

# **Service providers' cultural self-awareness and responsible use of racial power when working with ethnic minority victims/survivors of child sexual abuse: Results from a program evaluation study in Australia**

**Abstract:** With Australia's expanding diversity, there is a rising onus for the whole mental health and sexual assault workforce to be appropriately trained in 'racial self-awareness' to help enhance the quality of services; a combination of cultural self-awareness and awareness of white privilege. Client's fear of breached confidentiality and ensuing preference for a non-ethnically matched worker, as well as risk of increased harm from judgmental ethnic minority workers or interpreters, further add to this need. To help address it, a professional development program was delivered and evaluated over six months using a mixed methods design (T1 n = 112, T2 n = 44). Since most participants were social workers and counsellors, they were already trained in social justice issues. Thus, instead of *gains* in knowledge about white privilege, they more appreciated the *opportunity* to have frank discussions about racism, skin colour, and intersectionality (which distinguishes white from brown feminism). Although the cross-wave sample size was small, the results contribute new and innovative empirical data. Overall, the results show that the relevant workforce is as diverse as the client group, who may be seeking either 'culturally safe' or 'colour blind' services. Psychiatrists can assist clinically unwell victims/survivors, general practitioners (GPs) can model good engagement with other professionals and provide referrals, and social workers, counsellors, and psychologists can talk through and share trauma with the aim of reducing the symptoms of emotional distress. When practitioners receive training in cultural competency, the ethnic minority client victim/survivor is more likely to receive a service aware of how racial power could be abused (even unintentionally) in the clinical setting and therefore have a chance to take professional responsibility for it.

**Keywords:** child sexual abuse; ethnic minorities; racism; white privilege; intersectionality; ethnic-matching

## **Highlights**

- Ethnic minority CSA victims/survivors rarely access services due to grave barriers.
- Clinicians' lack of cultural and racial self-awareness is not an affordable risk.
- A CPD program was evaluated, partly exploring racism in the clinical setting.
- Participants appreciated the chance to have frank discussions about racism.
- Self-identified cultural self-awareness and awareness of white privilege were high.
- Addressing barriers to participation among medicos require development.

# **Service providers' cultural self-awareness and responsible use of racial power when working with ethnic minority victims/survivors of child sexual abuse: Results from a program evaluation study in Australia**

## **1. Introduction**

### *1.1 Background and hypotheses*

While research attention is growing, overall little is still known about the needs and experiences of ethnic minority victims/survivors of child sexual abuse (CSA). This reflects that culture, race, and migration are generally seen as marginal issues, especially in Australia where there are less than five scholarly publications on this issue in the last 20 years. Multiculturalism in western countries like Australia, United States, United Kingdom, Canada, and New Zealand, force researchers to challenge any assumptions they may make that the psychosocial experience of CSA is essentially universal. This, in turn, requires a professional need and personal want to engage with the complex and challenging mental and emotional load of working with ethnic minority communities ethically, and with ethnic minority children safely, in ways that do not make these two goals compete with one other. That is, it requires intense critical reflection and self-awareness. It is therefore unsurprising that factors like culture, race, and migration are only slowly being explored within the literature.

Political sensitivities also make funding in this area difficult, and 'hierarchies of evidence' that treat quantitative research as more rigorous and trustworthy than qualitative research make publishing difficult. As an example, the author's collective works in this area over the last four years – mostly qualitative, but quantitative too – have thus far been subject to 40 rounds of rejection and not all have yet been accepted for publication (Sawrikar, 2019a; Sawrikar, 2018a; Sawrikar & McAuliffe, 2019). This reflects structural sexism and racism in the academic sector, worsened by neoliberalism (Morrish & Sauntson, 2016), in which the knowledge and voice of women of colour scholars is not by default prioritised, taken seriously, or respectfully listened to and learned from. Instead, it is dismissed, devalued, or discredited to a point where it could be silenced. This substantially slows down capacity-building in the services sector. It leaves practitioners needing to learn about this group while *in* the clinical space itself, and from the few who finally seek help after navigating a deep and grave list of barriers to doing so (Sawrikar & Katz, 2017a). Poor funding and research stifle the development of overarching theoretical frameworks practitioners can use to better understand and embed their clinical experiences, and imbue them with

confidence in the practice wisdom they are acquiring. Indeed, persistence to withstand the disrespect and demoralisation experienced within the peer-review system, and its implicit resistance to decolonising social work knowledge and practice, is driven by utmost commitment to what is in the best interests of ethnic minority victims/survivors of CSA in the clinical setting. It is a parallel demonstration within the arena of knowledge-production of the need for *responsible use of racial power*, which this paper examines.

Adding to this, ethnic minorities are ‘hard to reach’ in terms of conducting research and meeting their clinical service needs because of cultural pressure to remain silent (i.e. protect their family name) as well as racial pressure (i.e. protect their whole community from racist stereotyping). Strong overt traditional gender roles in highly patriarchal societies further intensifies sexism as an additional ‘silencer’ (Sawrikar, 2018b). As such, thorough literature reviews on *sub-themes*, such as the one addressed in this paper – redressing racism among service providers who engage with ethnic minority victims/survivors of CSA – are not easy to conduct. They call instead for the development of theoretical rationales (see Section 1.2). That is, rather than scoping, reviewing, and summarising what is known so far to help historically contextualise the significance of the present study’s findings and what it adds to the current body of work, it puts forward new but still cogent ideas worth considering. Indeed, a systematic literature review conducted in the *broad* area of ethnic minority communities and CSA in 2016 only located 135 peer-reviewed articles published between 2000 and 2016 from around the world (Sawrikar & Katz, 2018a, 2018b, 2017a, 2017b, 2017c). Compared to approximately 15,000 research papers based on western (mostly white) samples published in that same period (Sawrikar, 2019b), the nuanced needs and experiences of ethnic minorities remain largely unrecognised.

A full definition of ‘ethnic minorities’ has been described by the author elsewhere, as the pros and cons of various terminology for this group is one of her key research areas (Sawrikar, 2017). For this paper, a briefer definition and description are offered. Ethnic minorities are distinguished from Indigenous Australians (Aboriginal and/or Torres Strait Islander peoples) and Anglo Australians (the dominant mainstream group). They include first, second, and later generation members of migrant and refugee communities living in western countries, and include those of mixed phenotypic race. Thus, the categorisation is not based on explicit or objective criteria such as citizenship status, but on the politicised category of race even though that demarcation remains unsaid due to national sensitivities. Seminal author O’Hagan (1999) identifies four main dimensions of ‘ethnicity’ – language, religion, culture, and race. Consistent with this, non-Indigenous ethnic minorities tend to (a) originate from non-English speaking countries, (b) may not be of Christian faith, dominant in the west, (c) tend to come from countries

high on collectivism or ‘familism’, and (d) tend to be visibly different, such as in skin colour or religious/cultural attire. Putting it crudely, ethnic minorities are ‘everyone else’ – those who are not Indigenous or white. To describe them as ethnic *minoritised* communities (Di Angelo, 2018) would be more accurate, so as to highlight that it is global white power and privilege that determines minority-majority status not population size. However, this term has not been selected for use here only for language ease.

In Australia, this group are not referred to as ‘ethnic minorities’ but as the ‘Culturally and Linguistically Diverse’ (CALD). This term was used on the evaluation instrument in this study for consistency with national protocol, but is not ideal (see Sawrikar & Katz, 2009 for in-depth critique). Summarily, one of its limitations is its failure to acknowledge two of the four elements of ethnicity – religion and race – and therefore white privilege. There is also lack of understanding and/or consensus of what culture means, with the effect of ultimately reducing understanding of this group to language differences from the English-speaking mainstream. Collectivist cultures prioritise family over individual goals so value social roles and responsibilities perceived to meet and protect them, such as overt hierarchical distributions of power to males and older people. Family honour, family cohesion, standing within the community, and filial piety are all therefore highly valued. Collectivist cultures are differentiated from individualistic cultures, which western countries are generally high on, and which value more independence, autonomy, initiative, uniqueness, competition, horizontal relationships based on equality, and belief that individuals have the eventual right and responsibility to look after themselves (Bond, 2002; Hofstede, 1980; Triandis, 1990). Framing and understanding culture along this dichotomy, again, requires deep critical reflection, self-awareness, cultural humility, and personal motivation to learn such knowledge from less powerful minoritised community members and/or ‘sit with’ any ensuing discomfort about the implications of those differences for social work practice. That is, understanding culture means understanding self; it is not just something that belongs to ethnic minorities, and no culture is ideal.

To help address the paucity of research and knowledge in this area, especially nationally with so little prior publications, a three-staged project was designed. It aims to gently prise open the lid, and stimulate ethical dialogue around, this highly sensitive and complex issue to help improve clinical outcomes for this client group. The project was informed by the aforementioned systematic literature review conducted by the author in 2016. Stage 1 is now complete, and was conducted in 2019. It engaged with *service providers* by developing, delivering, and evaluating a program on ethnic minority victims/survivors of CSA, and which aimed to improve their and their organisation’s cultural competency. This professional development education/training program has now

been converted to online mode to be accessible internationally ([www.nomoresilence.info](http://www.nomoresilence.info)). Stages 2 and 3 will be conducted pending future funding. Stage 2 will engage with *ethnic minority communities*, with the aim of increasing their awareness of CSA and therefore ability to protect their children from re/victimisation. Stage 3 will work with *culturally diverse schools*, with the aim of delivering and evaluating a modified prevention program that is culturally informed and sensitive compared to the current generic education model being delivered. All three target audiences – service providers, ethnic minority communities, and culturally diverse schools – require deep understanding of the need to be committed to responsible uses of white and male privilege. Such commitment is fundamental for protecting children from additional trauma encountered in the clinical setting when there is ignorance or minimisation of such issues.

Stage 1 explored eight research questions, which map across the program’s full content (see Section 2.1). The results of only one research question is being reported here, with the remaining being reported elsewhere (in preparation). This question asks: six months post program attendance, do service providers more appreciate the need for cultural self-awareness to help take responsibility for racial power? The two hypotheses were:

1. Service providers will improve on their self-rated cultural self-awareness.
2. The number of service providers who have heard of ‘white privilege’ will increase.

As is acknowledged again later, the terms used in this paper are not easy to define or clearly differentiate from one another. Thus, the *essence* of their inter-relations is that if one is aware of how they are impacted by their culture (cultural self-awareness), then they are likely to engage in critical reflection and/or demonstrate cultural humility, and therefore also make room for self-construal that extends beyond within-group cultural norms and traditions to include between-group racial elements too (racial self-awareness). In turn, service providers would be better able to mitigate a potential abuse of racial power in the clinical setting, and therefore risk to good clinical outcomes for victims/survivors that rarely access such services due to cultural and racial barriers but which they might benefit greatly from. That is, even unintentional racism through lack of self-awareness is too high a risk in the clinical setting for when an ethnic minority victim/survivor of CSA finally does access mental health services.

Moreover, racial self-awareness requires awareness of white privilege but manifests in work practice differently for Anglo and ethnic minority service providers. That is, ‘responsible use of racial power’ means different things to them. A question that attempted to directly measure responsible use of racial power would also trigger high

social desirability concerns. Thus, self-identified cultural self-awareness and awareness of white privilege were assessed instead.

## *1.2 Theoretical rationale*

### *1.2.1 Fundamental Attribution Error (FAE) and white privilege*

As has been conceptualised and described more fully elsewhere (Sawrikar & Katz, 2017a), there are three types of barriers to disclosure of CSA and uptake of formal services among ethnic minority victims/survivors: non-cultural, cultural, and migratory. However, service providers may believe that most or all barriers are ‘cultural’ (and so belong to the group), rather than also taking into account ‘non-cultural’ factors (which are shared cross-culturally), or confusing cultural factors with ‘migratory’ ones (which occur for ethnic minority groups but only *after* migration, including racism). Failing to take into account cross-cultural similarities (which should neither be over- nor under-stated), or failing to understand racialised power dynamics in broader white-majority society (in which an ethnic minority individual exists and manages pressures to assimilate and cede authentic identity), carry the effect of localising understanding *of* the client *to* the client. That is to say, ‘everything about ethnic minority groups is cultural, so it is something about them that explains them’.

This cognitive bias reflects the fundamental attribution error (FAE; Ross, 1977), in which causal reasoning for a behaviour is tipped toward dispositional factors (i.e. characteristics of the person) even when situational factors in the external environment are clear causal contenders (Vaughan & Hogg, 2002). Research has long ago also shown that the FAE is more prevalent in western/individualistic societies (Miller, 1984), because of the personal agency that is both valued and bestowed to individuals with having both the right and responsibility to be independent, autonomous, and self-sufficient.

Thus, if Anglo Australian service providers fail to appreciate that in the dyadic clinical relationship, the ethnic minority client is seeking and receiving services from a perceived representative (consciously or otherwise) of that white-majority society in which their ethnic group has lower power (social, cultural, economic, and political; Giddens, 1997), then there is a risk that those professionals may not be aware of and therefore take responsibility for their racial power inherited from Anglo Australian group membership. That is, if a professionals’ understanding of Australian racial politics excludes the role of group-level power, solely focuses on individual prejudices as the cause of racism, makes every effort to work with all clients in a non-racist way, and therefore believes that race is not really a critical variable to be aware of in the clinical setting, then an unintended abuse of

racial power could occur. As Fontes and Plummer (2010) write, “cultural humility refers to self-awareness and habits of self-reflection (Tervalon & Murray-García, 1998)...(that are critical for good practice because) even when professionals are unaware of (racial) biases and assumptions, clients often perceive them (Perez Foster, 1999)” (p. 509).

### 1.2.2 Professional differences, client differences, and ethnic-matching

Social workers receive education in their curricular on social justice and therefore sociological conceptualisations of racism. Within the discipline of sociology, racism is defined as the combination of prejudice plus power (Cazaneve & Maddern, 1999) and therefore does not only discuss prejudicial cognition the way the discipline of psychology does (Allport, 1979). Thus, there is a risk that psychologists miss vital education on understanding ethnic minority clients as ‘ethnic minorities’ (i.e. minoritised) in Australia. Medicos such as general practitioners (GPs) and psychiatrists may also miss the vital education psychologists receive about cognitive errors that lead to racial prejudice.

At the same time, ethnic minority client victims/survivors may be seeking Anglo Australian service providers precisely for their assumed *lack* of cultural knowledge and self-awareness. It could be perceived as the vehicle to being treated as just a person like any other, with no special knowledge or accommodations required or wanted. Indeed, with greater knowledge come more questions, so lack of racial awareness can also simplify the clinical setting rendering it more effective.

Ethnic minority client victims/survivors, like any other group of clients, will be diverse in their needs and expectations about services. For this reason, racial self-awareness by virtue of being critically reflective on one’s own cultural norms, traditions, values, and beliefs, as well as group-level power inherited from group membership and therefore independent of personal cognitions, was seen in this project to enhance the quality of services but not essential for them to meet basic needs in the clinical setting with ethnic minority victims/survivors.

Research has shown that there is a tendency for ethnic minority service providers to be seen as best placed to engage with ethnic minority clients because they will have tacit cultural knowledge that allows them to better understand ‘where they are coming from’ (Alladin, 2002; Chenot, Benton, Iglesias, & Boutakidis, 2019; Knipscheer & Kleber, 2004; Sawrikar, 2013; Ziguras, Klimidis, Lewis, & Stuart, 2003). While racial similarity does increase empathy because of biased stereotypes socialised for different others (Xu, Zuo, Wang, & Han, 2009), it can also increase judgement or risk of harm. For example, (especially male) interpreters may abuse their

power and tell (especially female) victims of domestic and family violence to return to their spouse and spare family shame (Sawrikar, 2015). Feared breaches of confidentiality with ethnic minority service providers in turn threatening community standing are a substantial barrier to service uptake (Allimant & Ostapiej-Piatkowski, 2011; Okur, van der Knaap, & Bogaerts, 2016; Singh, 2009), and can lead ethnic minority victims/survivors to seek what they see as a culturally neutral and therefore safe space with an Anglo Australian. Thus, ethnic minority clients will not necessarily want an ethnically-matched service provider, leading to an onus for the whole Australian mental health and sexual assault workforce to be trained in cultural competency and not just leave 'ethnic minority matters' to ethnic minority workers.

In short, all service providers have different and expert knowledge that together allows them to meet the diverse range of needs ethnic minority victims/survivors may present with. Those that are clinically unwell can benefit from liaising with a psychiatrist with the professional power to administer appropriate medications. GPs are an appropriate point of referral to psychiatrists, social workers, counsellors, and psychologists, all of whom work to talk through and share trauma with the aim of reducing the symptoms of emotional distress. Good engagement with a GP also has the power to act as a sign of good engagement with other professionals whose work encompasses recovery from sexual assault. All service providers differ in the extent to which they receive education in social justice, and this may sometimes be of benefit to ethnic minority victims/survivors and at other times not. However, this project errs on the side that while 'ignorance may be bliss' it is also dangerous; it is better to have cultural and racial self-awareness and use it accordingly, than to not have it and risk adding to abuses of power already incurred by the victim, and therefore good clinical outcomes. As the education program was not centrally about 'white privilege', it only aimed to examine change over time in the number of service providers who were now aware of the concept after having taken part in the program.

(Note: in the literature, 'white privilege' can sometimes be capitalised and an author's choice warrants consideration and explanation. In this project, the lower case 'w' has been selected to denote skin colour not phenotypic race. By analogy, 'Black' is not a race, 'black' is a skin colour. It also helps decolonise practice in social work and other related disciplines).

## **2. Method**

### *2.1 Program development*

The content of the program was informed by the results of the 2016 systematic literature review. It reflects knowledge about CSA, ethnic minority communities, and good service provision. The program's full content is outlined below to help provide surrounding context, but only those that are italicised are examined here:

(A) Knowledge about CSA and ethnic minority communities:

- Prevalence is high across all cultures
- Likely perpetrators are those known to the victim, rather than unknown strangers
- Myths about CSA reflect false beliefs that can shift culpability to the victim
- Supportive responses to disclosure are critical for mediating mental ill-health
- Family reputation is of utmost importance in ethnic minority communities high on collectivism
- Relying on extended family and community for child rearing and child safety is normative in collectivist cultures
- Discussing any matters to do with sex including abuse is a social taboo
- *Racism is a unique barrier to disclosure of CSA among ethnic minority communities*

(B) Knowledge about service provision for ethnic minority victims/survivors of CSA:

- Personal factors
  - *Having a sense of efficacy (including cultural knowledge, confidence, and sensitivity/respect) in working with ethnic minority client victims/survivors of CSA*
  - Being aware of and sensitive to non-ethnic factors for ethnic minority client victims/survivors of CSA
  - Being aware of the pros and cons of medicalising mental illness due to CSA over the use of a sociological framework in ethnic minority communities
  - *Being aware of and constructively engaging with the concept of 'white privilege'*
  - Encouraging additional self-help, family, and group therapy to avoid professional omnipotence in a one-on-one setting
- Organisational/institutional factors
  - Having an ethnically diverse workforce including in management positions
  - Using interpreters trained in matters to do with sexual assault and providing such training

- Providing regular training in cultural competency to staff to respond to new and emerging communities and staff turnover
- Using ‘a multicultural framework’ within the service organisation’s mission statements, philosophies, practice frameworks, etc.
- Mandatorily collecting data on ethnicity-related variables (e.g. country of birth, languages spoken at home, etc.)

## *2.2 Ethics and endorsement*

Approval for Stage 1 was obtained from Griffith University’s Human Research Ethics Committee (GU HREC Approval No: 2018/953). This included approval for the purpose-built evaluation instrument, designed to collect data on the study’s eight research questions. The project strictly observes ethical principles identified in the 2018 Ethical Research Code of Conduct, including informed consent, voluntary participation, arms-length recruitment, permission to record, deidentified research outputs, and language that is non-racist, non-sexist, and non-defamatory of victims/survivors of CSA, ethnic minority, Indigenous, and Anglo communities. Application to the Australian Association of Social Workers (AASW) for Continuing Professional Development (CPD) endorsement was also obtained in 2018 (Reference No. AASW181112).

## *2.3 Recruitment and delivery*

There were two primary target audiences for this study. The first was practitioners that provide mental health services and advocacy to victims/survivors of CSA, such as counsellors, social workers, psychologists, general practitioners (GPs), and psychiatrists. The second was researchers, program trainers, and other related professionals that worked in sexual assault, other forms of violence (e.g. domestic and family violence [DFV], intimate partner violence [IPV], gender-based violence [GBV], etc.), or any and all forms of child maltreatment (i.e. physical abuse, sexual abuse, emotional abuse, and chronic neglect).

To help recruit these relevant professionals, 267 organisations across four culturally diverse cities in Australia – Sydney, Melbourne, Brisbane, and Adelaide – were invited via email in January 2019 to attend. The programs were then delivered in each city within one week during March–April 2019, in the neutral space of a hotel meeting/conference room.

Registrants received five CPD hours for taking part in the half-day program. The Introduction included an Acknowledgment of Country, affirmation of the need for a slow approach when addressing taboo topics, discussion on the limitations of the term 'CALD', and establishing boundaries on the need to protect psychological and cultural safety and respect when sharing.

The Ethics Information Statement was then explicitly talked through to help ensure registrants were fully clear of their ethical rights before providing written informed consent to participate in the baseline data collection phase of the program evaluation study. These included clear articulation that participation was voluntary, consent could be withdrawn at any time, and all research outputs would be deidentified. Permission to record the open 'Q&A forum' (held at the end of the day) for accurate transcription was also obtained. The baseline survey was then administered and completed individually by participants who had consented.

The full program content (as stated in Section 2.1) was then delivered, with a short break in the middle. On its completion, the Q&A forum was opened so that participants could ask further questions or make comments from their own professional experiences. Finally, an anonymous voluntary program satisfaction survey was circulated. Six months later, the same evaluation instrument was sent out via email and all registrants were invited to complete the online version again. Further information on the study's methodology, as well as the results of the process evaluation (not documented here), can be found in the Technical Report (Sawrikar, 2019b).

#### *2.4 Baseline and follow-up sample description*

Of the 120 registrants that attended, 112 completed the T1 baseline (BL) survey, and 44 completed the T2 follow-up (FU) survey (cross-wave retention rate = 40%). There were 53 organisations represented at T1 and 33 at T2, and most were mainstream (i.e. not focused on specific groups or issues).

At both waves: (a) there were substantially more female registrants (females T1 n = 101, T2 n = 39; males T1 n = 11, T2 n = 4; no answer T2 n = 1); (b) most registrants were social workers (social workers T1 n = 56, T2 n = 23; counsellors T1 n = 16, T2 n = 4; psychologists T1 n = 12, T2 n = 5; researchers and other related not previously identified professionals T1 n = 28, T2 n = 10; no answer T2 n = 2); (c) there were roughly even numbers of registrants from an ethnic minority or Anglo background (ethnic minority T1 n = 59, T2 n = 23; Anglo T1 n = 53, T2 n = 23); (d) most organisations were service organisations (service organisations T1 n = 47, T2 n = 29; university T1 n = 3, T2 n = 0; private practice T1 n = 3, T2 n = 1; no answer T1 n = 0, T2 n = 3); (e) some organisations were specialised for ethnic minority communities; i.e. 'multicultural' or 'ethno-specific'

(specialised T1 n = 13, T2 n = 7; not specialised T1 n = 40, T2 n = 26); (f) a sizeable proportion were specialised for sexual assault and/or DFV (specialised T1 n = 19, T2 n = 6; not specialised T1 n = 34, T2 n = 27); (g) attendees' age varied from 23 to 70 years at T1 (M = 42.4, SD = 12.0, n = 112), and from 25 to 70 years at T2 (M = 44.5, SD = 12.6, n = 42); and (h) attendees' relevant work experience varied from 0.5 to 49.5 years at T1 (M = 14.1, SD = 11.1, n = 111), and from 2 to 38 years at T2 (M = 15.1, SD = 10.4, n = 42).

## 2.5 Measures and analysis

Two questions from the full evaluation instrument (see Technical Report; Sawrikar, 2019b) were directly relevant to the hypotheses in this paper. The first was, *'How self-aware of your own cultural background do you feel you are?'* with options varying from 1 = Not at all to 5 = Completely. The second question was, *'Have you ever heard of the phrase 'white privilege'?'* with options Yes or No.

Three other questions from the full evaluation instrument have also been included for analysis in this paper. Specifically, participants were asked to rate themselves on three components of cultural self-efficacy, on a Likert scale of 1 to 5, with 1 = Not at all and 5 = Completely: (i) cultural knowledge (*'How knowledgeable do you think you are about CALD groups generally?'*), (ii) cultural confidence (*'How confident do you feel to work with CALD victims/survivors of child sexual abuse?'*), and (iii) cultural sensitivity (*'How respectful of ethnic diversity (i.e. race, culture, language, and/or religion) do you feel you are in your daily work?'*).

It is important to note that in this study repeated measures statistical analyses were not conducted to examine if changes over time were significant because to do so would require matching the two data sets (T1 and T2) with a unique identifier. Collecting such data in relation to highly sensitive material, especially on such a small (cross-wave) sample, would have compromised perceptions the survey was completely anonymous. That is, obtaining valid data at each time point was intentionally prioritised over, and sacrificed to, ability to conduct longitudinal tests that would empirically establish the in/effectiveness of the program. Instead, the results are described, with speculation offered about the *possible* effectiveness of the program in contributing to observed changes. In comparison, cross-sectional analyses (independent samples t-tests and bivariate correlations) were conducted. The inherent limitations associated with self-report measures also need to be acknowledged.

Qualitative data was obtained from open-ended questions on the anonymous program satisfaction survey and from the Q&A forum. It was also explained that their contributions would be used to finalise the program's content before being converted to online mode to be internationally accessible for CPD purposes. In this regard, the study

does not centrally use a participatory action approach given most of the content is informed by the systematic literature review conducted in 2016, but it does to some extent borrow principles of co-design for its updating and finalising. The qualitative data reported here saturates all relevant verbatim quotes, as a way of describing the comprehensive scope of discussion and representation of participant voice, knowledge, and experience (Denzin & Lincoln, 2018).

### 3. Results

#### 3.1 Cultural self-awareness

##### 3.1.1 By cultural background of service provider

Data for the total sample is presented in this paper, but discussion is by the cultural background of the service provider (ethnic minority or Anglo). As can be seen from Table 1, scores on cultural self-awareness only marginally increased for ethnic minority service providers from T1 ( $M = 4.2$ ) to T2 ( $M = 4.4$ ), and for Anglo service providers from T1 ( $M = 3.9$ ) to T2 ( $M = 4.1$ ). These lack of substantial changes over time indicate that cultural self-awareness is already high among all relevant service providers, and therefore that the program was not likely to be effective in improving it. Indeed, scores were significantly lower for Anglo than ethnic minority service providers at T1 ( $t(109) = 2.82, p < 0.01$ ) but not by a great margin, and not significantly different at T2 ( $t(42) = 1.56, p > 0.05$ ).

**Table 1:** Descriptive data on cultural self-awareness

|                 | T1  |     |     |     |     | T2  |     |    |     |     |
|-----------------|-----|-----|-----|-----|-----|-----|-----|----|-----|-----|
|                 | M   | SD  | N   | Min | Max | M   | SD  | N  | Min | Max |
| Ethnic minority | 4.2 | 0.7 | 58  | 3   | 5   | 4.4 | 0.6 | 23 | 3   | 5   |
| Anglo           | 3.9 | 0.7 | 53  | 2   | 5   | 4.1 | 0.6 | 21 | 3   | 5   |
| Total           | 4.1 | 0.7 | 111 | 2   | 5   | 4.3 | 0.6 | 44 | 3   | 5   |

On the other hand, had GPs and psychiatrists been involved in the evaluation study, differences between service provider types ('medicos' cf. 'non-medicos') may have been observed. Specifically, improvements in cultural self-awareness may have occurred among medicos as a result of taking part in the program, thereby demonstrating its effectiveness on this necessary component of being able to provide services in ways that responsibly use racial power. Arguably, social workers and counsellors, and then psychologists or other indirectly related professionals,

are likely to receive training in social justice in their curricular and/or daily work practice and therefore their need of exposure to such information is lower than for medical practitioners.

### 3.1.2 Relationship with cultural self-efficacy

The correlations between cultural self-awareness and cultural self-efficacy (knowledge, confidence, and sensitivity) are in Table 2. They show that for both ethnic minority and Anglo service providers, the correlations were moderate and positive (if not significant) at both T1 ( $0.13 < r < 0.45^{***}$ ) and T2 ( $0.18 < r < 0.53^{***}$ ). Thus, independent of the program but as expected, service providers increased on their self-rated cultural self-awareness as they increased on their self-rated cultural knowledge, confidence, and sensitivity. Importantly, it is not clear if or to what extent *cultural* self-awareness reflects *racial* self-awareness (see Section 3.1.3 for further discussion); themselves ‘blurry’ terms.

**Table 2:** Correlations between cultural self-efficacy (knowledge, confidence, and sensitivity) and cultural self-awareness

|                              | T1      |        |         | T2      |       |       |
|------------------------------|---------|--------|---------|---------|-------|-------|
|                              | Know    | Conf   | Sens    | Know    | Conf  | Sens  |
| Ethnic minority <sup>a</sup> | 0.45*** | 0.13   | 0.35**  | 0.48*   | 0.18  | 0.26  |
| Anglo <sup>b</sup>           | 0.32*   | 0.32*  | 0.22    | 0.52*   | 0.40  | 0.33  |
| Total <sup>c</sup>           | 0.45*** | 0.26** | 0.34*** | 0.53*** | 0.34* | 0.33* |

\*  $p < 0.05$ , \*\*  $p < 0.01$ , \*\*\*  $p < 0.001$ ; a – T1  $n = 59$ , T2  $n = 22$ ; b – T1  $50 < n < 53$ , T2  $n = 20$ ; c – T1  $109 < n < 112$ , T2  $n = 42$ .

### 3.1.3 Qualitative data

Qualitative data about the program promoting cultural self-awareness was not extensive, perhaps because it is already high among this service provider group. Still, important and relevant comments were obtained on the anonymous satisfaction survey (SS) administered at the end of the program:

*Excellent information re importance of family reputation and racism to disclosing CSA (SS\_15).*

*Great opportunity to reflect about my own understanding (of) cultural competency and racism (SS\_61).*

*(What did you like best about the program?) Awareness and reflection of white privilege and power, important to reflect on this (SS\_99).*

*Excellent to see sociological approach to working with CALD communities, revisiting and highlighting the importance of white privilege. Thanks very much for valuable and needed contributions to practice in this field (SS\_88).*

*Great presentation, glad to see patriarchy in the mix and mention of feminism/intersectionality/social justice in service delivery. Raising awareness of white privilege is a good starting point to develop cultural competency (SS\_64).*

Thus, the program was seen to promote self-reflection, which in turn is a critical component of self-awareness. However, further research would be required to examine what exactly constitutes as cultural self-awareness for Anglo and ethnic minority service providers, and how this translates to better self-understanding and engagement with clients of all backgrounds, and appreciation of cross-cultural similarities and differences in daily work practice.

In comparison, much more qualitative data was generated on the issue of racism itself – as opposed to the role it plays for ethnic minority victims/survivors in disclosing abuse and accessing clinical services, which was the primary aim of this research question (this discussion is documented in Section 3.2 on ‘white privilege’). Only one such relevant comment was made in the open comments section available on the follow-up (FU) survey:

*I learnt the importance of understanding how cultural norms can influence the ability for child’s sexual abuse victims’ to report the perpetrator(s). The most interesting learning for me was about groups and sub groups and how they like to protect their own, which then explains why most victims or victim’s parent do not report sexual abuse to protect either the victim or perpetrator. This has given me space to be impartial when dealing with CALD victims of child sexual abuse or their families (FU\_5).*

Finally, a discussion between two colleagues during the open Q&A forum held after the program demonstrated the preference for a non-ethnically matched service provider, and therefore the need for a fully trained workforce rather than one in which ‘ethnic minority matters’ are left to ethnic minority workers. One practitioner sought further clarification on how to implement confidentiality in a statutory setting, and the other provided that clarification by pointing out that it is not confidentiality from other workers but from other members of their ethnic minority community that is sought:

*I'm from the Department of Child Protection, and you were talking about confidentiality and how crucial that is for clients. That can be really difficult for us. Confidentiality with who? We might have to tell the Court, we have to report to our supervisors and our seniors on certain points, so confidentiality in a statutory organisation can be very blurred (Q&A Forum\_Adel).*

*I work for the Department of Child Protection (too), within a team called Multicultural Services. I think communities are mainly concerned around confidentiality within their community, so they don't really mind us talking to police or to doctors, but their fears are 'don't tell the pastor at my church', or 'what if they tell my sister or my cousin?' (Q&A Forum\_Adel).*

### 3.2 White privilege

All but one service provider reported being aware of the phrase 'white privilege' at T1 (n = 111/112; 99%); herself of ethnic minority background. As mentioned previously, had medical practitioners (GPs and psychiatrists) been involved in the evaluation study, more substantial differences between service provider types and therefore change over time may have been observed, thus demonstrating the effectiveness of the program in promoting self-awareness and therefore responsible use of racial power in professional settings. Such differences, if they were to occur, would likely be the result of curricular on social justice and daily work practice reflecting its pursuit. Three themes related to 'white privilege' – terminology, skin colour, and intersectionality – are discussed below.

#### 3.2.1 The term 'CALD'

During the Introduction, an explanation of the use of the term 'CALD' in the Stage 1 program (and larger three-staged project) was provided; namely, that it is only being used for consistency with terminology used by Australian governments, but that it suffers two critical issues: (i) while it celebrates 'the diverse' it hides that it is really about 'the different', and (ii) it does not allow discussion and therefore recognise a fundamental experience for those who belong in this group – racism.

This discussion was seen favourably by many of the participants (n = 30), and none reported unfavourable responses or saw it as redundant (when asked on the anonymous satisfaction survey). They also provided feedback on the baseline survey (BL), at the open Q&A forums held after the program, or via email. As examples, they said:

*Diverse -> different (CALD) (SS\_3).*

*Loved challenging term “CALD” (SS\_51).*

*Liked the discussion re CALD title (SS\_32).*

*(Liked best?) CALD – explanation (cause division) (SS\_42).*

*I also feel the term CALD is not useful – and is othering (SS\_34).*

*The “D” stands for ‘different’ rather than diverse was great – I’ll use that! (SS\_93).*

*(Liked best?) The initial talk about the CALD acronym and its lack of transparency (SS\_6).*

*Wonderful work you are doing! Well done and loved your critic of the word “CALD” (BL\_79).*

*Really got a huge amount out of the critique of CALD terminology and appreciate the invitation to think about this differently (SS\_66).*

*CALD – D = different; this is a great way to think about this and something I will explore with my team and pose as a discussion point in training (SS\_7).*

*Racism is so important to mention, we need to name it. You were clear you were talking about clinical settings (Q&A Forum\_Bris).*

*You discussed with us the inappropriateness of the term CALD, and how it reasserts to further marginalise. I’d love to know your thoughts on what you propose would be a more equitable term (Q&A Forum\_Bris).*

*If you talk about CALD communities, where to draw the line? Because the second or third generation may not want to consider them [as CALD]. See, my daughter, she’ll say, ‘I’m Australian’, whereas I consider myself Sri Lankan even though I’m an Australian citizen. There is a barrier between a migrant and a second and third generation, that’s an issue as well (Q&A Forum\_Syd).*

*CALD is a term developed by government. To make it easier we use NESB (non-English speaking background). But that (still) excludes international students, women on tourist visas, women on temporary visas whose children have been sexually assaulted or in situations of domestic violence. So how we name people, I guess a name is a name, but who we include and exclude for supports because of their immigration status, that shouldn’t happen (Q&A Forum\_Bris).*

*I think the term ethnicity is really limited. When we talk about culture (in our organisation), we define that in the context of ethnicity, language, and faith. We did some consultation with kids, and many of them identify themselves as Australian-Vietnamese, Australian-Greek, Australian-Turkish, and I think for me CALD is relevant and 'ethnic minority' doesn't do it to me. I'm from a CALD background, I'm second generation, my kids are third generation, and they identify themselves as CALD, so there's a sense of the breadth and depth of the migration experience in this term (Q&A Forum\_Syd).*

*Thanks so much. I have been thinking lots about your intro and the discussion about the term CALD. I was impressed with the idea of D as different not diverse and carrying a negative judgement. I wonder what difference it makes to your intro now that, for young people in Victoria, we have more than 50% with one or both parents born overseas? That first large circle becomes a nonsense and is the first part of the deceit. That and the fact that there were 75 different cultures on the first boats coming over from England 200 years ago also mask the idea that 'we were all white(right) until the 'foreigners' started coming. I have decided to revamp my training intro based on these ideas. Thanks for the inspiration (T1\_Email).*

Two participants noted that while the discussion on the limitations of the term CALD were good, they still required further thinking through. Specifically, the role of religion needs to not always be subsumed within the role of culture, and the false synonymous use of culture and ethnicity needs to be called out:

*(It) would have been good if culture and religion were not group(ed) together all the time as it can be really powerful to be able to understand that some things are not the same as each other (SS\_25).*

*The concept of CALD is diverse/not one group – references to migration etc. but I think is an issue if not unpacked further. Reference to ethnicity which captures culture, and inference that culture is part of ethnicity – yet term culture used more generally (SS\_45).*

Discussions about terminology were only a 'foreword' to the program, but research centred on language for 'racial others' and on CSA in minoritised groups, are inextricably linked. Thus, these comments are seen as useful suggestions, and further research can progress such goals.

### *3.2.2 Skin colour*

Throughout the program, skin colour – namely, white, black, and brown – was used to talk about racial diversity. It was anticipated that this would cause discomfort for some people, and was therefore acknowledged and

encouraged to be shared on the satisfaction survey (see Full Report; Sawrikar, 2019b). Three participants took this encouragement up, saying:

*I believe you assume racism is only between whites and non-whites when there is also between us, brown to brown (SS\_75).*

*The use of black and white would have been said differently. The speaker identified herself as brown and the session seems to refer to white or black when referring to racism (SS\_11).*

*Talking in reference to “brown” woman is almost suggesting the issues are only for people with brown skin. This is not an issue of skin it’s a cultural issue which goes beyond colour (SS\_6).*

There is indeed validity in all three comments, which primarily serve to highlight the complexity of the issue of racism. Nevertheless, more attendees appreciated and were comfortable with the use of this language (n = 6). They said:

*Excellent presenter from ‘CALD’ community (SS\_67).*

*I appreciated the “openness” of the conversation (SS\_76).*

*Less PC (politically correct) which was very refreshing (SS\_21).*

*(Liked best?) The instructor was very honest in the way she addressed the issues of concern (SS\_59).*

*I could sense the brown comment made some uneasy, but I personally had no issue and agree that colour is the first thing people see and then make a judgment on (SS\_7).*

*I enjoyed hearing about the concerns that CALD members face. As a white Australian, I do my best to acknowledge the cultural differences but I will never really know so seeing that and hearing that makes a difference (SS\_24).*

### 3.2.3 Intersectionality

Many participants appreciated the intersectional approach of the program. They said:

*(Liked best?) Unpacking the complexity (SS\_18).*

*(Liked best?) Exploration around power (SS\_25).*

*(Liked best?) Intersectionality – culture, gender, person, trauma (SS\_54).*

*(Any other comments?) Introduction to the term of ‘misogynoir’ (SS\_82).*

*(Liked best?) Thoughtful. Talked about racism and feminism – and still culturally appropriate (SS\_67).*

*Engaging talk and nuanced discussion about racism, intersectionality, sexism, and survivor experiences (SS\_48).*

*I came across the word intersectionality only a couple of months ago listening to a Ted Talk. Thanks, great presentation with excellence and knowledge (SS\_97).*

In comparison, one participant did not appreciate the intersectional approach of the program. They said:

*A fair bit of intersectional-focused material seemed unhelpful in terms of supporting individuals. ‘White privilege’, ‘patriarchy’ are such fuzzy ideas (you could substitute ‘evil’ and not lose much information). I’m not sure these concepts help clients, and the presentation wasn’t persuasive with regards to this (SS\_14).*

The relevance of intersectionality became manifest in several comments made by attendees during the open Q&A forums after program delivery. For example, one noted that ‘white feminism’ is not the same as ‘brown feminism’; calling for responsible use of language and (an inexplicit) reminder of the need for and importance of self-determination:

*I think we have to be very sensitive when we’re trying to educate people on feminist language, that we’re not imposing our own ideology on them, because it’s important to us I think, but it might not be important to them. Some of them want to adhere to their own version of feminism, and that will also take them out of their community (Q&A Forum\_Adel).*

Another participant extended this point, saying:

*I think the reality is that for a lot of women, they do stand up, because they have to, to survive, not be murdered, whether that’s around domestic violence or sexual assault that sits within that, the fact that they leave that relationship and get help, that can ostracise them completely, so they’ve already made a statement and stood up to stuff. And then learnt that sexual assault is against the law here in Australia, but they didn’t know that through their marriage, and can’t cope with it anymore... (Q&A Forum\_Adel).*

The discussion then swung back to a reminder that although some women do break from tradition, the social expectations are nevertheless strong and pervasive:

*...But often they don't leave their marriages, and they won't disclose to be honest, they're so afraid of organisations (Q&A Forum\_Adel).*

*The issue of legal rights is really important. All the CALD women I've worked with, either they don't believe they have the same rights as other white people or they believe if they exercise their rights, their partners or the abuser will actually put them down. I have heard dozens of times, "my husband said if I go to the police, the police will lock me up because I'm complaining about my husband. If I go to a housing estate, they will throw me out because the lease is in his name". Even really well educated European women have extensive legal battles in family court because they don't understand our system, or they don't have confidence that our system will treat them the same and respect their rights. So there's a lot of work to actually build up their understanding and esteem, to say, 'we will work with you, the community legal system will support you, will walk you through it' (Q&A Forum\_Adel).*

Two opposing but equally valid comments offered by white women perhaps best demonstrate the need for an intersectional lens. One made the point that the same cultural beliefs that contribute to difficulties for victims/survivors of sexual assault in accessing services can be held by workers within multicultural organisations, undermining the quality of the support they might offer. The other made the point that sometimes no matter how much training white service providers receive they cannot really understand 'the lot' of a woman of colour, who navigates two systems of oppression (race and gender), and due to the FAE is at risk of being labelled as 'behaving badly' and without genteel the way passive feminine women 'should' when she expresses and experiences rage at their combined injustice.

That is, lack of institutional safety can come from both white and brown spaces; white feminists may not have solidarity with ethnic minority women because of an inability to understand and relate to the experience of racism, and ethnic minority feminists still operate within patriarchal cultural norms that can be suffocating. The dialogue was a reminder that 'safety' from a good service worker cannot ultimately or wholly be predicted by her (or his) skin colour, and why all service providers require training:

*I just wanted to make mention, particularly for mainstream services, risk around connecting with culturally diverse service providers, particularly sexual assault specialist organisations. The risk for those organisations where they also hold those myths, those values, the trauma of the people that we work with, is because they have*

*tried their faith leader, they've tried their migrant service, they've tried bilingual workers, and it's that additional trauma that the service system has given, so there is a risk in saying, 'please connect with cultural community groups'. We very much need to respect that, but we then also need to challenge our colleagues, our co-workers, and other organisations that are faith-based, community-based, religious-based, to then highlight child sexual abuse as an issue, that is an issue across the board. So I just wanted to put that out there, because I do want people to be mindful that when they run to their local CALD services, they're going to be hit with this, because they are also part of the community. That it's not just the clients that hold these views, the service system (also) holds these views (Q&A Forum\_Syd).*

*One of the concerns I have, working on the [name of local area that is not highly ethnically diverse], [is that] I work a lot with [CALD] women who go through domestic abuse, and it's really hard the way they are treated in refuges. They tend to get a different treatment to what other people might have, and that causes me great concern. We need cultural awareness training to understand cultural differences, however what we still are up against is that, still those individuals have their own belief systems, and you can't change that, it's just embedded, and that does still come out in the services they provide. So I think that's difficult. It doesn't matter how much training they might get, that does not mean they will see things differently. Maybe at the surface, but there are other issues (Q&A Forum\_Syd).*

## **4. Discussion**

### *4.1 Summary of key findings*

Ethnic minority client victims/survivors of CSA are diverse in their needs and expectations about services. Some will want services that appear to have cultural knowledge, sensitivity, and regard for cultural safety, whereas others will want a 'colour blind' service that appears to make no accommodations for their cultural differences from the mainstream and treats them 'like any other'.

This diversity is not seen to justify lack of cultural knowledge among service providers, but rather an onus for them to have cultural and racial self-awareness and use it according to an individual's emerging preferences. This is because lack of such knowledge could lead to an unintended abuse of racial power, which then adds to the abuses of power the victim/survivor of sexual abuse has already incurred, and alienates them from accessing services that could be highly beneficial for their mental well-being.

Awareness of racial power takes the form of understanding that white practitioners benefit from white group membership by virtue of their higher social power in broader society, which then impacts on power dynamics in the clinical setting. This further assists with understanding that not all barriers experienced by ethnic minority victims/survivors are due to ‘their own culture’, as if they are responsible for all parts of their needs and barriers (the FAE).

As the education program was not centrally about ‘white privilege’, the research question analysed in this paper only aimed to examine change over time in the number of service providers who were now aware of the concept after having taken part in the program. It was predicted that more social workers and counsellors would have heard of this phrase than psychologists due to social justice curricular, who in turn would be more aware of it than medical practitioners due to daily clinical work in which the relevance of at least cognitive errors underpinning racial prejudice would be apparent. Support for this hypothesis could not be found as there were an insufficient number of psychologists to compare with social workers and counsellors, and no medical practitioners, in the sample. Thus, almost the entire sample had heard of white privilege, and so the program was not going to be effective in providing this knowledge.

Nevertheless, the qualitative data did show that participants appreciated the discussions on white privilege and saw them as useful for framing how best to understand and engage with this client group. In particular, the program was seen to promote self-reflection which in turn is a critical component of self-awareness. Terminology when talking about ethnic minorities, acknowledging the role of skin colour in racism, and identifying its complex intersecting role with other structural disadvantages were also seen as fruitful for service providers working in this space (especially differentiating ‘white feminism’ from ‘brown feminism’).

It was also found that cultural self-awareness was high for both ethnic minority and Anglo service providers at both T1 and T2. However, further research is required to examine what exactly constitutes as cultural self-awareness for each of them, and how it translates to better self-understanding and engagement with clients of all backgrounds, and appreciation of cross-cultural similarities and differences in daily work practice.

Correlational data showed that as service providers increase on cultural self-awareness, they increase on cultural knowledge, confidence, and sensitivity, but that these correlations did not strengthen after the program. It is also unclear if or to what extent *cultural* self-awareness reflects *racial* self-awareness. Overall, racial self-awareness – by virtue of being critically reflective on one’s own cultural norms, traditions, values, and beliefs, as well as

group-level power inherited from group membership and therefore independent of personal cognitions – is not seen as essential for meeting *basic* needs in the clinical setting, but is seen to enhance the quality of services for ethnic minority victims/survivors.

Moreover, the need to develop this cultural competency and racial self-awareness is growing with Australia's expanding diversity. Combined with a fear of breached confidentiality and therefore preference for a non-ethnically matched worker, as well as risk for increasing harm from judgmental ethnic minority workers or interpreters, there is a rising onus for the whole Australian mental health and sexual assault workforce to be appropriately trained and not just leave 'ethnic minority matters' to ethnic minority workers. Given that psychiatrists can assist clinically unwell victims/survivors, GPs can model good engagement with other professionals and provide referrals, and social workers, counsellors, and psychologists can talk through and share trauma with the aim of reducing the symptoms of emotional distress, the relevant workforce is as diverse as the client group.

#### *4.2 Methodological strengths and limitations and areas for future research*

Stage 1 developed a program that aimed to educate relevant service providers and other professionals about the psychosocial experience, and needs in the clinical setting, of ethnic minority victims/survivors of CSA, as well as exploring whether and how the program improved cultural competency in the moderate term. It thus used a mixed-methods and longitudinal design; triangulating quantitative survey data with qualitative open-ended data over a six month period. Being purpose-built, the instrument also offers the field new and innovative data. Excluding verbatim quotes in relation to the term 'CALD' (see Section 3.2.1) where a wide rather than full array was provided for the sake of brevity, all relevant qualitative data has been reported here. This demonstrates ethical commitment to the saturation, honouring, privileging, and representation of the voices of research participants. Finally, the contents of the program were informed by a systematic literature review conducted in the area, thereby building empirical data collection on exhaustive theoretical foundations.

Despite its many methodological strengths in relation to rigorous study development, design, implementation, and analysis, some limitations need to be acknowledged. The first is that although the sample was nationally representative, interest among medical professionals (GPs and psychiatrists) was unexpectedly nil and considerably reduced the anticipated sample size. This was despite advertising with the Australian Medical Association (AMA), Australian Association of Social Workers (AASW), and Australian Psychological Society

(APS) being equally funded. A power analysis (Cohen, 1992) testing differences between two independent means (medium effect size (ES);  $\alpha = 0.05$ ) indicated that a sample of 64 per group would be required to detect statistically significant differences. This was nearly obtained when examining the data by the service provider's cultural background (59 ethnic minority and 53 Anglo), but only at baseline.

Future replication studies are therefore required, with larger samples and all target audiences represented, to verify the tentative findings reported here. With a larger sample, participants may arguably feel less fearful, permitting collection of a unique identifier to match the data sets across time. Such studies could then conduct repeated measures analyses to empirically establish the program's effectiveness. Positively, however, the mean score on the T1 satisfaction survey was 4.2 (SD = 0.7,  $n = 99$ ), on a scale ranging from 1 (Overall, not at all satisfied) to 5 (Overall, completely satisfied), and with most participants completing the survey ( $100/120 = 83.3\%$  response rate). This provides strong evidence for the overall effectiveness of the program, and is critical to celebrate given the complexity and sensitivity of the topic. That is, 'overall satisfaction' is a sufficient indicator for now of the worthwhileness of the program, independent of its outcomes in relation to the eight research questions.

Future research could also squarely use participatory action research (PAR) methods with each type of service provider to more deeply understand and progress good clinical outcomes within both the medical and non-medical approaches of improving well-being for this client group. Indeed, the predominance of social workers and counsellors suggests that the well-being of ethnic minority victims/survivors of CSA is of more professional importance or relevance to them, and exploring in the future why it may be less so for GPs and psychiatrists is warranted. In addition to exploring barriers to participation in such research, the specific training that is of interest to medicos and non-medicos could also be examined. Given the current study has only explored the effect of the program in the moderate six-month term, designing longer-term studies would also be fruitful. These could look at links between exposure to knowledge of cultural awareness and white privilege, and attitudinal and behavioural change in practice, situated within a well-articulated theory of change.

Finally, it is important to acknowledge that the author administered the evaluation instrument and delivered the program; inviting potential criticism for conflict of interest. Although it does happen in research, it is preferable for program evaluations to be independent to improve trust in the data obtained. This was acknowledged when designing the study, and implemented and managed as best as possible, by: (i) ensuring and iterating often that all survey data collected was completely anonymous, (ii) administering the baseline survey before rapport was established during program delivery time, and (iii) asking registrants to place themselves the anonymous baseline

and program satisfaction surveys in a box marked ‘confidential’ at the back of the room rather than collecting them. During the time allocated for explaining the Ethics Statement and obtaining informed consent, the importance of researcher independence from the collation of survey material was clearly explained and emphasised. It is outside the word scope of this article to explain the study’s methodology more deeply, but in one testimonial from a national expert in child protection about the Technical Report (Sawrikar, 2019b), it was said “*This report’s attention to detail, comprehensiveness, and transparency are commendable. It is rare the scholarly community are gifted with such a detailed project account*” ([www.nomoresilence/publications](http://www.nomoresilence/publications)).

## **5. Conclusion**

One reason why cross-cultural diversity in the psychosocial experience of CSA has been historically under-researched is because of how many factors it needs to take into account. The theoretical framework of intersectionality is therefore necessary and appropriate. It can provide practitioners with a language for how to navigate the complexities and sensitivities of this issue. Normalising this way of understanding this client group can help mitigate against the FAE, and better see the barriers this group are oppressed by. In turn, responsible uses of racial power in the clinical setting can be better exercised.

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