowerment and determination to resist would-be assailants or abusers.

Political activism

Political activism, such as playing an active role in anti-abuse campaigns and being more open about sexual maltreatment were also seen as helping prevent it:

'Young people should participate and contribute to the efforts of organisations fighting sexual abuse. We need to discuss sexual abuse openly and try to prevent it from happening' (T30f).

Other preventive strategies

In some cases the threat of further sexual maltreatment was abated when the perpetrator's circumstances changed, for example when they moved house. Some participants conjectured that the would-be perpetrator gave up their pursuit when they accepted they would not get their way, or were fearful of being reported or prosecuted. Some participants (n=6) stated that God had helped them escape being abused or re-abused.

Preventive interventions by professionals

The lay participants were asked what they think needs to be done by professionals to help prevent UASM from being sexually abused or sexually assaulted in the UK. Their responses fell into three main types of action: education, protection, and greater openness.

Protection of minors

Appropriate accommodation

The circumstances in which UASM live were thought to contribute greatly to their vulnerability to sexual maltreatment. Many lay participants suggested that authorities should ensure UASM are protected by providing them with appropriate accommodation. It is the responsibility of the London Asylum Seekers Consortium (LASC) to find suitable accommodation for UASM (as well as other groups). The accommodation for them is reported to consist of,

'...single bedrooms, communal areas, kitchen, bathroom linen and laundry facilities.... Each household has access to 24-hour on-call staff who are police checked. All properties undergo a thorough environmental, health and safety check and is regularly inspected by LASC's monitoring staff' (LASC 2006).

LASC also stipulates that each young person must be provided with a key worker upon arrival to LASC accommodation whose responsibilities include undertaking an assessment of client's needs and delivering an individually tailored support plan.

The 'service provider' is expected to '*assist young people with access to education, health and related needs including contact with suitable community groups*'.

Nine (n=9) lay participants mentioned the need for single sex housing, as one of them put it, '*Men and women should not live together in a hotel as it invites sexual abuse*' (T40f).

'If they wanted to protect me, the least they could do was to place me with women than placing me with older men. If they have a shortage of social workers, they could have allocated me a key worker so that I could have been guided fully. It is not easy for someone to travel from Africa and come all the way to Europe. Even the system is different. At the end of the day the life of these people is in their hands. They should have done more' (C3f).

UASM will often have greater needs than indigenous children and yet they frequently felt they were provided with a less than adequate service, many had unmet needs. For example, several (n=13) expressed the need for more monitoring and another twelve (n=12) said they felt more protection generally was needed for 'underage children' to protect them from sexual maltreatment. There was a request made for twice weekly visits from social workers to those living in hostels and other types of accommodation said to have little or no supervision.

Authorities to act and act more promptly

There was a clear message that even when incidents or near misses were reported to social workers action was not always taken, as a lay participant said, '*Some social workers are not responsive. Some do not help when problems arise*' (T24f). Another reiterated this view, '*social workers should be open minded and be friendly to underage children. They should listen to them and also try to sort out their problems*' (T38f).

Some lay participants felt let down by social services, for example a lay participant reported that social services were going to improve their housing circumstances but did not. The participant suspected that they were biding time until they reached 18 and came out of their jurisdiction: '*When I reported the incident to them, they were*

supposed to move me to another house to overcome the problem. They waited until I was 18' (T38f).

Several lay participants felt that if the authorities had taken positive action immediately upon disclosure of sexual maltreatment or near misses (further) incidents might have been averted, *'Professionals and authorities should address our problems when we tell them. It is good if they move us to another area, because we are sexually abused by people living nearby' (T31f).*

Seven participants suggested more foster care for minors and this was seen as preferable to hostels as they would feel part of a family, have more opportunities for development, and would be better protected from sexual abuse, as a young woman explained:

'I was new to this country and I knew no one when I arrived. Secondly I was not speaking English. If I was living with a foster parent they could have helped me in these things. I could have developed well if I was living with a foster parent. I could have changed and matured.... They could have taught me many things. They could have cared for me as a member of a family. If I was living with a foster parent I would not have been sexually assaulted' (T16f).

Some of the lay participants recognised that the assumption of safety from sexual maltreatment in foster care was a false one; some of them had been sexually abused in foster care, or had felt in danger of being. For example, a lay participant cautioned against female children being placed with a foster family if the foster father spends the whole day at home intimating that this would increase the young person's risk to sexual maltreatment.

Introduce to community organisations

Some felt that they would have been protected from being drawn into abusive situations with their fellow country people if they had been introduced to their community organisations early on:

'...they have to be introduced to the Ethiopian community to learn about the environment and get advice. Otherwise if they meet some one else by themselves they will take advantage of them' (J1f).

Some of those who had contact with their community organisations reported it to have been beneficial for their welfare, as a female participant described:

'Well, in the first place, I felt that I found my family because they are like your family. They are older and understanding. They lived in this country for so long and understand your problem. ... I was happy that they understood me when I talked to them. I was expecting them to help me. They were there for me when I most needed them. That was what I wanted. I would like to thank them on this occasion if this goes to them' (C3f).

Education as prevention

By far the most common type of education wanted was education about sexual abuse, which was mentioned by nearly half of the lay participants (n=22) followed by education about their rights in the UK (n=12). Many participants suggested multiple ways that professionals could intervene to help prevent sexual maltreatment:

'Young men and women need to be given advice and information on sexual abuse when they arrive in this country. They should be advised to report to relevant organisations in case of sexual abuse. It is good to inform young girls not to walk alone at night. They should be told about the problems they could face regarding sexual abuse. They should know how and where to report sexual abuse and other things' (T16f).

Several other participants (n=9) felt that UASM agreed that they should be taught such things on arrival in the UK. Others offered their opinions about who should provide the education, information or advice, these included: community organisations (n=6); the Government (n=5), social workers (n=3), via the Internet and the media (n=2); their own people (n=1); the church (n=1) and youth groups (n=1). However, they stressed the importance of collaboration between agencies and of help being culturally and linguistically appropriate:

'Professionals and people in authority work hand in hand to provide advice to young people. They should help teenagers to grow up properly. They should organise advocacy services in the council and other areas to provide advice and information to this group. When such things are organised, it is important to take into account religious and linguistic differences. People should be taught in the language they understand. Community organisations could contribute in providing advice to young people on sexual abuse' (T30f).

Some of the key professionals also felt education was a key element in preventing sexual maltreatment. The National Asylum Support Service (NASS) worker for example felt there should be an induction process on arrival which would include being taught in an educational and 'safe setting' their rights in the UK, the roles of different services that they will encounter, how to live in the UK and what support they can expect to receive. However the police sergeant suggested that such induction processes would be difficult to fit in, as there are often many practical problems to be dealt with early on, such as housing. Innovative ways are required of ensuring UASM receive all the help and information they need when they need it.

Educating perpetrators

Although many lay participants advocated for UASM being educated to prevent them from being sexually maltreated, some pointed out the importance of educating the perpetrators of sexual abuse as well:

'First of all students who had committed sexual abuse should be identified. It is advisable to provide lessons to these people on sexual abuse to help them understand that it is a crime and damaging to girls' (T26f).

This alludes to our finding that a large majority of the perpetrators were not British and some may have been asylum seekers themselves and may indeed have been unaware of the law relating to sexual offences in the UK, hence were perhaps less afraid of the consequences of it. Finkelhor's (1984) four preconditions to committing sexual abuse include the potential perpetrator's ability to overcome their own internal inhibitors, such as the fear of prosecution and punishment. Another would

be feeling empathy for their victim. Raising empathy for victims, as suggested above, is a goal of sexual offender treatment programmes. Again this would only be of benefit to the few who are convicted of sex offences or those who enter therapy voluntarily. Increasing the capacity of males to empathise needs to occur during their childhood.

Greater openness about sexual maltreatment

Several felt that the authorities should engender a culture of openness in relation to sexual abuse and assault, *'They should be told openly that they should not be scared to complain and report things to concerned bodies when things happen to them. They should be open to tell their problems'* (T18f). Another said, *'Social services and foster parents should discuss openly about sexual abuse with young people'* (T24f). As indicated earlier, discussion about the dangers of sexual abuse may positively impact on the likelihood of it being disclosed.

Eight lay participants said it was important for victims of sexual maltreatment to be given advice to disclose the incident to the police or others in authority and to be taught how to do this. Victims may feel encouraged to report incidents or near misses if they believed there would be a positive outcome from it, such as was experienced by a female participant who disclosed it to her teacher:

'What helped prevent a serious attack from happening was that as soon as I told my teacher she took a swift measure. ...She warned him to stop his action two or three times. When he failed to listen she reported him to the police. Thereafter he was dismissed from the school' (T26f).

More openness about sexual maltreatment is probably the single most important factor in both preventing sexual maltreatment, and in ensuring the perpetrators are brought to justice. Without disclosure of sexual maltreatment the problem remains hidden and intractable.

Take action against the offenders

The need to punish offenders was mentioned by two young people. Another said the offender should be removed from the locality. However, another pointed out that

it is better if the victim is re-housed otherwise if the offender knows where they live they may take retributive action.

Professionals' views on prevention

The professional participants were asked what they felt could be done to better prevent sexual maltreatment of UASM. Their responses related to both policy and practice and they provide a fairly diverse view of it.

Sentencing perpetrators

The police sergeant with project SAPPHIRE (specialist metropolitan police teams who investigate sexual assault) emphasised the need for offenders to be properly punished and to undergo treatment at the same time to reduce recidivism:

'The main thing is sentencing. The Government needs to ensure people get proper sentencing to help deter people from committing the crime in the first place. They should be detained for the full sentence and have opportunities to be reformed whilst in prison' (KP5)

This police officer recognised that the low level of prosecutions for sex crimes contributes to its perpetration as it reduces victim's motivation to report such crimes if they feel there will not be a positive outcome. It also signals to potential offenders that they can commit sexual offences with little risk of punishment. He believed that when justice is seen to be done in such cases it has a preventive effect.

Retaining and sharing professional expertise

The National Asylum Support (NASS) officer highlighted the lack of professional expertise in dealing with UASM, he suggested that there is a need for what he termed '*specialist regional resources*'. He saw these resources as offering professionals a guaranteed career within asylum /immigration with the opportunity to specialise in the different areas within it, such as abuse, trafficking, or international development. He suggested that services need to acknowledge that there will be

fluctuating numbers of UASM and build in enough flexibility to deal with that, whilst retaining staff with the requisite skills and experience.

The police sergeant praised the metropolitan police for a recent initiative called the *Community and Cultural Resource Unit* which is a database detailing officers' special skills that are outside their normal remit, such as other languages. Officers with these skills can be called in when needed.

Training staff

Training health and social care professionals to be more culturally competent was a commonly suggested recommendation for preventing the sexual maltreatment of minors. Participants' suggestions for the content of such training are listed in Box 6.1.

Box 6.1: Aims of cultural competence training

- Increased awareness of cultural differences.
- To gain culture-specific knowledge of the main cultures of their clients.
- To understand the differences between asylum seekers and refugees.
- To know what organisations to refer UASM to for help and support.
- To know about what is acceptable and appropriate in relation to child protection within different cultures.
- Understand the issues related to cross cultural working.

Some services, such as the police have acknowledged the need for culturally competent services, as the police sergeant explained:

'The message is that we must treat everyone according to their needs. For example, we wouldn't treat a Somali girl who has been circumcised the same way as we would treat a teenage single mother from the UK'.

Educating asylum seeking children about sexual maltreatment

The key professionals suggested a number of educative interventions that might help prevent sexual maltreatment of UASM including sex education in schools to provide information about sexual maltreatment and what to do about it when it

occurs. A former Ethiopian community worker highlighted how the multiple agencies that cater for the welfare of UASM have an educative role to play:

'...if there is a social worker who is allocated for this child, the social worker she has to teach, she has to give information to this young girl or young boy, also to the foster parents.... The schools I think have a role to play in protecting children from abuse. They can inform these young people to look after themselves; to complain if something happens to them. So Ethiopian community organisations, some of them have people who deal with young people, these people they can give information to young people to understand about sexual abuse and to know what to do if something happens to them. And the other thing is they have to train them in what sexual abuse is in the first place, that it is not only physical attack...' (KP4).

This participant may have been alluding to the frequent incidents of sexual intimidation and harassment where physical contact does not occur and the fact that sexual abuse often does not involve physical force.

Modifying the general education of UASM

A key professional highlighted how the education of UASM generally in schools may need to be different in some respects in recognition of their special needs:

'I'm saying they are special. They are unique in some ways and that's a nettle that has to be grasped. So, their education may need to be different; they may need to wait a while before joining the national curriculum.' (KP1).

Accessible services

Other issues raised by the professional participants regarding protecting this group were related to providing services in a culturally appropriate manner. For example, ensuring the information provided is in a language they fully comprehend; providing services with open access such as drop –in services; and provision of a safe environment in which they feel they can talk openly about difficult issues. Many other suggestions were made about how services for these young people can be improved, including services being more user-friendly and not too authoritarian, and

access to free and long-term therapy when required. A lack of knowledge of the help that was available to them was however a significant block to them getting help. Operation Paladin Child recommended in its report on UASM that, *'The Government considers the initiative to make available on arrival a card with dedicated help-line numbers for NSPCC and ChildLine at all UK ports'* (Metropolitan Police 2004: Recommendation 25). Our findings would endorse this view.

Information provision

Providing UASM with relevant information soon after their arrival, such as help-line numbers as part of an induction process was seen as an important way of helping protect them from sexual maltreatment. However, providing information leaflets, such as the one the Home Office is said to be working on was not felt to be enough by a participant:

'What I'd like to see is the contents of that leaflet worked up into perhaps and ESOL [English as a Second Language to Overseas Learners] course but delivered through an educational, safe setting so that they understand what the roles of the different people are that they encounter. What rights those people have and what rights they have as children and are better prepared... You know, I don't think handing somebody information is the same as receiving information in a class from an authority figure like a teacher' (KP1).

Ensuring information is available in locations that UASM frequent was also felt to be important, as well as providing it in their native languages. Other ways of targeting information towards this group needs to be considered. For example, many young people use the Internet such as at school, college or at Internet Cafe's. Community radio may be another useful way of getting relevant information across. However, such technologically dependent means of transmitting information may cause it to be inaccessible to some young people, particularly those such as UASM who may have limited access to technology-based media. The delivery of information in person may be preferred in some cases, such as through social workers, key workers, teachers, healthcare staff and the like. Other UASM who have been in the UK for some time may be able to contribute to a 'buddy' system for supporting newcomers. This would need to be managed and coordinated by an established

organisation; some schools and colleges have buddy or mentoring schemes (Wade *et al* 2005).

Conclusions

In summary, the prevention of sexual maltreatment of UASM requires a multi-faceted approach which recognises their unique position as children arriving in the UK without any parental, familial or community support; with many different beliefs and customs from the majority population. They need to be provided proactively with the opportunities to strengthen their personal resources, such as their self-esteem, assertiveness and self-confidence; and to improve their skills for living in the UK, such as English language skills, and knowledge of the social welfare system including community centres for their ethnic group. This needs to be backed up by strong external protection mechanisms, particularly in the early stages of their lives in the UK when their internal protective resources are weak and they are very vulnerable to sexual maltreatment.

Chapter 7

Perceptions and contradictions

Examining the issue of the sexual maltreatment of minors from cultures vastly different from the dominant culture in the UK illuminates its complexity and the dangers of making assumptions, particularly ones based on an ethnocentric perspective. This chapter discussed the various perceptions of the study participants that appear to be contradictory or contentious to help illuminate where caution may be needed in developing services and providing support for these young people.

The following passage illustrates the contradictions that many of our lay participants experienced as unaccompanied asylum seeking minors in the UK:

'...repeated trauma in childhood forms and deforms the personality. The child trapped in an abusive environment is faced with formidable tasks of adaptation. She must find a way to preserve a sense of trust in people who are untrustworthy, safety in a situation that is unsafe, control in a situation that is terrifyingly unpredictable, power in a situation of helplessness' (Herman 1992: 96).

Social denial and stigmatisation

Denial, repression, and dissociation operate as defence mechanisms against full acknowledgement of horrific events, such as rape, not only on a personal but also on a social level. People who experience such traumatic events may find that their experiences are not socially validated and that their story is 'unspeakable' (Herman 1992). Herman gives the example of Freud the founder of psychoanalysis who suffered professional ostracisation when he acknowledged the discovery of childhood sexual exploitation in the aetiology of hysteria, which he later denied. She argues that the study of psychological trauma requires the support of political movements, such as feminism which has done much to raise awareness of sexual abuse, sexual assault and domestic violence and to lifting the veil of silence that had

obscured the issue for hundreds of years. Some feminists argue that preventing CSA requires 'radical changes' to the structure of society (Waldby *et al* 1989), as our patriarchal society confers greater power to males and to adults. They argue that in many ways society legitimises the abuse of power through for example, not providing effective deterrents to those who choose to abuse their power.

Challenging assumptions

There is a common belief that it is better to place children with foster parents from the same ethnic group. However, although this may be found to be conducive to mutual understanding and cultural appropriateness, it also has the potential for negative outcomes. For example, Lees and Lovett (n.d:11) raised the issue of how some adolescent women may wish to '*...escape the confines of an oppressive culture*' and therefore may prefer not to be placed with a foster parent of their own culture. Another issue is that of national or ethnic loyalty (discussed in Chapter 5) which may lead to non-disclosure of negative care experiences to the authorities, as a female who arrived from Eritrea at the age of fifteen explained, '*When the child and foster parent are from the same ethnicity, the child does not tell her problems to the social worker*' (T1f). The issue of loyalty to one's community was highlighted by Droisen (in Driver and Droisen 1989) whereby black children may face a dilemma when considering reporting sexual abuse by a black person to a white person in that they do not want to add to racial prejudices.

Another issue for support workers or police is establishing the exact relationship of the carer or perpetrator to the minor, as in the Horn of Africa the perception of 'kinship' may extend beyond close blood relations to include a whole ethnic group. A 'designated teacher' explains the confusion that can be caused by this:

'The term 'uncle' is different, a culturally different meaning which I have found and 'brother' and 'cousin' obviously.'

(Interviewer) *'All of those terms would have a different meaning?'*

(Teacher) *'Especially for young people – cousin and brother – it's very Shakespearian actually it's just sort of my friend, he's my cousin, he's from the same ethnic group as me, he's my cousin.'*

(Interviewer) *'So a tribal affiliation?'*

(Teacher) *'Yes, so we say is it your mother or... and they go, "No, what are you talking about?" It's a complete cultural shift and the term 'uncle' can just be a trusted man who is taking parental responsibility not necessarily the father or mother's brother.'*

So professionals need to be aware of the many and various meanings that can be applied to what might otherwise (ethnocentrically) be considered common terms.

Professionals' definitions of child sexual abuse

The key professionals were asked how they would define child sexual abuse. Their responses indicated that there are some divergent perceptions and understandings amongst professionals as to the definitions and meanings of child sexual abuse, as two of the professional participants described:

(Counsellor) *'... I mean I got confused about the age of consent because I think if it's abuse, it is abuse. I think it's difficult to define where childhood ends... I'm not sure about that really.'*

(Interviewer) *'It's culturally based isn't it. A child in the UK is no longer a child at eighteen.'*

(Counsellor) *'Yes, exactly... ...and I think very individually based, some can be quite mature at a certain age and someone else isn't, but it's still abusive what's happened to them.'*

Another said,

'Sixteen is the age of consent, I suppose that's logical ... and um... I'd say different laws interpreted differently at eighteen. But contrary to my own thinking, I think the young person is still a young person at the age of twenty-one. Some local authorities have young persons who are aged between thirteen and twenty five, so there's quite a variation in definition of 'child' but I would say nought to sixteen' (KP2).

Definitional issues were also raised by a nurse educationalist:

'I mean I suppose deep down I really don't believe there is one specific definition for child abuse. It's all a very individual thing. And I suppose what you see yourself as being child abuse.'

According to these participants the age of the victim and the fact they cease to be children legally at eighteen years of age is less important than their emotional maturity and they stress the need to see each child or young person individually.

The fact that the victim may not see themselves as experiencing an abusive relationship may create problems for the professional, as the social services manager described, *'...it may be my view that the relationship is abusive, it may not be theirs [the victim's] and it can take quite a long time to work that through, so.'*

The concept of child sexual abuse is contentious and complicated particularly when attempting to relate it to different cultural contexts in which 'child' may have a different meaning and where there may be different perceptions of and tolerances to 'abuse'.

Impact of media campaigns

Child sexual abuse has received much public attention in the UK and other parts of Europe in the past twenty years or so. A positive outcome of this is that the public is much less denying of its occurrence. However, high profile cases have led to public campaigns against known paedophiles and there is concern, articulated by campaigning groups such as Save the Children, that this focus on sexual 'deviance' detracts from the fact that child sexual abuse is also perpetrated by those who are not paedophiles; it is much more widespread, being committed by a diverse range of people (Save the Children 2003).

Our participants indicated that there is a negative impact of high profile coverage in the media of paedophile cases in that it can cause fear of sexual maltreatment amongst young people. This fear can impact on their freedom to develop socially by restricting their movements and relationships, which for asylum seekers is likely to reduce their capacity to integrate. A female participant explained the impact such fear had on her:

'At that time we were confined to our house. When we wanted to walk, we walked a short distance. When we went shopping we used to go with her. At that time there was a lot of bad news on the TV about sexual abuse. We were scared of such things not to happen on us' (T6f).

On the positive side there is some evidence that media coverage of the issue has coincided with an increase in reporting by victims of CSA to anonymous telephone help-lines such as that provided by ChildLine. However, children who migrate to the UK from countries who have not been exposed to these messages are likely to be unaware of such support and consequently will not use it. None of our lay participants had used help-lines. This may also in part be due to cultural factors as asylum seeking children retain the beliefs and attitudes about sexual abuse and rape from their homelands which are bound up with secrecy, shame and social ostracisation, and worse (see chapter 1). The private sphere of the body and sexuality within a context of male ownership of women has historically relegated

sexual violation to a taboo subject. Herman (1992) poignantly reminds us that unlike the (male) casualties and survivors of war,

'...the most common trauma of women remains confined to the sphere of private life, without formal recognition or restitution from the community. There is no public monument for rape survivors' (p.73).

It seems likely to be true that healing from the trauma of sexual maltreatment (and successful strategies for its prevention) can only occur in the presence of total public acknowledgement within the context of a political movement. The Women's Movement has done much to try and make this personal issue political. Without such support, social denial and repression of the truth about sexual abuse and assault prevails, as is currently the case across much of the globe. Our participants often said they wanted to forget their sexual maltreatment. They may have felt this was the only option available as they were aware of the stigma surrounding it and the dangers of admitting to being sexually violated. Herman (1992) argues that *'In the absence of strong political movements for human rights, the active process of bearing witness inevitably gives way to the active process of forgetting'* (p.9).

Conclusions

Rape and sexual abuse need to become more than 'crimes in theory' and more needs to be done to bring the perpetrators to justice. Additionally, as one of our participants suggested, the shame and humiliation that survivors have historically taken as theirs needs to be transferred to the perpetrators and those who fail to protect the more vulnerable members of our society. Reducing the stigma that surrounds sexual abuse and assault in the UK will help encourage disclosure, thereby increasing the risk to perpetrators of being punished, increasing the chances of conviction and thereby reducing the incidence of sexual maltreatment. Clearly changing the underlying reasons behind the sexual maltreatment of children would be preferable to having to resort to child protection measures.

Chapter 8

Professional practice

Introduction

There are a number of diverse services in the UK that contribute directly to the protection of minors, these include: social services; the police; the NHS; counselling and therapy services; schools and colleges; and non-government organisations (NGOs), such as the NSPCC and Save the Children, ethnic community organisations, and youth groups. Many charities work on several fronts, such as the NSPCC which not only campaigns and educates in relation to child abuse but also helps shape the law in the UK, such as the new sexual offences legislation (NSPCC 2005). Many other organisations and services impact on the protection of children indirectly or without specification, including local government and transport agencies through their monitoring and surveillance systems, amongst others. Under-girding these organisation's policies and procedures are some common concepts and principles, such as the imperative to safeguard children; to work collaboratively with one another; and to provide services that are responsive to the needs of the full diversity of people living in the UK (to be culturally competent). This chapter discusses some of the strengths and weaknesses in professional practice relating to these principles in terms of their impact on the welfare of unaccompanied asylum seeking minors.

Issues relating to the use of services by UASM

Poor understanding or professionals' roles

UASM from the Horn of Africa may have difficulties understanding the different roles and functions of the professionals who become involved in their care, particularly when such professionals do not exist in their homelands. Indeed, some of our lay participants may not have discriminated between a statutory social worker and a key worker. This lack of understanding disadvantages them in comparison to indigenous children for whom the social welfare system has been designed and they are more

likely to be familiar with it. Poor English language skills further disadvantages the UASM in terms of learning about and utilising the welfare system.

Lack of knowledge of services

There are many resources that the UASM could have been 'plugged into' to receive help and support, such as community organisations specifically for their ethnic group and services for refugees, but the UASM were frequently not made aware of them by their carers. An interviewer's field note reported that an interviewee had,

'...continuously blamed social services for not giving her the information about the Ethiopian community centre who could give her appropriate services in the language she understands. She would have been in a position to get help, even how to report it to police and the perpetrator would have been arrested before he does the same to other young girls who are vulnerable.'

This failure to refer to community groups deprived the UASM of a useful source of support, information and advice as well as opportunities to commune with people from their homelands within a safe environment. The lack of formal and safe support meant that the UASM in our sample often turned to or accepted help from adults from their home country who were casual acquaintances. This often resulted in their sexual maltreatment, as a young woman explained:

'The thing that made me a victim of this person was that I needed an interpreter who would help me in interpreting Amharic into English and vice versa. I needed help for housing and other services. I met this Somalian who used to speak my language. I was happy to meet him. We got on well after that. He used to help me in interpreting. Slowly and gradually his situation started to change' (T16f).

UASM therefore need to be proactively directed toward professional and community services with a full explanation of their roles so they know who to turn to in any given circumstance.

Racism and discrimination

A professional participant suggested that professionals may have a sense of ambivalence about asylum seekers caused by the '*demonology about the numbers of people arriving in the country*' (KP1). There were suggestions made by some lay participants that the service they received was less than adequate as a consequence of discrimination based on their status as asylum seekers. For example, a young woman reported that when she had complained to her social worker regarding problems she had with her foster parent the social worker had said, '*Why do you complain, you are coming from a poor country and this is enough for you.*' In addition, the Stephen Lawrence Inquiry (MacPherson Report 1999) highlighted presence of institutional racism in Britain's police force; this is likely to be embedded in other organisations.

Cultural imposition

An issue for professionals was fear of imposing their own cultural beliefs and values onto their understanding of their client and their situation, as described by a designated teacher:

'...people do worry, they get very hung up on, "Oh I don't want to upset that cultural community by saying this is wrong and that's right, I don't want to impose my culture" and we can get very hung up on that' (KP8).

Fear of cultural imposition can create a significant barrier to child protection and this was a factor that was in the Victoria Climbié Inquiry report (2003) which concluded that,

'... we live in a culturally diverse society and that safeguards must be in place to ensure that skin colour does not influence either the assessment of need or the quality of services delivered' (16:13).

Imposing one's own cultural values and beliefs onto others, racial stereotyping and allowing fear of appearing racist to influence assessment or care does indeed need to be avoided. Culturally competent care requires professionals to

disregard their assumptions about minority groups or asylum seekers and to elicit each client's individual narrative. This can be done by carefully assessing the client by also taking into account the political and socio-economic factors that are impacting on their welfare, as well as their client's personal analysis of their situation, problems and solutions. From here the professional can devise, in partnership with the client, a care package that not only meets their needs but is also acceptable to them.

Distrust

Professionals dealing with UASM need to be aware that the young person may have been tortured in their homeland or witnessed the torture, rape or killing of family, friends and neighbours and how this may seriously impact on their capacity to trust people. This is born out by the fact that only four participants reported their experience of sexual maltreatment to the police. One of them had expressed a belief that the police do not trust refugees and that her report of abuse would be thought of as a lie. Lies, deception and propaganda are weapons of war, so such distortions of belief are likely to be common amongst those who come from areas where conflict and war are common. The police officer who participated in this study (who was working with project SAPPHIRE, a specialist team that investigates sexual assault) reported that foreign nationals often distrust the police because of police corruption in their homelands. Such distrust of the police and the perception that the police will not believe reports of sexual maltreatment is clearly incompatible with effective policing. These young people in effect live without complete protection of the law. UASM need positive experiences of policing to develop their trust in the service.

Young people who are new to this country, such as UASM, will not understand the British criminal justice system and the procedures for reporting crimes to the police; they probably will not be aware of the number to dial in case of emergency. Such basic information needs to be fully explained to them. They also need to be actively encouraged to report incidents of sexual maltreatment or near misses irrespective of whether they believe there will be sufficient evidence, and to know that even if a

perpetrator cannot be charged the police can still take action to prevent future occurrences.

Responsive interventions

UASM need to be reassured that professionals in the UK will respond to allegations of sexual maltreatment in ways that will not jeopardise their well-being or their asylum application. Fear of being returned to their country of origin may be intense, as returnees have been reported to suffer greatly. A report by the Danish Immigration Service (2004) cites Wolken who had indicated that *'young Somalis returning from abroad (particularly western countries, but also neighbouring countries such as Kenya) are vulnerable to physical abuse, and are viewed with suspicion by their relatives and local communities.'* Wolken had also reported that *'young females are at risk of rape and FGM'* (ibid: 45). Assurances that they will not be deported subsequent to reporting a sexual offence against them need to be made.

Institutional responses to sexual maltreatment of UASM

Considerations for social services

Finkelhor (1984), in discussing professional responses in the USA to CSA noted that criminal justice workers favoured pressing for criminal charges and were less concerned about keeping families together. Social services on the other hand favoured trying to keep the family together and emphasised less the need to press for criminal charges. As UASM have already been separated from their family this issue does not arise for their social workers in the UK who could take the necessary action to press charges against the perpetrator. This action may run counter to their proclivities and require them to challenge their own previously held professional values.

Inaction by social workers was a frequent complaint:

'We asked the social workers to transfer us to other accommodation. They said that our request was not satisfactory. We told them that we were scared of the young people living in the neighbourhood. They said that our reasons were

not convincing. We had complained several times to the social workers in social services' (T34f).

Sharland et al's (1996) study of professional interventions in child sexual abuse concluded that children who were abused by people from outside the family were more likely to have a response that was 'less than adequate' (p.201), a greater focus being placed on CSA within families.

Considerations for the medical professions

Our study indicated that there is a high degree of stigma surrounding rape, sexual assault and child sexual abuse particularly in the UASM's countries of origin which contributes to low levels of reporting of such crimes. Those delivering health care or other services need to be aware that such events may have occurred to their patients or clients and that they may be suffering from emotional or physical after effects. Psychological disturbance may manifest as somatic symptoms and this was common amongst our lay participants who often suffered headaches, insomnia, and eating disorders. They may also carry hidden infections such as chlamydia or suffer gynaecological problems particularly if they, like most females from the Horn of Africa, have been 'circumcised' (FGM). FGM may make vaginal examination impossible or difficult and painful depending on the type they have had performed.

Considerations for mental health professionals

There have been estimates of the prevalence of 'serious mental health disorders' among young refugees that suggest it may be as high as 40-50% (Hodes 1998 cited by Walker 2005: p.88). Because of the stigma of mental illness in the Horn of Africa, migrants from these countries (and others where it is highly stigmatised) may seek to conceal the outward signs of it and consequently delay seeking help for it (Papadopoulos *et al* 2006). Not only may mental health problems be concealed or expressed through somatic complaints, finding ways of helping refugees overcome such problems in a culturally acceptable way may present practitioners with difficulties. Bracken *et al* (1995) argued that,

'helping alleviate distress by the exploration of intrapsychic cognitions, emotions and conflicts is a form of healing somewhat peculiar to western societies and doubtful relevance to societies holding different core assumptions about the nature of the self and illness' (p.4).

Indeed, our own earlier study of Ethiopian refugees (Papadopoulos and Gebrehiwot 2002) found that People from the Horn of Africa may not wish to take up counselling, but may prefer to have more practical and less formal support, such as from their church and from friends. Their tendency to wish to forget the events was voiced by several participants as a goal for recovery:

'I have a lot of Ethiopian friends and we discussed this problem together. The problem did not happen to me only and I am taking it easy. Following their advice, I think I will change myself in future and as the time goes I may forget all about it. When I have a better life and have more friends in future, I am hoping to forget it all' (C1F).

For some however, not telling about sexual maltreatment is part of forgetting and they may believe that this is the only option because of the stigma attached to it in their countries of origin and the consequences for rape victims there (Chapter 1). Survivors of sexual maltreatment need reassurance that they will be believed and cared for subsequent to telling their secret, and that they will not be rejected.

Counselling may seem threatening to a young survivor of sexual maltreatment, they may fear it will force them to confess a 'sinful' event to a stranger that they may not be able to trust and they may fear this information will be used against them. An Ethiopian professional explained the existence of alternative 'cultural therapies' that are part of a cultural tradition which differ substantially from conventional mental health therapies:

'...people see members of the community. They look for those who are providing these sorts of therapy. So for example the church, they can go to the church and ask the priest to give them holy water or ask the priest to pray for

them. There is also someone - old people who are providing cultural counselling. They know how to talk to young people who are experiencing distress as a result of sexual assault and so on...' (KP4).

Some UASM had been or were currently under psychiatric care or counselling, but it is possible that they simply went along with it, as it was all that what was offered. Migrants learn to describe their distress by using the terminology of the professionals and this may be seen as part of their integration. Summerfield (2005) suggests that asylum seekers may feel that being able to articulate their distress in terminology that has currency in the UK is crucial for their asylum application. As they become more familiar with British culture and norms a dual system of health beliefs and behaviours that co-exists with their traditional system of beliefs and behaviours will develop. However, each individual migrant's help-seeking behaviour will depend not only on preferences but also on what is available at the time (Papadopoulos and Gebrehiwot 2002). Learning the indigenous ways of expressing distress and obtaining help is an adaptive response like learning to speak the language. However, many will value being offered choices where these are available, so helping them access traditional remedies or support would be a culturally competent approach. In a world full of strangers and severed from their culture many asylum seekers find that the church provides an environment that offers a degree of familiarity and continuity with their lives back home (Papadopoulos and Gebrehiwot 2002). Whereas counselling with its focus on the individual and its emphasis on talking may be an alien concept to UASM from the Horn of Africa. A participant said, *'She had provided me with counselling to help me overcome the abuse but they did not take any action and there was no change'* (T41f). However, she went onto say that they did link her up with 'church goers' for spiritual support. Several lay participants said that God had helped them through their ordeal of sexual maltreatment.

Encouraging disclosure

Less than half the lay participants said they had sought professional help subsequent to their sexual maltreatment; even when they did approach a

professional some did not disclose the incident to them. Fear was the main reason for not doing so. For young people who are living at the margins of society, fear is a constant companion. Professionals caring for them therefore need to be highly skilled in helping them overcome their fears and facilitate their disclosure of any maltreatment. Ascertaining who they feel might be a suitable person to confide in could be helpful; some may wish to avoid discussing personal issues with members of their own or other specific ethnic groups. Careful consideration of each child's background, culture and current situation should guide the practitioner's choice of method for encouraging disclosure.

Direct questioning

None of the lay participants reported having been asked if they had been sexually maltreated and professionals may erroneously assume that UASM will open up to their carers and talk about painful past experiences. Jensen *et al's* (2005) study of disclosure of CSA in Norwegian family situations noted the importance of adults initiating discussion about a child's apparent distress. Children may however do their utmost to conceal their distress. Another study by Diaz and Manigat (1999) suggested that questioning children directly about child sexual abuse experiences increases disclosure. It is possible however that the child or young person who is an unaccompanied asylum seeker may feel they have more to lose from such a disclosure having weighed up the risks and benefits.

Conclusions

UASM are extremely vulnerable to sexual maltreatment in the UK. The fact that many are repeatedly sexually victimised is a sign of failed child protection mechanisms. Changes are needed in the social and welfare system to prevent these young people from suffering the long-term psychological and physical damage and poor integration it often causes. It seems justifiable for professionals to assume that sexual maltreatment of UASM will occur if adequate protection is not provided. Adequate protection should not be dependent on the disclosure of incidents of it. Primary prevention not secondary prevention should be the goal. As fear of the consequences of disclosure is strong, even secondary prevention is in jeopardy if

professionals do not recognise the extreme vulnerability of UASM and their tendency not to feel able to disclose sexual maltreatment in the UK.

The need for close collaboration between professionals and others involved in the welfare of such groups has long been recognised and steps have been taken to improve it. However, it seems that the children and young people themselves need to be encouraged to be a central partner in this alliance. If they are fearful, distrustful and overly concerned about the sensitivities of those who care for them, as many are, their needs will not be met.

Chapter 9

Conclusions and recommendations

Conclusions

Child protection is an area of rapid growth, change and improvement; there have been many changes in policy and law this century, in particular since the inquiry into Victoria Climbié's tragic and preventable death from child abuse. The accounts provided in this report predate many of these changes but we feel the findings from this study provide some justification for many of them. This report particularly raises and addresses the issues related to the sexual maltreatment of unaccompanied asylum seeking minors who are amongst the most disadvantaged and marginalised in our society. Although they are a very small contingent their case deserves special attention not least because of its capacity to highlight the gaps and problems in services and knowledge that the study of mainstream cases may fail to illuminate.

As the first study of the sexual maltreatment of unaccompanied asylum seeking minors in the UK, the SAFER UK study has had to blaze a new trail. In so doing it has made some useful new discoveries and connections. Here we present these in the form of suggestions and recommendations, many of which come directly from the lay and key professional participants (LP/KP) and the project's Advisory Group. Other recommendations are derived from a synthesis of the literature and interpretation of findings. The recommendations are presented under headings denoting each of Finkelhor's (1984) four preconditions to child sexual abuse. A model based on this that we devised for conceptualising the protection of children from sexual maltreatment is also given. Finally a summary of some of the main recommendations for the improvement of services is provided.

Recommendations for the prevention of sexual maltreatment

Key: 'LP' denotes suggestions by lay participants and 'KP' denotes suggestions by professional participants.

Reduce motivation to commit sex acts with inappropriate/ unwilling partners

- Remove the temptation: young asylum seeking males should not be housed with or near young female asylum seekers
- Reduce time asylum seekers spend waiting for their asylum decision
- Provide asylum seekers (particularly young males) with opportunities to build self-esteem and to gain emotional fulfilment
- Disallow unsupervised male visitors to female only accommodation, e.g. permit only in common areas under supervision

Strengthen perpetrator's (offenders) internal barriers to (re)committing sexual offences

- Educate young asylum seekers of both genders and perpetrators/offenders about sex offences and their penalties (LP/KP)
- Ensure perpetrators /offenders are punished (LP/ KP) as this will act as a deterrent to others
- Reform offenders whilst in prison (KP)
- Educate perpetrators /offenders about the harm they cause to victims (LP) to help increase their empathy
- Educate males to respect females and not abuse power over them (LP/KP)

Strengthen external barriers to perpetrators' (re)committing sexual maltreatment of UASM

- Provide UASM with a safe environment including appropriate accommodation (LP/KP) – single sex, male visitors not allowed in unsupervised, and foster care for those aged 16+ if seem particularly vulnerable (as well as those aged under 16)
- Re-house victims to prevent re-victimisation or re-house offender (LP)

- Institute more monitoring and supervision of UASM (LP/ KP)
- Engender a societal culture of openness about sexual maltreatment and encourage disclosure e.g. through active participation in anti-abuse campaigns (LP)
- Provide prompt professional action upon disclosure of sexual maltreatment (LP)
- Strengthen professionals' skills, especially their cultural competence and knowledge about where they can refer UASM to, particularly community organisations for specific ethnic groups (LP/KP)
- Improve interagency working (LP/ KP)
- Improve relations between police, migrants and minority ethnic groups (KP)
- Consider providing care under section 20 of the Children's Act for all UASM in order to enable them to have more support and support on leaving care (KP)

Strengthen resistance of potential victims (and make them less likely to be targeted)

- Teach UASM about sexual maltreatment, how to recognise the danger signs and steps they can take to help protect themselves
- Provide information, advice and support on how to report incidents of sexual maltreatment (LP/ KP); UASM need to see that action will be taken; give feedback on action taken and results
- Teach UASM about their rights in the UK and the support available to them soon after arrival e.g. through community organisations (LP/ KP)
- Create regular opportunities for UASM to have private discussions with their social worker (LP)
- Encourage UASM to take up English language skills courses as soon as possible; use language courses as a way of educating them about the system (KP).

A model for child protection

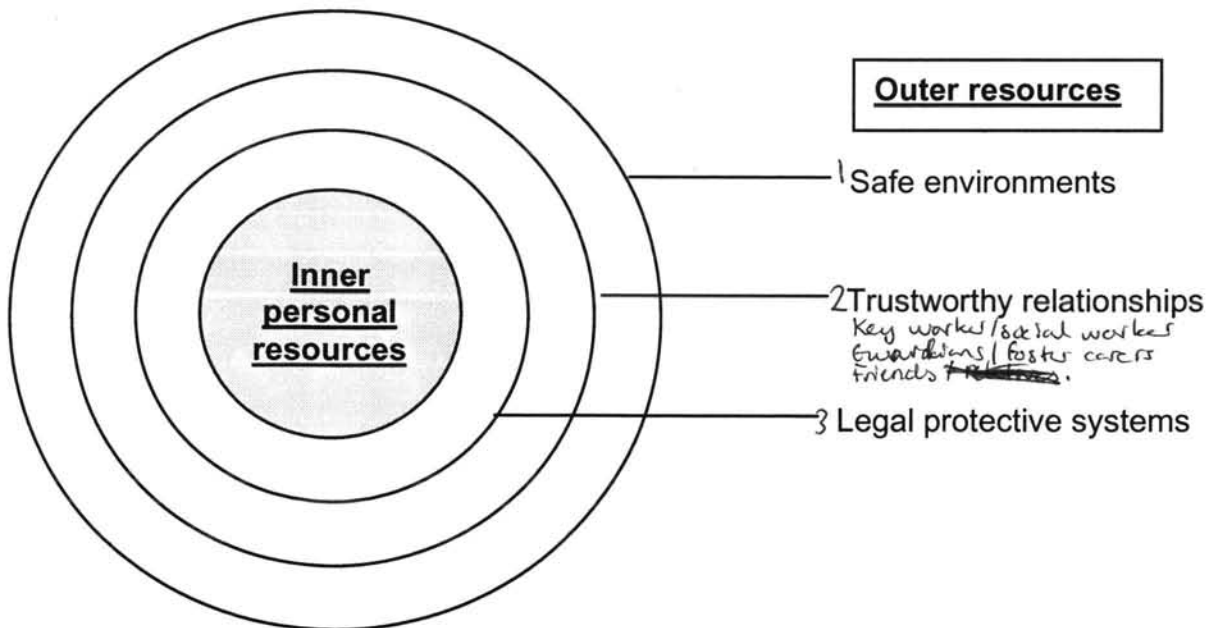
We have devised a model for the protection of minors that is also useful for conceptualising risk assessment. The model is based on two of Finkelhor's

preconditions to child sexual abuse: the external barriers and the child's resistance (termed personal resources in our model). It places the child (minor) at the centre of the model and credits them with having some internal personal resources that can be drawn upon to defend themselves, or that make them a less likely target for sexual assault. These internal personal resources could include (according to the participants in this study) the following components in varying degrees: language and communication skills; self-esteem and self-confidence; assertiveness; awareness of the potential to be sexually abused or assaulted; awareness of perpetrators' modus operandi; awareness of their rights not to be abused or assaulted; and awareness and knowledge of the outer resources around them which can be drawn upon for protection; the knowledge of how to access them, and the means to do so.

The second aspect of the model is the 'outer resources'; these can be conceptualised in terms of first, second and third lines of defence which in the model are denoted by concentric circles around the child's inner personal resources. The outer protective barrier represents the environment, e.g. the safety and security of their accommodation, place of education, and the local community; the second line of defence represents human resources, including their formal support networks such as their foster parents and social/key worker, and their informal social support networks made up of friends and others. The third line of defence represents legal protection, such as is provided by the police and criminal justice system that are activated when the first and second lines of defence are breached or fail.

Our study has shown how UASM may become exposed to the risk of sexual maltreatment and that this tends to happen when their inner personal resources are depleted or when the outer resources fail to function. When this happens UASM will venture into unprotected territory and may become the victims of unscrupulous individuals.

Figure 9.1: The SAFER UK model for child protection



External barriers and the child's resistance

Recommendations related to improving all relevant services

Notwithstanding improvements in services that may have taken place since the data collection period of our study, we recommend that services need to be improved along the following lines if they are to help implement the actions listed above.

A) Improve access to and cultural competence of services by:

1. providing information about them in the user's language,
2. providing professional interpreters and advocates as and when they are needed,
3. establishing user friendly service environments,
4. providing less authoritarian services,
5. employing more black and ethnic minority workers,
6. developing special regional resources,
7. improving career prospects for those working in specialist fields with UASM to encourage their retention,
8. establishing a 'buddy' (peer) support scheme for UASM

B) Improve the effectiveness of all relevant services through:

9. the development of joint protocols for seamless services which apply preventative practices, are able to identify and solve problems quickly and stop UASM falling through their protective nets,
10. raising awareness about each others roles through networking and joint meetings,
11. using new technologies such as ICT to share information in ethical and culturally appropriate ways,
12. the establishment of joint appointments in key roles.

C) Improve the cultural competence of service providers through:

13. the provision of multi-disciplinary training and continuous professional development;
14. the provision and easy access of relevant information on as many ethnic groups as possible, such as that of heritage, cultural/ethnic identities, cultural practices, gender and sexuality, religion, wars/conflicts, possible traumas/violence they may have experienced or witnessed, socio-political systems of countries of origins etc;
15. seeking the views of UASM when developing or reviewing services, policies and procedures relevant to them.

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SAFER UK PROJECT

CONFIDENTIAL QUESTIONNAIRE

ID Code: _____ (for office use only)

Instructions for completion

1. Please complete this questionnaire before your interview and hand it to your interviewer.
2. Do not write your name on this confidential questionnaire.
3. If there are questions you would rather not answer you do not have to, but please try to answer as many questions as you can.
4. Please tick one response only unless stated otherwise.

Section 1. Questions about you

Q. 1. Are you:

- 1 Male
- 2 Female
- 3 Transgender (living as opposite sex)

Q.2. What is your age? _____ years

Q.3. How old were you when you arrived here as an asylum seeker ____ years.

Q.4. Before you came to the UK, in which country did you spend most of your life?

- 1 Ethiopia
- 2 Eritrea
- 3 Somalia
- 4 Other – please specify

Q5. What is your ethnic origin?

- 1 Ethiopian
- 2 Somali
- 3 Eritrean
- 4 Mixed (please specify) _____
- 5 Other (please specify) _____

Q6. What is your religion?

- 1 Christian
- 2 Muslim
- 3 Jewish
- 4 Atheist /agnostic
- 5 Other (please state which) _____

Q7. How did you find out about this study?

- 1 Ethiopian radio station
- 2 Approached by an interviewer from the project
- 3 Told about it by a friend / associate
- 4 Received /saw a leaflet about the project
- 5 Saw a poster about the project
- 6 Other (please specify) _____

Q8. Which town or Borough do you live in now?

Section 2. We would now like you to try and answer some questions about your experiences of sexual assault /abuse as a child in the UK, or your experiences of when it nearly happened.

Q9. How many 'good' adult relationships with family or friends did you have in the UK around the time you were first sexually abused or sexually assaulted as a child (by 'good' we mean people you could trust) _____

Q10. Around the time you were first sexually abused or assaulted, how frequently approximately did you get to meet with someone you had a good relationship with?

- 9 Not applicable
0 Not at all
1 Less than monthly
2 Once a month
3 Once a week
4 Daily

If you are unsure of the terms 'sexual abuse' or 'sexual assault', please ask the interviewer to give you definitions.

If you are MALE, please continue here, if FEMALE go to question 11b.

Q11. Sexual abuse and sexual assault can involve any of the following acts. If you are male please indicate what you experienced whilst being sexually abused or sexually assaulted as a child in the UK by ticking the box against the act(s)

(Please tick all that apply):

- Hand to genital touching
 Other types of fondling
 Intercourse with a female
 Giving anal intercourse to a male
 Receiving anal intercourse from a male
 You performing oral sex on a male
 You performing oral sex on a female
 Oral sex done to you by a male
 Oral sex done to you by a female
 Enforced sex with animals
 Pornographic photography
 Other (please specify):

Q11b. Sexual abuse and sexual assault can involve any of the following acts. If you are female, please indicate what you experienced whilst being sexually abused or sexually assaulted by ticking the box against the act(s)

(Please tick all that apply):

- Hand to genital touching

- Other types of fondling
- Intercourse with a male
- Anal intercourse with a male
- Simulated intercourse with a female
- You performing oral sex on a male
- You performing oral sex on a female
- Oral sex done to you by a male
- Oral sex done to you by a female
- Enforced sex with animals
- Pornographic photography
- Other (*please specify*):

Q12. Approximately how many separate incidents of sexual abuse or sexual assault were you subjected to before you were aged 16 in the UK?

- 1 One
- 2 2-3
- 3 4-6
- 4 7-9
- 5 10 or more

Q13. Have you experienced any of the above acts listed in Question 11 /11b whilst aged under 16 in the UK in situations

that involved more than one adult, or a group(s) of adults at the same time?

- 1 Yes
- 2 No

Q14. Some children are given material rewards or special treats for giving adults sexual 'favours', did this apply to you?

- 1 Yes
- 2 No
- 3 Not sure

Q.15 Have you been sexually abused or sexually assaulted since you were aged 16 in the UK?

- 1 Yes
- 2 No
- 3 Not sure

Q16. How would you describe your education about sexual matters?

- 1 It was good – I was taught most things I wanted to know about
- 2 It was fairly good –but some things I wanted to know about were not taught
- 3 It was not good – it only covered some basics
- 4 It was non-existent

Q17. Do you recall being taught as a child to be aware that adults might sexually abuse you?

- 1 Yes
- 2 No

Q17b. If 'Yes', please tick who warned or taught you about this

Tick all that apply

- Told in school in England
- Told in school in Ethiopia/ Eritrea /Somalia
- Parents or other adult warned me
- Sisters /brother/ other child warned me
- Found out another way (*please specify*):



Section 3. Now some questions about the possible effects of being sexually abused /assaulted, or experiencing a 'near miss'.

Q18. Have you experienced any of the following problems since your experiences of childhood sexual abuse or sexual assault, or a near miss?

Tick all that apply

- Symptoms of mental distress (such as anxiety, depression, sleeplessness, phobias etc)
- Persistent nightmares
- Drug or alcohol abuse
- Blanks in your memory about / or around the time of the abuse /assault
- An eating disorder (e.g. anorexia or bulimia)
- Psychiatric symptoms requiring medication or hospitalisation
- Feeling life was not worth living
- Harmed your self, or tried to commit suicide
- Difficulties forming or keeping friendships or sexual relationships
- Lack of interest in sex, fear of intimate contact or similar psychological reaction

- Lack of self esteem or self –confidence
- Problems concentrating on study or work leading to poor achievement
- Difficulty integrating into English society
- None of the above
- Other psychological problems – please describe:

Q19. Did you seek any professional help or advice about what happened to you or its consequences from anyone?

- 1 Yes
2 No

- If you did seek professional help, who did you seek help from?

Tick all that apply

- Telephone advice line
- Accident and emergency department
- GP
- Sexual health clinic
- Social worker
- Counsellor or therapist
- Other – *please specify:*

- If you did not seek professional help, why was this?

If you are female please answer question 20, if male please skip to question 21.

Q20. Have you been circumcised?

- 1 Yes
2 No

If you are female OR male, please answer the following questions about your health:

Q21. Have you suffered any physical health problems that you feel are a consequence of sexual abuse or sexual assault that you experienced before you were aged 16 in the UK?

- 1 Yes
2 No

- If 'Yes', please state what it was/ is:

Q22. Have you attended counselling or psychotherapy since being sexually abused, sexually assaulted, or having a near miss event in the UK?

- 1 Yes
2 No

Q23. Have you received any psychiatric treatment or assessments since you were sexually abused or sexually assaulted, or had a 'near miss' event in the UK?

- 1 Yes
2 No

Thank you very much for answering these questions.

Appendix 2: Lay participants' interview schedule

SAFER UK PROJECT

Interview Schedule for Lay Participants

ID code: _____

MAKE SURE THEY READ THE INFORMATION SHEET AND SIGN THE CONSENT FORM (if a telephone interview see the note below*). PLEASE REMIND THE INTERVIEWEE THAT THE INTERVIEW IS CONFIDENTIAL AND THAT THERE IS ABSOLUTELY NO CONNECTION WITH THE HOME OFFICE.

Introduction (no need to record)

Thank you for agreeing to be interviewed for this research project.

As the information sheet explains, the SAFER UK study aims to help prevent sexual abuse and sexual assault of vulnerable young people in the UK and to help professionals deal with it better when it happens.

The experiences you had may seem relatively minor to you, or they may have been severe or long lasting, either way we are interested to hear about your experiences. We are also interested to hear about when you felt at risk of people doing sexual things to you that you didn't want them to do when you were a child in the UK.

*You have indicated on your questionnaire that someone **did** treat you in a sexual way when you were a child in the UK. I would like to ask you to tell me more about the circumstances around these experiences, are you still happy to do this?*

It would be easier if you can tell me about the first incident, or near incident, and then proceed through time to tell me about any further incidents.

*** Please Note: If a telephone interview – tell them you need to obtain their consent to participate by recording their responses to the following questions:**

- Do you confirm that you have read and understand the information sheet dated 05/05/05 for the SAFER UK study and have had the opportunity to ask questions? (*Await response. If they have not read it, please read it out to them (you don't need to record doing this and repeat this question ensuring you record it.)*)
- Do you understand that your participation is voluntary and that you are free to withdraw at any time, without giving any reason? (*Await response*)

- Do you agree to take part in the above study? (*Await response*)
- Do you agree to your personal interview being tape recorded? (*Await response*)

Before commencing the interview, review the questionnaire to ascertain their history and their experiences. Refer to their questionnaire responses during the interview.

Ask the following questions for each incidence of sexual abuse/ sexual assault /near miss.

Q1. I would like to ask you some questions about the [first/ next] time you were sexually abused or assaulted, or when you [first/ next] felt at risk of this as a child in the UK.

- Where did the [first / next] incident / near incident take place?
- How old were you when it happened?
- What were the circumstances around the event / near event (e.g. what led up to it)?
- How many people sexually abused or sexually assaulted you, or attempted to do this that time?
- What was your relationship to the group or the individual?
- If you knew the person/ people, what were the circumstances of you getting to know them?
- Approximately how old was the person/ people who sexually abused, sexually assaulted you, or attempted to do it?
- What was the sex of the person/ the people who did it?
- What was the ethnicity or country(ies) of origin of this person / these people?
- What were your housing circumstances at the time?
- If you were living with foster parents, what was their ethnicity?
- Which borough or town did you live in?
- Did you have a social worker at the time?
- What was your immigration status at the time?

Q2. What do you feel made you vulnerable to this happening /nearly happening?

Q3. **(If a near miss)** What do you think helped prevent it from actually happening?

Q3b **(If it happened)** What do you feel might have prevented it from happening?

Q4. Have you told anyone about this incident? *[If 'Yes' ask the follow- up questions]*

- Who did you tell?
- If you have not told anybody, why was this?
- Is there someone you would like to have told?
- Who would you like to have told?

Q5. What was the reaction of the person(s) you told? *[If told more than one person, ask about each person's reactions in turn and get them to state the person's role or relationship to them, but not their names].*

- How did you feel about their reactions?
- How would you like them to have reacted?
- What did they do after you told them?
- How did you feel about what they did?
- What would you have liked them to have done?

Q6. Did you report this incident to the police?

- *(If reported)* What was the outcome of you reporting it to the police?

E.g. case dropped for lack of evidence/ prosecution etc)

Q6b. *(If did not report to police)* Why did you not report this incident to the police?

If abused more than once by the same person, ask:

Q7. How many times were you abused by the same person approximately? *(Try and get an approximate figure)* _____

Q8. How old were you when the abuse by this person started? _____ years

Q8b. How old were you when the abuse stopped? _____ years

Q9. What social support organisations were you in contact with during the period(s) when the sexual abuse / assault(s) happened?

For example, ECCUK, social services, the housing department.

***Repeat the questions from the beginning to here for each incident with different perpetrator(s)**

Q10. When you think back to being sexually abused /assaulted how does it make you feel?

Q11. What do you think needs to be done by professionals and people in authority to help prevent young refugees from being sexually abused or sexually assaulted in the UK?

Thank you for participating in this important research project. Remember that what you have told me will not be linked to you in any way and your name will not be mentioned in any documents coming from the research.

END recording

Advice on counselling services

Example of what you might say:

You may feel upset by what we have discussed today and feel you need to talk to someone. There are organisations in England that offer counselling to help people cope with difficult events and feelings, many of which are free. I will give you a leaflet giving you details of these organisations and how to contact them. If a service you choose charges a fee, the leaflet tells you how you may be able to get this paid for by the research project.

There are many other counselling organisations which you can find by looking on the Internet, in the telephone directory, or by asking your doctor.

APPENDIX 3 : Professional participants' self-completion questionnaire



Charity Registration No.1087526
Company Registration No.4215772

SAFER UK PROJECT



**Middlesex
University**

**RESEARCH CENTRE FOR
TRANSCULTURAL
STUDIES IN HEALTH**

ID code: (for office use only) _____

SELF COMPLETION QUESTIONNAIRE FOR KEY PROFESSIONALS

**Thank you for agreeing to participate in this important study.
The information you provide will be kept in the strictest confidence and no
names will be mentioned in any outputs from the study.**

INSTRUCTIONS

- **Please read the attached study information sheet prior to completing this questionnaire which should be completed prior to the interview.**

Section 1:

- What is your professional title:
- The name of the organisation you work for:
- Your specialism or field of work:
- Name of the department if relevant:
- Area or borough where based:
- Does your role usually have a local / national / international remit? (*Delete as appropriate*)

Continued overleaf:

Section 2:

YOUR PROFESSIONAL ROLES AND EXPERIENCE IN RELATION TO THE RESEARCH TOPIC

Please give a *brief outline* below of any professional or voluntary experience you have had with the following:

- a) Dealing with people (please state if children) who have been sexually abused or sexually assaulted;
- b) Dealing with child refugees or asylum seekers, or such children who arrive in the UK unaccompanied by a parent or guardian.
- c) Developing policies that impact on the welfare of the above people.

Please give some indication of the amount of experience you have had and the nature of your role:

A)

B)

C)

Thank you.

APPENDIX 4: Professional participants' interview schedule



Charity Registration No.1087526
Company Registration No.4215772



Middlesex University

RESEARCH CENTRE FOR
TRANSCULTURAL
STUDIES IN HEALTH

INTERVIEW SCHEDULE FOR KEY PROFESSIONALS

Preamble (to be recorded in a telephone interview)

Thank you for agreeing to be interviewed today. The interview should not last longer than one hour. I would like to tape record the interview to ensure I capture the information accurately. I will not write your name on the tape or use your full name in the interview. The tape will be destroyed after it has been transcribed. Are you happy about the interview being tape recorded? All the information that you give me today will be held confidentially and will only be used for the purposes of research.

(**CONSENT FORM TO BE SIGNED if interviewed in person)

SECTION 1: SEXUAL ABUSE

Q1. In the literature there are a number of definitions of child sexual abuse, how would you define child sexual abuse yourself? *[power relations, age differentials, the acts]*

Ask the next question only if has had professional experience of dealing with cases of child sexual abuse (ask about the unaccompanied minors, if has experience with them according to self –completion questionnaire).

Situational analysis

Q2. Reflecting back on your experiences of dealing with cases of child sexual abuse in your capacity as a *[professional role]* can you tell me the sorts of events that commonly occurred and the sorts of circumstances that surrounded these events.

<i>Location of incident(s)</i>	<i>Housing type</i>	<i>Level of adult supervision</i>
<i>Time(s) of incident(s)</i>	<i>Carers</i>	<i>Relationship to perpetrator(s)</i>
<i>Nature of incident(s)</i>	<i>Co-habitees</i>	<i>Single or multiple events</i>

Q3. What do you believe are the factors that may make some children more vulnerable to child sexual abuse or sexual assault in the UK?

<i>Age</i>	<i>Parental absence</i>	<i>Fear of disclosure</i>	<i>Hard to prove</i>
<i>Gender</i>	<i>Previous trauma</i>	<i>Stigma & shame</i>	<i>Domestic violence</i>
<i>Ethnicity</i>	<i>Cultural factors</i>	<i>Attitudes</i>	<i>Language</i>
<i>Past abuse</i>	<i>Disabilities</i>	<i>Lack of adult support</i>	

SECTION 2: SUGGESTIONS FOR IMPROVEMENT

Q4. In your view, what more could your organisation do to help prevent sexual abuse and sexual assault of unaccompanied minors in the UK?

Policy; practice

Q5. What more could other agencies do to help prevent child sexual abuse and assault among unaccompanied minors in the UK?

*Social services Housing Immigration Health Education Police
Employment policies and procedures; employee screening; confidential systems for reporting incidents; training of staff; 'safe' housing; encouraging reporting of perpetrators; zero tolerance; training to spot victims/ vulnerability;*

Q6. How could such young people be helped to prevent it happening to themselves?

Education input – greater awareness; help to find appropriate relationships; increase their self-esteem; discourage use of alcohol and drugs; alert them to helping agencies; someone to turn to/ support and supervision

Q7. How could interventions and treatment be improved for such children and young people?

Encourage disclosure; inform re helping agencies on arrival to the UK such as ECCUK

Q8. How could interventions and treatment be made more culturally appropriate?

Language; Location of interventions; User participation in org; Gender or ethnicity of therapist; Training in cultural competence; Culturally competent policies

Q9. Are there any other policy issues in your view that need attention?

Q10. Are there and issues regarding interagency working that need attention?

END

APPENDIX 5: Dissemination activities

The study's preliminary findings were presented at the following international conference:

Lay, M., Papadopoulos I., Gebrehiwot A. (2006) *Preventing sexual maltreatment of unaccompanied asylum seeking minors and improving services for them (preliminary findings)*. Presented at: XV1th ISPCAN International Congress on Child Abuse and Neglect, 3-6 September 2006, York, UK. *Children in a Changing World: Getting it Right*. Available:

http://www.ispcan.org/congress2006/Book_Abstracts_06.pdf

Papadopoulos, I., Lay M., Gebrehiwot A. (2006) *Sexual maltreatment of unaccompanied child refugees*. Presented at: IVth International Conference of the International Society for Equity in Health (ISEqH), 11-13 2006 September, Adelaide, Australia. *Creating Healthy Societies through Inclusion and Equity*. Available at:

<http://www.iseqh.org/docs/BkOfAbstracts2006.pdf>



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Ethiopian Community Centre in the UK

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