RQ4: Do service providers more appreciate that there may be cross-cultural differences in belief of myths about child sexual abuse that shift culpability to the victim?

Background and rationale

Myths shift culpability to the victim

The CSAMS does not assess all myths about child sexual abuse (Cromer & Goldsmith, 2010), but is a reliable and valid measure designed to assess “false or overgeneralised beliefs that create a climate hostile to victims” (Collings, 1997, p. 672); attitudes that “effectively condone, justify, or excuse sexual assault” (Collings et al., 2009, p. 9). Extensive research has shown that acceptance\(^1\) of myths about child sexual abuse is associated with increased attributions of blame to victims and decreased perceptions of offender culpability (Collings, 1997).

Cross-cultural differences, limitations of research, and implications for mental health

Only one study examining the cross-cultural validity of the CSAMS was identified (Collings et al., 2009), indicating that it is not currently known if cultures differ in their beliefs of myths about child sexual abuse and therefore the extent to which they may be ‘victim-blaming’. The authors themselves note the paucity of work in this area, saying:

\(^1\) The literature uses the phrase ‘acceptance of myths about child sexual abuse’, however this project has chosen to use the phrase ‘belief of myths about child sexual abuse’ to help acknowledge that endorsement is not always conscious. The word ‘accept’ could imply that a person has first considered a myth but then still agrees with it, and therefore does not allow for unconscious cognitive errors relating to attributions of culpability. For example, if a child places herself at risk of revictimisation out of fear of the perpetrator for not complying with demands to make herself available again, others may see that the revictimisation is her fault and therefore less the perpetrator’s. Perceptions of culpability relate to a normal human cognitive error of over-estimating another person’s sense of agency (including a child’s) within any (traumatising and power-abusing) circumstance (Sawrikar, 2018c). The phrase ‘acceptance of myths about child sexual abuse’ has only been used in this project when citing other literature.
There has been no systematic attempt to examine the extent to which the instrument provides an adequate measure (of belief of myths about child sexual abuse) across different national or cultural groups. The omission is surprising in light of findings which indicate marked cross-cultural differences in attitudes towards important social issues … Westerners typically view the self as autonomous and independent, find self-relevance primarily in self-enhancing opportunities, and emphasise dispositional characteristics (when making causal attributions of social behaviour), and Easterners typically view the self as interdependent and grounded in social interrelationships, find self-relevance primarily in self-criticism opportunities, and emphasise social or situational explanations of social behaviour (p. 10).

Interestingly, in this preliminary investigation of three countries, it was found that for the South African sample (94% black African, n = 200), the mean score for males was 33.58 and for females 29.97; for the South Korean sample (100% Asian, n = 200), the mean score for males was 38.79 and for females 36.19; and for the Swedish sample (100% Caucasian, n = 200), the mean score for males was 25.99 and for females 19.71. It was also found that in the South Korean sample, 180 respondents (90%) “strongly agreed” with one or more of the 15 items on the scale, whereas there were 149 such respondents (74.5%) in the South African sample and only 70 respondents (35%) in the Swedish sample.

These descriptive statistics point to a possibility that Easterners are more believing of myths about child sexual abuse than Westerners. However, Collings et al. (2009) caution against such an inference because the results of the factor analyses showed that child sexual abuse is conceptualised across cultures in incomparable ways. Specifically, the items loading onto each factor, the ensuing names assigned to each factor, and the amount of variance each factor accounted for, differed such that there was no real resemblance or overlap between the three groups.

In the South African sample, Factor 1 (Blame Diffusion) accounted for 15.9% of the variance and was comprised of items 6, 9, 10, 11, and 14; Factor 2 (Denial of Abusiveness) accounted for 15.1% of the variance and was comprised of items 1, 2, 4, 5, and 15; and Factor 3 (Restrictive Stereotypes) accounted for 11.5% of the variance and was comprised of items 3, 7, 8, 12, and 13. In the South Korean sample, Factor 1 (Social Responsibility) accounted for 21.0% of the variance and was comprised of items 3, 6, 7, 8, and 13; Factor 2 (Child Responsibility) accounted for 10.5% of the variance and was comprised of items 4, 9, 10, 11, 14 and 15; and Factor 3 (Denial of Harm) accounted for 8.9% of the variance and was comprised of items 1, 2, 5 and 12. In the Swedish sample, Factor 1 (Sexual Mutuality) accounted for 37.7% of the variance and was comprised of items 1, 2, 4, 5, 9, 12, and 15; Factor 2 (Family Responsibility) accounted for 8.9% of the variance and was comprised of
items 3, 5, 6, 10, 11, 12, and 14; and Factor 3 (Social Responsibility) accounted for 8.2% of the variance and was comprised of items 3, 7, and 13.

Because of the lack of construct comparability, score comparability becomes invalid. Thus, more research in the area is required, however similar obstacles may be encountered: there is a universality in the experience of child sexual abuse which warrants and permits cross-cultural comparisons, but attitudes about child sexual abuse especially in relation to how much the victim is seen to be at fault may be too culture-specific to allow cross-cultural comparisons to be made with confidence.

Assuming it is possible to find evidence that belief of myths is greater in collectivist cultures, then the processes of fear of not being believed, increased self-blaming when the fear is affirmed with non-supportive and protective responses to disclosure from carers, and severe mental ill-health – already identified in the Western-based literature – could be intensified in CALD communities. When the ‘collectivist’ lens is overlaid on these processes, prohibitive social norms discussing sexual matters and an utmost need to protect family reputation which can then lead to a de-prioritising of the individual victim’s need for support and protection, could intensify it again; qualitatively, quantitatively, or both. CALD groups additionally experience many barriers to formal services, even if this was a supportive and protective response that carers considered taking up for their child and/or themselves.

For all these reasons, there is a chance that the proportion of CALD victims/survivors of child sexual abuse who experience severe mental illness is higher than non-CALD victims/survivors and/or that their symptoms are worse. Again, such a possibility does not warrant greater intervention from the state but rather greater support from services. It also does not negate the severity of the consequences of child sexual abuse in non-CALD victims/survivors because (in this project) all victims/survivors are equally valued. It is description and understanding of their unique psychosocial experience that is being pursued so that support services are appropriately tailored.

**Selecting exemplars**

The work of Cromer and Goldsmith (2010) shows that there are five types of myths about child sexual abuse: (i) those that minimise the extent of harm posed to victims, (ii) those that minimise the prevalence of child sexual abuse, (iii) those that blame the victim or others (e.g. non-offending mothers), (iv) stereotypes about perpetrators, and (v) stereotypes about child sexual abuse itself. All myths can serve to make it difficult to believe a child’s disclosure, which then has implications for (legal processes in which juror attitudes and beliefs influence trial outcomes – not of focus in this study, and) psychological processes in which victims’ likelihood of self-blame and therefore mental ill-health are affected. Although there is no data in the current literature to empirically support it, these myths are likely to be correlated with
each other, so ‘victim-blaming’ beliefs may be higher among those who also believe the other myth types.

For the purposes of this evaluation study, where brevity was critical, two exemplar items were selected for the question examining service providers’ beliefs about cross-cultural belief of myths that shift culpability to the victim: ‘Adolescent girls who wear very revealing clothing are asking to be sexually abused’ (Q10) and ‘Children who do not report ongoing sexual abuse must want the sexual contact to continue’ (Q14). In the study by Collings et al. (2009), these items loaded onto Factor 1 (Blame Diffusion) for the South African sample, Factor 2 (Child Responsibility) for the South Korean sample, and Factor 3 (Family Responsibility) for the Swedish sample. The findings show that ‘victim blaming’ is not independent of ‘offender or other blaming’; they are negatively correlated – the more victim-blaming a person is, the less offender-blaming they are. Thus, all myths about child sexual abuse could in some directly or indirectly causal way shift culpability to the victim. Structural equation modelling on a large nationally representative longitudinal data set collected using rigorous methods would be required to explore this possibility empirically. Here, the argument is being made that any two exemplar items could have been selected for the evaluation study.

Summary (including barriers to formal services)

Figure 6 summarises the hypothesised relationships between belief of myths that shift culpability to the victim and severe mental ill-health among CALD victims/survivors of child sexual abuse. It begins with the suggestion that all myths about child sexual abuse have the capacity to shift culpability to the victim to a greater or lesser extent; essentially reflecting “the climate of hostility to victims” (Collings, 1997).

Belief of myths could be higher in CALD communities because emphasis on social relatedness might mean that more blame for child sexual abuse is assigned to “social problems such as unemployment, poverty, and alcohol abuse” (Q13 CSAMS) or “poor, disorganised, unstable families” (Q7 CSAMS) – a finding in the Eastern South Korean sample of the study by Collings et al. (2009), and contrary to the findings of Cromer (2006) where less than 10% of participants (college students in the US) agreed with these statements. Blaming ‘bad families’ makes sense within the collectivist framework, and aids in indirectly shifting culpability away from the perpetrator and toward the victim. In counter-argument, belief of myths that shift culpability to the victim could be higher in ‘individualistic’ cultures because of the emphasis on the dispositional characteristics of individuals when making attributions about social behaviour. That is, ‘something about the victim has caused the crime to occur’. Thus, vastly different reasons may underlie cross-cultural belief of myths about
child sexual abuse, and therefore it may not be possible to identify whether they are greater in collectivist than individualistic cultures.

In collectivist cultures, norms prohibiting discussion on matters to do with sex reflect value for a woman’s virginal purity, which may also be related to the extent to which significant males (e.g. fathers, brothers, etc.) are able to protect the sexual honour of women. These norms are higher in overtly patriarchal cultures (Sawrikar, 2018). When even sexual assault is not openly discussed because it then denotes the lack of a woman’s sexual purity and therefore tarnishes men’s honour and the family name, it becomes particularly challenging to debunk myths that shift culpability to the victim.

The psychological process of interpreting the self as blameworthy for the crime and experiencing fear of not being believed upon disclosure is cross-culturally universal, as is the tendency for primary carers (usually the mother) to respond to their child’s disclosure in ways that are not supportive or protective (e.g. believing the disclosure, providing informal emotional support, accessing formal services, and/or preventing opportunity for the perpetrator to re-victimise the child) because it can suggest she has failed in her responsibility to protect the child. However, within the collectivist lens, carers are likely to be driven by an utmost need to keep the family together at all costs and therefore protect family reputation, thereby intensifying non-supportive and protective responses. That is, the needs of the individual victim are de-prioritised to the needs of the family.

If a CALD carer does wish to access formal support services they may still need to overcome a range of barriers, grouped here into three types: non-cultural, migratory/acculturative, and cultural. Non-cultural barriers occur for people from all cultural backgrounds, migratory/acculturative barriers occur for CALD groups but do not ‘belong’ to them, and cultural barriers do not just occur after migration.

Three types of non-cultural barriers are identified. The first is lack of awareness of services, which occurs because people are unlikely to know what is available in the local community unless there is a need for it (Allimant & Ostapiej-Piatkowski, 2011). However, this barrier could interact with the migratory barrier of low English proficiency and cultural barrier of shame for seeking support from outside of the family for CALD groups, and so is not wholly a non-cultural barrier for them.

Another non-cultural barrier is lack of worthiness and wanting to forget. As Mathews et al. (2013) say, “victims may not see themselves as deserving of formal help due to low self-esteem or self-blame. They may also fear being ‘taken back’ to events they want to ‘forget’ in the therapeutic process. Caretakers may also want the child to forget about the abuse, move on, and not talk about it” (p. 651).
Finally, fear of children being removed may prevent all families from accessing formal services. However for CALD families, fear of authorities is heightened because of poor experiences in the country of origin such as abuses of power by police (Taylor & Putt, 2007) or collectivist value for deference to hierarchical authorities (Sawrikar, 2018). If a CALD family does access services, it is critical that they are aware that service providers are mandatory reporters, that not all children who are sexually abused are removed from the home (many factors are involved in this decision), and that after assessment a child protection worker may recommend formal service uptake to demonstrate supportive and protective responses for the victimised child. Thus, again, this ‘non-cultural’ barrier can interact with migratory and cultural factors making it not wholly non-cultural for CALD communities.

Two types of migratory/acculturative barriers are identified. The first is fear of deportation. If CALD victims believe that seeking professional help will endanger their immigration status, then they are not likely to access it (Allimant & Ostapiej-Piatkowski, 2011). The second barrier is low English proficiency (which only occurs after migration). If interpreters or bilingual staff are seen to not be available, then this compromises good practice with CALD families (Sawrikar, 2015).

Finally, three cultural barriers are identified. The first is fatalistic or religious beliefs. For example, some groups may not utilise mental health services because of a fatalism inherent in the religious belief that ‘God is the cause of all that is’ (Haboush & Alyan, 2013). Some groups may also seek help from spiritual leaders instead of Western-based formal services, and so have their needs for support met within that religious context (Kanukollu & Mahalingam, 2011).

Another cultural barrier to formal service uptake is normative reliance on the family for emotional support. In fact, “the idea of seeking help from strangers could be quite strange and bewildering to them” (Nesci, 2006, p. 44). There is also, in Western psychotherapies, a focus on the individual paying attention to themselves – their thoughts and feelings – for emotional insight, which then in turn asks for value for the self, honest disclosures, and an ability to be verbally expressive. These may go against Eastern values placed on showing deference, respect, and obedience to the superior (in this case, the therapist) – especially if they are older and male to maintain hierarchical expectations, and keep disagreements and any negative feelings to themselves to demonstrate emotional control that maintains social harmony (Kanukollu & Mahalingam, 2011).

Thirdly, there is the issue of shame for seeking support outside of the family. Doing so may be seen as a sign of weakness, and it goes against cultural values for self-control, suffering, and perseverance in the face of adversity (Futa et al., 2001). While shame for seeking help is also a barrier in Anglo populations, that shame extends to all members of the family in
CALD collectivist cultures. For this reason, some women have reported they would rather be killed than have their experiences and contact with a sexual assault service publicly disclosed in the community (Allimant & Ostapiej-Piatkowski, 2011).

While acknowledging that formal services are not essential to becoming a resilient, empowered survivor (addressed in more depth in RQ7), they do offer a critical opportunity for victims/survivors to not remain isolated in their trauma and its effect on their mental well-being. Sharing the trauma and developing skills and strategies on managing any mental ill-health have the capacity to reduce the intensity of symptoms (Cromer & Goldsmith, 2010).

In short, the aim of this study was not to find empirical evidence for the possibility that CALD groups may be more believing of myths about child sexual abuse that shift culpability to the victim (especially since it may not even be possible), and therefore a possible link to even worse mental ill-health (intensity of symptoms or number of victims with severe mental illness). Instead, the aim was to imbue service providers with an appreciation that there may be cross-cultural differences in belief of such myths because the psychosocial experience of child sexual abuse is not universal, and that collectivism, patriarchy, and migration would have a role in explaining why.

**Measures**

Program attendees were asked one question in relation to RQ4: *B.9 – ‘One effect of myths about child sexual abuse is that they can shift culpability (i.e. blameworthiness) from the perpetrator to the victim. Two examples of such myths are: (i) “Adolescent girls who wear very revealing clothing are asking to be sexually abused”, and (ii) “Children who do not report ongoing sexual abuse must want the sexual contact to continue”. Compared to Western populations (e.g. Anglo Australians), do you think CALD communities are:’* Options varied from 1 = Significantly less likely to believe myths about child sexual abuse that shift culpability to the victim, 2 = Less likely to believe myths about child sexual abuse that shift culpability to the victim, 3 = Equally likely to believe myths about child sexual abuse that shift culpability to the victim, 4 = More likely to believe myths about child sexual abuse that shift culpability to the victim, and 5 = Significantly more likely to believe myths about child sexual abuse that shift culpability to the victim.
Figure 6: Summary of hypothesised relationships between myths that shift culpability to the victim and severe mental ill-health among CALD communities

Myths about child sexual abuse can shift culpability to the victim

Prohibitive social norms discussing sexual matters make it difficult to challenge/de-bunk these myths

This could increase the chances of internalising blame for the crime and/or fear of not being believed

Unsupportive and protective responses from parents to protect family name affirm fears of not being believed

If there is more self-blame and barriers to formal service uptake then mental health outcomes could be worse

Belief of these myths may be higher in collectivist cultures (currently unknown and may not be possible to know)

The more conservative a culture is about ‘female purity’ and ‘male honour’, the harder it may be to challenge myths that blame the victim

Fear of not being believed and risk of (heightened) self-blame due to belief of myths by the child’s carers is cross-culturally shared

Family reputation is important in all groups, but utmost in collectivist cultures

Potential for severe mental ill-health (e.g. PTSD, BPD, suicidality, etc.) to be more common or symptoms more intense in CALD victims/survivors
Changes over time

Cross-cultural belief of myths that shift culpability to the victim

By cultural background of service provider

As can be seen from Figure 7 (and Data Table G.4), the proportion of CALD service providers who thought that belief of myths about child sexual abuse that shift culpability to the victim is cross-culturally equivalent decreased from T1 (42%, n = 25) to T2 (32%, n = 7), as it did for Anglo service providers from T1 (57%, n = 30) to T2 (48%, n = 10). Notably, the proportion of Anglo service providers is higher than CALD service providers at both T1 and T2. This suggests a tendency toward assumptions of universality in experience among Anglo service providers and/or a need for them to appear ‘colour blind’. It is consistent with the means (see Table 12), which show no movement on this item among Anglo service providers from T1 to T2 (M = 3.3).

Figure 7: Percentage distribution on cross-cultural belief of myths that shift culpability to the victim by cultural background of service provider (T1 and T2)
The proportion of CALD service providers who thought that CALD communities are significantly more likely to believe myths about child sexual abuse that shift culpability to the victim increased from T1 (14%, n = 8) to T2 (27%, n = 6), as it slightly did for Anglo service providers from T1 (4%, n = 2) to T2 (5%, n = 1). Notably, the proportion of CALD service providers is higher than Anglo service providers at both T1 and T2. This likely reflects tacit cultural knowledge among CALD service providers. It is consistent with the means (see Table 12), which are higher than Anglo service providers at T1 (CALD M = 3.5, Anglo M = 3.3) and T2 (CALD M = 3.8, Anglo M = 3.3).

Interestingly, the proportion of CALD service providers who thought that CALD communities are more likely to believe myths about child sexual abuse that shift culpability to the victim did not really increase from T1 (36%, n = 21) to T2 (36%, n = 8), nor for Anglo service providers from T1 (32%, n = 17) to T2 (38%, n = 8). This suggests that there is already knowledge among all service providers that CALD communities may be more believing of myths that shift culpability to the victim.

Overall, these changes over time suggest that as a result of the program, service providers are engaging more with cross-cultural differences in the psychosocial experience of child sexual abuse, and so are less likely to universalise it as if it were essentially the same for all victims/survivors. That is, leanings toward cross-cultural equivalence lessen after the program, with service providers more appreciating that CALD communities may be more likely to believe myths that shift culpability to the victim.

Table 12: Descriptive data on cross-cultural belief of myths that shift culpability to the victim by cultural background of service provider (T1 and T2)

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<tr>
<th></th>
<th>T1</th>
<th>T2</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Cross-cultural belief of myths that shift culpability to victim (B.9)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CALD</td>
<td>3.5</td>
<td>0.9</td>
</tr>
<tr>
<td>Anglo</td>
<td>3.3</td>
<td>0.7</td>
</tr>
<tr>
<td>Total</td>
<td>3.4</td>
<td>0.8</td>
</tr>
</tbody>
</table>

Relationship with cultural self-efficacy

As can be seen from Table 13, the correlation between cross-cultural belief of myths that shift culpability to the victim and cultural knowledge, confidence, and sensitivity were not significant and all close to zero at T1. At first glance, these results suggest assumptions of universality among all service providers; the independence of cultural self-efficacy indicates that prior to program delivery practitioners were not aware that there may be cross-cultural
differences in belief of myths that shift culpability to the victim. However, the frequency and descriptive data counters this, showing that service providers do have some cultural knowledge regarding this. Thus, the lack of association is more likely to suggest that this practice wisdom does not translate into conscious self-ratings of cultural self-efficacy.

At T2, the correlations remained not significant but did increase in strength. Two trends across time are particularly noted. The first is that for both CALD (T1 r = 0.02, T2 r = 0.19) and Anglo (T1 r = -0.05, T2 r = 0.18) service providers, confidence to work with CALD victims/survivors increased after attending the program the more they thought CALD communities were more likely to believe myths that shift culpability to the victim. This finding supports the effectiveness of the program in relation to RQ3; imbuing service providers with an appreciation that there may be cross-cultural differences in belief of myths that shift culpability to the victim.

The second observation was for CALD service providers at T2 (r = -0.24); after attending the program, the more they thought CALD communities were more likely to believe myths that shift culpability to the victim, the more cultural sensitivity/respect decreased. Similar to previous findings in this study, this result demonstrates a tendency toward higher judgment of CALD communities by CALD service providers. Combined with the concurrently opposing result of high empathy for CALD communities among CALD service providers, the results tell a larger story of internal conflict. This conflict is marked by both a greater expectation for CALD communities to take self-determined responsibility and disappointment when this fails to occur, with empathy for their people and the barriers they face which make such self-determination difficult if not impossible.

**Qualitative data**

All qualitative data relating to cross-cultural belief of myths (RQs 3, 4) includes:

(Liked best?) Debunking myth *(Satisfaction Survey_18).*

*Good refresher on the myths etc. *(Satisfaction Survey_78).*

(Liked best?) Review myths in CSA *(Satisfaction Survey_42).*

(Liked best?) Providing and discussing myths *(Satisfaction Survey_1).*

(Liked best?) Myth connection and link to CALD community *(Satisfaction Survey_57).*

(Liked best?) Further explanation around sexual assault myths in CALD communities – great explanation *(Satisfaction Survey_40).*
Dispelling the myths of child sexual abuse is paramount to making the male perpetrator accountable (Satisfaction Survey_52).

It helped reaffirm my knowledge – we work as a specialist service which services diverse communities and so need to respectfully challenge myths and unhelpful beliefs which people state are ‘cultural’ (Follow up Survey_34).

It’ll be interesting to see the Royal Commission, and the issues of what’s coming out of the Catholic Church, and the impact of sexual abuse, whether that’s a driver for communities exploring what child sexual abuse actually is in terms of the myths (Q&A Forum_Syd).
Table 13: Correlations between cross-cultural belief of myths that shift culpability to the victim and cultural self-efficacy by cultural background of service provider (T1 and T2)

<table>
<thead>
<tr>
<th></th>
<th>T1</th>
<th>T2</th>
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<tbody>
<tr>
<td></td>
<td>Cultural knowledge</td>
<td>Cultural confidence</td>
</tr>
<tr>
<td>CALD(^a)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cross-cultural belief of myths that culpability to the victim</td>
<td>0.01</td>
<td>0.02</td>
</tr>
<tr>
<td>Anglo(^b)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cross-cultural belief of myths that culpability to the victim</td>
<td>-0.01</td>
<td>-0.05</td>
</tr>
<tr>
<td>Total(^c)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cross-cultural belief of myths that culpability to the victim</td>
<td>0.06</td>
<td>0.03</td>
</tr>
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* p < 0.05, ** p < 0.01, *** p < 0.001; a – T1 n = 59, T2 n = 22; b – T1 50 < n < 53, T2 n = 21; c – T1 109 < n < 112, T2 n = 43.
Summary

- Myths about child sexual abuse refer to false or overgeneralised beliefs. The more they are believed by others, the more victims are seen to be at fault for the crime rather than the perpetrator. This then has implications for the mental health trajectory of victims. Specifically, myths about child sexual abuse create a hostile climate for victims which increase their fear of not being believed and/or likelihood of self-blaming. If these are affirmed with non-supportive and protective responses to disclosure from carers, it becomes associated with severe mental ill-health.

- It is not currently known if there are cross-cultural differences in belief of myths about child sexual abuse, and therefore differences in ‘victim-blaming’ and severity of mental ill-health, because extensive research in the area has not been conducted to date. However, it may not be possible to make such cross-cultural comparisons because differences between Western cultures that value autonomy and independence and Eastern cultures that value social relatedness and interdependence, may create very different attributions about culpability. Thus, there is some universality in the psychosocial experience of child sexual abuse which warrants and permits cross-cultural comparisons, but there are also limits that compromise making such comparisons with confidence.

- After accounting for this limitation, there is still a possibility that victim-blaming and therefore severity of mental ill-health among victims is higher in collectivist cultures, which needs to be acknowledged. Such a possibility does not warrant greater intervention from the state but rather greater support from services, and is being acknowledged in the spirit that unique cross-cultural descriptions and understandings of experience allow support services to be appropriately tailored. It is not being put forward to minimise the severity of consequences of child sexual abuse among non-CALD victims/survivors.

- The heightened risk of victim-blaming in collectivist cultures is brought about because of prohibitive social norms on discussing any sexual matters including abuse, to protect female purity and male honour and therefore family reputation. This in turn makes conversations that strive to at least challenge but at best debunk myths about child sexual abuse near impossible.

- The heightened risk of severe mental ill-health among CALD victims is brought about by a de-prioritising of the individual’s needs to those of the family (namely, keeping the family intact and therefore protecting its reputation at all costs), as well as barriers to formal help-seeking which could assist with alleviating the symptoms of mental ill-health.
Barriers may be non-cultural, migratory/acculturative, and/or cultural in nature. Non-cultural barriers include lack of awareness of services, lack of worthiness and wanting to forget, and fear of children being removed. Migratory/acculturative barriers include fear of deportation and low English proficiency. Cultural barriers include fatalistic or religious beliefs, normative reliance on family for emotional support, and shame for seeking extra-familial support.

Thus, the purpose of RQ4 was to examine whether it effectively imbued service providers with an appreciation that the psychosocial experience of child sexual abuse is not universal; belief of myths that shift culpability to the victim, and therefore severe mental ill-health, may be higher in CALD communities due to the roles of collectivism, patriarchy, and migration.

In this study, only change over time in the number of service providers who thought that belief of myths that shift culpability to the victim was cross-culturally equal was examined. Supporting evidence was found for both CALD and Anglo service providers, demonstrating the effectiveness of the program in challenging assumptions of universality; by T2, less service providers thought that belief of myths that shift culpability to the victim is cross-culturally equal, and more service providers thought that they were significantly more likely in CALD communities.

Due to practice wisdom (and tacit cultural knowledge among CALD service providers), both CALD and Anglo service providers believe that CALD communities are more likely to believe myths about child sexual abuse that shift culpability to the victim.

However, Anglo service providers may lean toward reporting cross-cultural equivalence in belief of myths that shift culpability to the victim as an attempt to use white privilege responsibly, with the effect of appearing ‘colour blind’ and therefore universalising the psychosocial experience of child sexual abuse across cultures.

Indeed, service providers seemed to lack confidence in their practice wisdom, leading to a lack of association with cultural self-efficacy, with the program affirming their knowledge and therefore confidence to work with CALD victims/survivors.

Thus, it seems that service providers already appreciate that there are cross-cultural differences in belief of myths that shift culpability to the victim, but that the program content – explicitly discussing and linking myths to culture – gives ‘permission’ to acknowledge it.

The most troubling finding was for CALD service providers, for whom across all the results of the study thus far, show a deep internal conflict marked by juxtaposed disappointment with and understanding of the strengths and needs of their culture and the responsibilities and barriers faced by their cultural group.