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Title: Professional responses to sibling sexual abuse

Key Words

Sibling Sexual Abuse, Sexual Violence, professional practice

ABSTRACT

Professional confidence and knowledge are essential in effectively responding to sibling sexual abuse (SSA). If professionals do not have knowledge of the area and confidence in their skills to deliver effective support, then there could be negative consequences for the victims.

The methods consisted of narrative interviewing of N=30 professionals and N=2 young victim/survivors. This approach was chosen as it provided a thorough and robust picture of practitioner responses to SSA.

Through thematic analysis, three dominant themes emerged across both the young person and practitioner data in relation to practitioner responses to SSA, these being minimisation, exaggeration and catastrophising.

SSA is an area in its own right with its own nuances and considerations that make it distinct other forms of sexual abuse, which means that professional responses and training needs to be re-examined to develop new, more appropriate ways of working with victims of as well as those who commit SSA.

Impact Statement

The impact of this paper is both clinical and professional. It gives insight into a little researched area and highlights the complex issues in relation to sibling sexual abuse and how this is framed and approached by professionals. This points out the critical need for more work and training in this area to when working with SSA and the need for more bespoke professional knowledge.

Introduction

Sibling sexual abuse (SSA) is an emerging research and practice issue (Yates and Allardyce, 2021), although it is not a new concept, as historically SSA would fall under the purview of incest. What is becoming clear is that SSA is an area in its own right with its own nuances and considerations that make it distinct from child sexual abuse, peer-on-peer sexual abuse and incest; which means that we need to re-examine the behaviour and develop new, more appropriate, ways of working with victims of as well as those who commit SSA. This article will re-examine the concept of professional responses to SSA based on empirical research carried out via a Home Office funded research project in collaboration with Purple Leaf (West Mercia Rape and Sexual Abuse Support Centre) and consider what this emerging knowledge means in respect to the identification, treatment and potential prevention, or at least intervention, of SSA. The article will examine problematic practitioner responses to SSA, ascertained through thematic analysis of data collected through N=30 interviews with professionals and N=2 young people. This paper specifically focuses on three central subthemes within professional responses: minimisation, catastrophising and access to resources. Ultimately, the authors offer insight into the why such responses occur, and what might be done to create better supportive experiences for young people and families effected by SSA in the future.

Literature Review

SSA definition and contexts

Defining SSA is notoriously complex and there is a distinct lack of specific literature in the field (Caffaro 2020; Yates, 2017; Tapara, 2012; Stathopoulos, 2012; Krienert & Walsh, 2011; Allardyce and Yates, 2009). Within the existing literature, no singular, agreed upon definition is evident for SSA and there is variation in how CYP 'who have harmed' and those who 'have been harmed' to SSA are defined (Yates, 2017; Yates & Allardyce, 2021). Yates (2017) and Yates and Allardyce (2021) assert that SSA can be viewed through a framework that consist of:

i. harmless play/normative interactions between siblings
ii. mutually initiated sexual behaviour/inappropriate and/or problematic behaviour between siblings
iii. harmful sexual behaviour/ sibling sexual abuse

Using this staged model Yates and Allardyce (2021) state that only those behaviours in the harmful category constitute SSA. Yet Caffaro (2020, p. 759) furthers this model stating that SSA is 'minor or advanced' non-consensual behaviour between siblings. This complexity is exacerbated by the difficulty in defining what constitutes a 'sibling' as outlined in the study carried out by King-Hill, Gilsenan, Beavis and Barrie, (2021). Furthermore, SSA prevalence data is limited due to the under-reporting from both families and CYP (Caffaro, 2020; Caffaro & Conn-Caffaro, 2005; King-Hill et al, 2021, Yates & Allardyce, 2021). Collation of available data suggests that 25% to 50% of CSA is related to SSA and is estimated in the UK to be twice as likely than abuse by a parent (Finkelhor et al, 2009; Beckett, 2006; Shaw et al, 2000; Hackett et al, 1998;).

Professional practice and SSA

There are significant issues surrounding the disclosure of and subsequent practitioner responses to SSA. Krienet and Walsh (2011) state that minimisation of the behaviour by the family, CYP and professionals inhibits the disclosure process. This is amplified by the social stigma that surrounds SSA, sporadic services and the long waiting times for interventions (Warrington et al, 2017; King-Hill et al, 2021). These aspects appear to contribute to issues surrounding adequate referrals and interventions for CYP who have experienced SSA and their families.

There is a complex array of obstacles when considering professional practice and SSA. Embedded at its core is the misunderstandings that surround SSA and the difficulty in defining it and recognising when abuse is taking place (Caffaro, 2020; Caffaro & Conn-Caffaro, 2005). This is reinforced by the taboo aspects of SSA that in linked to how society views family, thus impacting on a professional judgement with the behaviour often remaining hidden (Yates, 2017; Krienert & Walsh, 2011). Yates and Allardyce (2021) highlight that interventions and services for CYP, and their families are under researched, and training is lacking which in turn results in professionals with little knowledge, experience and confidence. In this vein Caffaro (2020) advocates for more specific training in this area with more tailored interventions being available for the CYP and their families (Streich & Spreadbury, 2017). Caffaro and Conn-Caffaro, (2005) state that professionals lack confidence when working with SSA and this can then impact upon their reactions and is further inhibited by the resources available. Streich and Spreadbury, (2017) point to the difficulties of multi-agency working and that often over reaction is evident with the child being removed from the home but with no additional support in place. These barriers appear to be linked to the range

and difference in the infrastructures into which these services are embedded i.e., public sector/third sector.

It is, therefore, prudent to explore what best-practice looks like in relation to SSA, in terms of practitioner responses and interventions. The underpinning aspect of good practice appears to be related to confidence and knowledge (Barry, 2020). This advocated specific training for all professionals involved in responding to SSA to prevent adverse reactions of minimisation or over reaction (Yates & Allardyce, 2021). This ideally should encompass emotional reactions to SSA and professional support pathways in the form of robust supervision (Yates and Allardyce, 2021). The understanding of SSA by professionals must take on a holistic approach that encompasses the needs of the whole family and that making this an individual issue can impact upon the reactions of the professionals (Yates & Allardyce, 2021; Caffaro, 2020). In line with this both Yates and Allardyce (2021) and Caffaro (2020) strongly advocate for restorative approaches to be taken by professionals rather than a reactive punitive approach due to the familial nature of SSA. Additionally early intervention is outlined as a crucial element to successful outcomes for SSA (Barry, 2020), yet as noted by Yates and Allardyce (2021) these approaches are severely underdeveloped which negatively impact upon professional reactions to SSA and subsequent outcomes.

Confidence in professionals

In relation to practitioner confidence specifically in SSA little research exists, with many studies focussing upon adult sex offenders (Craig, 2005; Taylor et al., 2003; Hogue, 1995). However, empirical studies have been conducted into professional confidence when working in sensitive areas from which similarities can be derived. When referring to confidence in the CYP working practice the term confidence requires definition. Currie (2006) and Carpenter, et al. (2015) argue that confidence in the workplace is formed, not only from internal factors, but also via external factors which encompass various elements such as skills, support, experience, and knowledge. Confidence, in the CYP workforce, may also be an assumption made by service users. For example, parents may often perceive teachers as confident and competent in the area of sexual behaviours, whilst the teachers themselves may express a lack of confidence in these areas (Charnaud and Turner, 2015). Therefore, professionals in the field of CYP may feel ill-equipped to work with CYP in sexual behaviours, sexual health, and sexual development (Charnaud and Turner, 2015). Confidence in CYP professionals may relate to assurance in the policies, structures and procedures present in their working practice.

As the CYP workforce as a whole is diverse there is not one set of guidelines that reflect this (Charnaud and Turner, 2015). Nevertheless, expectation of this area of professionalism appears to warrant a confident approach to harmful sexual behaviours in CYP (Brady et al, 2014; Currie, 2006). Lack of training in sexual behaviours seemingly impacts upon confidence and affect the way that professionals approach and risk assess the sexual behaviours that identify.

According to Currie (2006), professional confidence is related to professionalism, self-awareness and self-efficacy and is linked to an individual faith in the capability to perform and accomplish behaviours that are essential to attain specific results. This is then linked to confidence in the workplace and the knowledge base that the professional has (the scope of this research did not allow for in-depth exploration of the cognitive constructs that surround this, for further reading see Bandura (1977, 1986, 1997). According to Currie (2006), gaining efficacy, and therefore confidence, stems from increasing knowledge about a topic via an educational route. These points are demonstrated by both Hackett et al (2012) and Hall (2006) who found that confidence is gained through training, which then impacts upon practice. Consolidation of learning, therefore, appears to be transformed into practice when the professional has a chance to apply it. Despite the sensitive nature of the content, short courses may still have a positive impact (Charnaud and Turner, 2015). Carpenter et al. (2015) assert that self-efficacy and confidence rises significantly after training has taken place.
A report produced for the NSPCC (Brady et al., 2014) considered the confidence of social workers when working with child sexual abuse (CSA) cases. The report suggests that practitioner confidence is reliant on many differing variables, including training, experience, and support. The study found that training was perceived as sporadic, inconsistent, and often dated, which influenced the multi-agency approach that could be given in terms of risk assessment and approach. The report also states that raised confidence supported professionals when dealing with difficult areas, such as assessing risk. Thus, providing the ability to critically evaluate situations and ideas, despite the ambiguities that surrounded the context of sensitive topics. Confidence, therefore, appears to be a consequence of learning and becomes a ‘motivational driver’ when considering professional practice (Currie, 2008). Brady et al. (2014) state that confidence stems from not only training but also experience and knowledge, within the professional context into which it is situated.

This indicates that training, experience, and knowledge ae key elements in professional confidence when considering sensitive topics. Despite differing contexts of professional practice these elements do appear to be present.

Research and evidence-based practice indicates that professional confidence and knowledge is essential in effectively responding to child sexual abuse cases, both from a victim and practitioner standpoint. Fundamentally, if professionals do not have knowledge of the area and confidence in their skills to deliver then there could be negative consequences for the victims, which is particularly salient in respect to SSA given the prevalent divides in professional's knowledge and skills base in this area (i.e. some see it as an extension of CSA or peer-to-peer abuse and do not feel they need skills and training, whereas others see it as a new area and do need skills and training). This article will now examine professional and victim's perspectives on SSA to better understand the research and practice challenges in developing a nuanced, and fit for purpose, way of working.

Methodology

The study aimed to elicit insight into the quality and availability of existing support for children and young people effected by SSA. Research into sensitive topics such as SSA is notoriously complex, and gleaning insight into sexual abuse and associated professional approaches can be difficult (Allnock, 2011). Due to this, a multi-faceted, qualitative approach was employed as this best enabled exploration of lived experiences and perspectives in relation to SSA (Marshall and Rossman 1995). Qualitative research, in this sense, is not concerned with producing generalisations and testing hypotheses, but rather capturing insight into social structures and understandings surrounding an issue. The chosen methods consisted of narrative interviewing of N=30 professionals and N=2 young victim/survivors.

Before commencing the empirical research, it was necessary to underpin the work carried out with knowledge of what was currently in place for practitioners in relation to assessing and interventions for SSA. This is reflected in the seminal works by Rose (1992, 1993) who states that to plan effective strategies one must look elsewhere and explore how contexts impact upon outcomes. Dolowitz and Marsh (1997, 2000) structure this investigation around questioning who is transferring the strategy, why it is being employed, where lessons are drawn from and what the constraints are. The environments (Evans et al., 2009), and

contexts, that professional practice is embedded in relation to SSA therefore became a key lens when exploring what was already taking place in relation to SSA and how this is dealt with. Therefore, investigation was not only based upon what was happening in professional practice but also how and why approaches were being used and why they have positive and/or negative outcomes.

Data Collection

Narrative Interviewing

The study used a narrative interview approach, allowing for the participant to tell their story and giving voice to the topic being studied (McQuillan, 2000; Riley & Hawe, 2005). By taking this approach, researchers are able to assign meaning to the social and contextual structures that approaches to SSA are embedded in, which also aligned with the exploratory nature of the study (Matthews & Ross 2010). This approach also offers context that is unlimited and provides a range of information that more prescriptive methods cannot (Matthews & Ross, 2010). This approach was also taken as by its nature the participant, rather than the interviewer is in control of the process, which is particularly pertinent due to the sensitive nature of SSA (Matthews & Ross, 2010). This allows the participant to avoid the potential stress and re-traumatisation, trauma caused through reliving or retelling traumatic events, of being forced into describing distressing events by the interviewer (Israel & Hay, 2006). Prior to commencing the interview, it was emphasised to each participant that the focus was not on what happened to them, but rather the professional process that happened thereafter.

However, whilst the practitioner interviews were underpinned by the principles of narrative interviewing, they had more structure, in the form of a topic guide that explored professional background, definitions of SSA, confidence levels, SSA training, referral process awareness, gas in knowledge and processes, experience of interventions, support for families and the complexities of interagency working.

Full consent, and full information was given to the participant in advance of the interviews. For the interviews conducted with the young survivors the information was given and also explained by a support worker to ensure full consent and knowledge of right to withdraw was clear to them with the emotional well-being of all participants being paramount (Payne & Payne, 2004; Israel & Hay, 2006; Cohen et al., 2007).

Sampling

A purposive sample of N=30 practitioners who worked with CYP in some capacity (see Table 1 below) was used for the professional interviews. The aim of this form of sampling in qualitative research is to ascertain theoretical data saturation. Theoretical data saturation is arguably demonstrated by three key markers:

> *'(a) no new or relevant data seem to be emerging regarding a category, (b) the category is well developed in terms of its properties and dimensions demonstrating variation, and (c) the relationships among categories are well established and validated'. (Strauss & Corbin, 1998, p. 212)*

In the current study, this was achieved through the selection of in-depth semi-structured interviews and including a range of professions within the practitioner sample.

Table 1: Roles and experience of professionals interviewed

Participant Job Title	**Years Experience**
Drama and Movement Therapist	*10 years*
Fostering Service Manager	*20 Years*
Harmful sexual behaviour (HSB) project manager and ex-head of Safeguarding for local authority	*30+ Years*
Local Authority Social Worker	*10 Years*
Children's Charity Practitioner (on harmful sexual behaviour team)	*25 years*
Child Sexual Exploitation practitioner for sexual violence organisation.	*15 years*
Art Therapist	*12 years*
Young People's Service Coordinator	*16 years*
Youth Worker in Safeguarding Team	*20 years*
Probation Service Practitioner and Behavioural Analyst	*35 years*
Young People's Recovery and Support Worker	*40 years*
Children and Young Person's Counsellor	*10+ years*
Psychotherapist for under 18s displaying harmful sexual behaviour	*20+ years*
Social Worker and Safeguarding Team Manager	*25 years*

Commented [AG(SPS+CF1]: Do we have data on years of experience for each practitioner?

Commented [SC2R1]: hmmm -can you revisit the Teams files and see? I am sure that we do.

Commented [SC3R1]: @Abby Gilsenan (PhD Soc Pol, Socio + Crim FT) have changed to 'table 1'

Ex-Police Officer and Force Trainer w/ focus on child abuse	*38 years*
Children and Young People's Service Manager	*Unknown*
Integrative Counsellor for sexual violence support organisation	*Unknown*
Social Worker	*5+ Years*
Children's Independent Sexual Violence Adviser (CHISVA)	*7 Years*
Forensic Psychologist	*Unknown*
Clinical and Forensic Psychologist	*Unknown*
Counsellor at sexual violence support organisation	*11+ years*
Children's charity worker and Counsellor	*1+ Year*
Social Worker within harmful sexual behaviour service	*4.5 years*
Director of Sexual Violence Charity	*25 years*
Senior practitioner for Children's Charity	*Unknown*
Social Worker for Children's Charity	*10 years*
School based counsellor and Sexual Violence charity worker	*11 years*
Forensic Psychologist	*6 years*
Social Worker for sexual violence organisation	*20+ years*

The semi-structured interview guide for professionals was piloted via the means of a convenience sample of n=5 participants consisting of professionals that work in the field of SSA.

Survivor perspectives were gleaned through N=2 interviews with15 year old females who had experienced sibling sexual abuse. They were recruited via a purposive sample (Thomas, 2017) and had been working with Purple Leaf for some time. Given the nature of the project and the risk of re-traumatisation and stress if this was a new environment, the survivors' established relationships with Purple Leaf were a crucial factor. Notably, the survivor sample size was limited, in part as it was decided to recruit only from young people currently receiving support from Purple Leaf. Furthermore, due to the highly sensitive nature of the topic, voluntary participation rates were low. Despite this, both interviews provided key insights into survivor experiences of support structures and play a valuable role in enhancing our understanding of SSA.

Interview logistics

Due to the sensitive nature of SSA it was imperative that the interviewer was not only skilled in interview techniques but also by someone with practitioner knowledge. This study was conducted in partnership with Purple Leaf, the preventative wing of the West Mercia Rape and Sexual Abuse Support Centre, as such all interviews were conducted by a Purple Leaf practitioner. Interviews took place in between March and May 2021. Due to Covid19 restrictions still being in place at this time, all N=30 professional interviews took place on MS Teams. However, it was emphasised that the interviews with the young people could only take place in person due to the support that may be required afterwards. Therefore, these interviews took place on Purple Leaf premises and were conducted by a Purple Leaf practitioner known to the CYP, with a support worker present. All interviews were recorded and transcribed.

Analysis

For both the professional and young victim/survivor interviews content analysis was employed. This was chosen as it provides a systematic framework from which to interpret verbatim transcriptions (Cohen et al., 2008). Due to the nature of the research, it was important to capture valid inferences from the transcripts (Krippendorff, 2018). Coding was a central part of this approach which accounted for the complexity of the topic, thus going on to translating the coding into specific themes (Miles & Huberman, 1994). The process used the four-stage process set out by Cohen et al (2008) (see table 4). NVivo software was used to aid the analysis and three researchers took part in the analysis to aid the validity and trustworthiness of the interpretations that were made.

Table 2: Content Analysis Process

Stage one – Coding	Data coded and sorted into categories. Three researchers split the interview transcripts. Before this stage commenced, calibration of the coding took place with all three researchers virtually analysing the same four transcripts and comparing results. Codes were both allocated and emergent.
Stage two – Sorting	Sorting data into key headings and areas.

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Commented [SC5R4]: Agree - happy for you to add

Stage 3 – Themes	Frequency that each item is referred to develop main themes and subordinate themes. Main themes are classified as the majority of the responses for that particular code. Cross sampling of four transcripts took place virtually at this stage to audit the process.
Stage 4 – Comments and review	Review and commentary on the themes that were found. This consisted of a one day, in person, workshop with all researchers to sort and organise the themes that were found.

In conducting a content analysis of the professional and young person interviews, a cohesive image of the gaps in current SSA assessment provision emerged. Using the analysed data, the researchers undertook a sorting and group discussion exercise to identify the central themes needed within an assessment of a young person presenting with potential SSA. From this, a draft assessment tool was drawn up, divided into specific sections to bolster holistic professional work with the whole family. The final version of this tool in now in use across several Rape Crisis Centres in England and Wales.

Ethics

This study obtained ethical approval from the [redacted] ethics committee prior to data collection. The study design and conduct were informed by ethical guidelines produced by the British Sociological Association (2017) and the National Organisation for the Treatment of Abuse (NOTA, 2022).

Findings

Through the process of thematic analysis, a dominant theme of problematic practitioner response emerged across both the young person and practitioner data. From this, three sub-themes were evident: minimisation, exaggeration, and access to resources. These are presented below, alongside the relevant coded transcript data.

Minimisation

Many practitioners reported prevalent minimising responses to referrals or cases potentially involving SSA, both from other professionals and within their own practice. They refer to

SSA being overlooked within practice, and the prevalence of insufficient responses where harm has been brought to attention, as shown below.

> *"'…when I was a social worker and we didn't know very much about each sexual behaviour at all, we often minimise it. I think we just saw it as a very chaotic functioning family, and therefore it's just a symptom of that…"*

> *"When it is brought to the attention… I feel like it's minimized a little bit. A little bit, probably a lot actually, you know."*

> *"So, for some professionals they will view it as exploration and some people will view it very much as, no, this is an abusive act."*

Building on this, dome practitioners felt that minimising responses from colleagues directly reflected a lack of knowledge and/or experience.

> *"Sometimes it's about you know peoples with a lack of knowledge. I don't mean that derogatory, I mean you know that they don't have knowledge in that area of work, so therefore they don't have things to kind of compare and contrast their own information with*"

Other practitioners tied the prevalence of minimising responses to a generalised discomfort in discussing sexual abuse, and a resultant lack of clarity around sexual behaviours within referrals.

> *"People feel much more comfortable talking about neglect, physical abuse, emotional abuse than they do sexual abuse. I see time and time again with referrals that we get in that censor when sexual abuse is going on. Just because people haven't been up to put it in black and white what's been happening."*

> *"It becomes a problem when…you feel like they haven't reacted appropriately… the severity of what's happened. And I found that's an issue with social services and I don't think it's a social workers fault."*

Ultimately, minimising responses were reported to result in a lack of appropriate and timely interventions for children and families.

> *"I've had some children I've worked with that have displayed maybe problematic kind of behaviour for a long time that hasn't come to the attention of services, and it's only when it's become harmful that a referral has been made … then you have to look at*

the bigger picture and think… Well maybe if this child had intervention earlier, you know they might not have got to the stage"

Minimizing practitioner responses were also demonstrated within the young person survivors' interviews, as shown below. Notably, this appeared to be most visible to the survivors through resultant inaction and lacking support.

"After that [removal of brother who harmed] they didn't offer me any support, they just left us [Social Services] and they weren't involved with me anymore because my brother wasn't there"

"They offered my mom counselling. I thought she said no to it, but they never offered me and obviously I was still I was there. I was old enough, I understood everything I knew what he was doing to me"

Where support was offered and intervention pathways were followed, the young victim/survivors reflect a lack of urgency and clarity around the provision of their support needs.

"The police were not that good, but then it did eventually go to court. It would have been better if I was informed more often about what was going on. And if it was quicker"

"It was not very good. It took nearly three years to go to court."

Catastrophising

In contrast to minimising responses, many practitioners in the study reflected on catastrophising responses to sibling sexual behaviour, whereby risk surrounding problematic behaviours is inflated. Across the practitioner data, this form of response is largely tied to professional anxiety and risk-averse practice. As demonstrated in the below quote, practitioners reflected a considerable pattern of 'catastrophising' responses to SSA, tied into the prevalent fear of 'getting it wrong.'

> *"Professional anxiety is massive, particularly around harmful sexual behaviours, partly because of societal attitudes towards sexual behaviours, but partly the reputational damage it can do to an agency if you get it wrong."*

This is further intensified by the looming consequence of reputational damage to the individual practitioner or intervening organisation, as highlighted by one of the participants. In turn, this creates pressure to make 'defensible' decisions, which as highlighted by one practitioner, can reinforced overly risk-averse choices.

> *"It's about defensible decision making isn't it's about being able to say with the information I had, I made this decision so, but the danger is that people become very, you know, risk averse"*

As a result, many practitioners highlighted a climate of reactivity surrounding SSA, with other professionals, and at times parents, jumping to disproportionate or inappropriate responses to behaviour that might be problematic, but not abusive, as presented below.

> *"Sometimes I think professionals, not just professionals, even parents. They can jump and dramatize to some degree..."*

> *'We don't see a lot of children in our organization at that end of the scale [*Abusive behaviour], *but sometimes assessments that come with them indicate they're sitting there. And quite quickly realized that they are more so in the middle of that scale"*

Across the data, participants emphasised that in some circumstances this climate of professional anxiety made lead to serious safety planning decisions being made prematurely, such as removal of a child from school or the family home or involving law enforcement. This is shown in the statements below:

> *"What often happens for kids who display harmful sexual behaviour, is, that because there's a high level of anxiety on the part of schools, they are often excluded for periods of time and then made to shift from one school to another"*

> *"They're like they go straight to like "Oh my God, this child could not be in this family unit. This child could not be in this education"*

> *"So, particularly if the professionals have never worked with these kinds of behaviours, never experienced it. Uhm? I think you know that there is a view that if there is sibling sexual abuse, the children need to come out, they need to be separated. We need to get the police involved in all those kinds of things. And while that might be, maybe depending on what's going on, actually that's not automatically what should be happening."*

As demonstrated in the quote below, escalation in practitioner anxiety can have a negative effect on multi-agency working and cause reactive responses in other professionals. This is also identified by Yates and Allardyce (2021) who argue that risk-averse responses may impede multi-agency working, and lead to insufficient, single agency interventions.

> *"you've also got professionals jumping up and down in the background that make it very hard, and you and certainly know my social workers can be quite reactive to that"*

It is worth noting that catastrophising responses may also reflect practitioner's feelings of fear and disgust surrounding sexual abuse and incest (Yates and Allardyce, 2021). This is shown in the practitioner discussions of shock in SSA cases below:

> *"I found it quite difficult. I was very shocked initially. I think it was one of my biggest learnings"*

> *"Sometimes opinions get a little bit… you know, because people are shocked by what they see"*

Broadly, catastrophising responses can be viewed as symptomatic of the broad lack of professional confidence in working with child sexual abuse. This is substantiated in the data, whereby one participant directly ties reactive responses of this nature to less experienced, thus less confident, practitioners:

> *"A lot of great social workers out there in the local authority who are confident with this, but there's a lot of social workers who haven't had that experience, so not knowing the kind of things to offer more needs to happen it is definitely an issue."*

> *"Quite little confidence because it's all the training that we you know we have coming into. This is always obviously geared to survivors, so the idea of working with the abusing person is just not in our training at all."*

As such, practitioners are forced to rely on experience in the field and 'learning on the job' as the central means to develop confidence in working with SSA, as shown below.

> *"We've learned a bit on the job, 'cause obviously I've been as long in this job as our children's and young people service has been in place"*

Access to Resources

Alongside minimising and catastrophising responses rooted in fear and misconceptions, both forms of response were also identified as strategies to gain access to support services. In terms of minimisation, practitioners reflected frequent downplaying or obscuring of harmful and potentially abusive sexual behaviours, with a view to gain access to services or placements, as seen across the quotes below:

> *"If you want to get a resource and you're making a referral. You sometimes, some people either downplay the sexual information because they're worried somebody might not take this on."*

> *"I think sometimes the social services minimize what's happened because they're worried we won't accept them if… it it's too serious, if that makes sense. So, you know, I've had things like Oh well, there was a few… a few cases of sexual harassment within high school, right? What does that mean?"*

> *"Sometimes we receive referrals from, say, social work department's where they are anxious to get a child into a [residential or therapeutic placement] …to be Frank, sometimes the social workers will lie about the information. They'll leave information out or they'll give you know an inaccurate breakdown of the actual case"*

This form of response appears to reflect pervasive anxiety that, due to levels of risk, organisations will be unable or unwilling to support the children and/or family. Conversely, in the context of specialist support organisations, it was found that some other professionals

may exaggerate behaviours exhibited by in order to meet the threshold to access certain forms of support.

> *"I've seen it the other way round where it's hyped up because, you know, it's a buzzword so. If you put sex into it and really make it sound very, significant serious, you're far more likely to get a resource in some respects."*

Arguably, both lines of response in this context reflect the scarcity of appropriate support for those effected by SSA and a lack of professional confidence. This emerged in the data, as demonstrated in the quotes below, when exploring access to services specifically for SSA.

> "[SSA services] *very patchy depending on where you live what services, but also who delivers it as well"*

> *"it's kind of almost a post code lottery. It very much depends on where children and young people live as to what, the area that child lives in, as to what service they get"*

> *"I think generally for harmful sexual behaviour there isn't enough resources around that or enough understanding that those young people are also likely to be victims of abuse as well."*

Discussion

Minimisation

The minimisation of harm associated with SSA has been identified across much of the literature in the field (Welfare, 2008; O'Brien, 1991; Yates, 2017). The participant quotations demonstrate that this minimisation is largely tied to misconstructions of sexual behaviour between siblings as a harmless, exploratory stage. This misconception is arguably shaped by Finkelhor's (1980) formative study within which over a quarter of college students surveyed reported sibling sexual behaviour in childhood, with the majority perceiving the experience as having had positive impact. Contrary to this, contemporary research has demonstrated that SSA can be every bit as harmful and traumatic as other forms of intra-familial sexual abuse (Caffaro & Con-Caffaro, 2005; Caffaro, 2020). Now, despite near unanimous agreement in the field that SSA is severely impactful, the construction of sibling sexual behaviours as harmless prevails within public discourse. As such, parents, professionals, and even survivors

themselves have been shown to minimise and dismiss the capacity for harm within SSA dynamics (Caffaro & Con-Caffaro, 2005). As reflected in the practitioner data, this notion may lead some professionals to dismiss harmful sexual behaviour between siblings as irrelevant (Yates, 2017).

As demonstrated, some practitioner responses associated minimising responses with a lack of professional knowledge surrounding SSA. This accords with the sparsity of research and practitioner guidance surrounding best practice with regard to sibling sexual behaviour. As highlighted by Caffaro (2020), there is no 'universal gold standard' for differentiating developmentally normal sibling sexual behaviour from SSA. At the time of writing, there is no national guidance or policy surrounding the intervention and treatment of SSA. As such, practitioners are broadly untrained in SSA specifically, therefore at times responses are insufficient to assess severity of the case at hand. Caffaro (2020) further argues that there is a dire need for training and professional development specific to SSA across local authority and third-sector support organisation. This too was reflected significantly across the practitioner data, with the majority of participants having never received formal training surrounding SSA. This is further discussed in the latter sections of this paper.

Yates (2017) argues that the taboo nature of sibling sexual behaviour may hinder practitioner ability to full recognise signs and disclosures of SSA and intervene appropriately. This is demonstrated within the practitioner statement discussing the inability of professionals to put in 'black and white' what has occurred, in turn preventing accurate assessments and interventions from taking place. This reflects two layers of hinderance. First, society as a whole is ill equipped to discuss sex and sexuality, particularly in the context of children as the two are viewed as mutuality exclusive (King-Hill, 2021; 2022; Schofield, 1994). As such, practitioners may feel uncomfortable describing behaviours that have occurred or using anatomically correct names for body parts. Second, abuse, particularly sexual abuse, is entirely incongruous with dominant understandings of sibling relationships (Yates, 2017). The notion that familial relationships largely conceived as loving and supportive hold capacity for abuse is abhorrent, as such, we broadly do not imagine it to be a possibility unless there is significant evidence to contrary (Yates, 2017). Yates' (2015) exploration of social worker decision making in SSA cases demonstrates that even where sibling dynamics were largely abusive, practitioners engaged in numerous strategies to maintain a favourable

understanding of sibling relationships. These mechanisms included a minimisation of behaviours and their subsequent impact, overall reflecting a resistance to understanding of some sibling dynamics as abusive (Yates, 2015). Crucially, this suggests that the practitioner statement around lack of clarity in referrals might reflect both a lack of language around children and sexual abuse, but also pervasive conceptual difficulties in understanding SSA.

Fundamentally, minimising responses becomes problematic in that opportunities for early invention are missed, potentially leading to an escalation in behaviours and therefore, increased harm. Furthermore, failure to recognise the severity of SSA as a discrete issue may lead to incorrect, if any, interventions taking place, leaving families and young people without the support required (Krienert & Walsh, 2011; Welfare, 2008).

Catastrophising

A climate of increasing bureaucratic pressure and high-profile local authority failings in child protection cases has led to a heightened sense of practitioner anxiety in work concerning the safety of children (Masson & Parton, 2020). Within this context, systematic attitudes to child-protection are argued to have become 'risk averse and reactive' (Masson & Parton, 2020). This becomes problematic considering that reactive decisions can have long-lasting, and potentially adverse, effects on the children and families involved (Streich & Spreadbury, 2017).

The majority of public reporting on sexual abuse rests on the construction of adults who perpetrate as monstruous predators, which in turn can lead to children who enact sexual harm being perceived through the same lens (Allardyce & Yates, 2018). This leads to a construction of children who enact harm as 'mini-adult sex offenders' (Yates & Allardyce, 2021). Furthermore, understanding that a child has enacted sexual harm may further escalate catastrophising reactions as this contravenes both dominant understandings of sexual abuse, but also our core expectations of childhood innocence (Yates & Allardyce, 2021). As such, it makes senses that, as highlighted in the data, practitioner reactions are shaped by their initial shock at the nature of SSA. In turn, this can lead to an inflammation of practitioner anxiety and understandings of risk level posed. Again, this may lead to more severe interventions and safety planning decisions being made without full consideration as to the impact on the child

and family. Furthermore, as identified by Yates and Allardyce (2021), risk-averse responses may impede multi-agency working, and lead to insufficient, single agency interventions.

Yates and Allardyce (2021) argue that reactive responses often occur in moments where professionals feel ill-equipped or out of their depth. As demonstrated by Brady et al. (2014) practitioner confidence is bolstered by the provision of training, experience in the field and professional support. Yet, as highlighted by the participants, there is a glaring lack of specific training and CPD opportunities available that deal specifically with SSA, particularly with regard to work with children who have enacted harm.

Ultimately, the prevalence and intensity of practitioner anxiety and lack of confidence surrounding SSA bolsters a culture of catastrophising, reactive responses to referrals detailing potentially problematic or harmful sexual behaviour. Crucially, this leads to incorrect and disproportionate interventions, and in turn renders children and families without the support they need.

Access to Resources

The third sub-theme, access to resources, reveals significant gaps in the current policy and service provision landscape surrounding SSA. The tendency for practitioners to 'downplay' the severity of sibling sexual behaviours in order to access support services, largely for the child who has harmed, reflects a prevalent gap in the availability of services fully equipped to work with harmful sexual behaviour in children. Conversely, the prevalence of exaggerated responses as a means to access resources arguably reflects a deliberate playing up to the culture of reactive responses to sexual behaviours (Yates & Allardyce, 2021), as a means of stimulating action.

Crucially, many of the participants highlighted the sporadic availability of specific support organisations as major prohibitive factor to effective practice in the context of SSA. In turn, this scarcity may force practitioners into tactically omitting or embellishing case information, with a view to access the limited services available in their locality. Overall, this finding suggests a pervasive and damaging oversight in the treatment of sexual violence in the UK.

Despite its prevalence (Finkelhor et al., 2009; Beckett, 2006; Shaw et al., 2000; Hackett et al., 1998;), there is, to date, no joined up, national approach to SSA (Strong, 2022). As such, in localities with less specialist services, practitioners are forced to use inadequate training and services, tailoring referral information so that survivors and families get *some* support. Ultimately, whilst this response largely reflects practitioner will to support those effected by SSA, it highlights significant systematic failings in the provision of suitable support nationwide.

Conclusion

The study highlighted some key areas for consideration in relation to professional approaches to SSA. The traditional understanding of sibling relationships and misconceptions around what constitutes abuse vs. exploratory behaviour can lead to pervasive minimisation of harm associated with SSA. Examining the young person survivor's responses against the prolific narratives of minimisation within the practitioner data, it appears the resulting impact and harm from SSA are pervasively overlooked, leaving survivors without the long-term support required. This highlights the prevalent need for a discursive shift in how sibling sexual behaviour is understood and problematised. Without a robust national strategy, practitioner training and enhanced education around the impact of SSA, the dominant perceptions of SSA as 'exploratory' persist. Without providing resources and language for practitioners to address harmful sexual behaviour, the issue often remains hidden or obscured by other problems within the family structure. Whilst emergent research (King-Hill et al., 2021) attempts to address the need to support practitioners in recognising and intervening in cases of SSA, much more work is needed in this area to ensure young people and families experiences and needs are recognised

Furthermore, Pressurised and risk-adverse child-protection climates, combined with normative narratives of 'monstrous' sexual predators lead to an inflation of risk associated with children who harm and in turn, can lead to disproportionate catastrophising responses to behaviour that might actually be developmentally normal. Both lines of response can leave children and families without the support they need. Due to pervasive lack of specialist support services and intervention pathways, practitioners can be forced into downplaying or exaggerating behaviours exhibited between siblings, with a view to accessing the limited services available.

Considering the findings of this paper, a number of policy and practice recommendations become salient. First, the implementation of a cohesive national approach and guidance, with designated services in each locality, would tackle the issues of sporadic services and encourage consistency in practitioner responses. Furthermore, when the interventions are put in place, professionals need to be supported to consider the whole family and the full complexity of SSA. Building on this, offering bespoke training and CPD opportunities from the inception of professional career will increase knowledge and increase professional confidence when working with SSA. This should incorporate considerations of language, definitions and societal assumptions and stigma. King-Hill and Gilsenan (2023) have made some progress in this area through the development of a specialist mapping tool and accompanying training for frontline social workers working with sibling sexual behaviour. Similarly, Purple Leaf (2021) have developed robust practitioner training based on the findings of original Home Office project which is offered a to variety of professionals looking to expand their skillset in this area. Despite these foundational steps, much more work in needed to ensure all practitioners working with SSA have access to similar professional development opportunities. Finally, early identification of intervention pathways and communication across agencies from referral should be embedded within practice. It is evident that more needs to be done for families that experience SSA and one of the first steps in this is to support the practitioners that are working with them through each stage of recovery.

Overall, the study indicates a pervasive need for enhanced knowledge and confidence building and training opportunities for professionals and a renewed focus on building national consistency in support service availability.

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