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**“It was... Like a Fight and Rape Club”: A Foucauldian Discourse Analysis of New Zealand’s Abuse in
Care Inquiry, Exploring Child Sexual Abuse in Residential Care**

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Abstract

Children and adolescents brought to the attention of New Zealand care and protection authorities are sometimes removed from their homes and placed into State-run residential care facilities. While the aim placing young people into residences is to improve their wellbeing, child sexual abuse is common in this setting and more pronounced than in the general population. There are many psychological theories, perspectives and movements which have attempted to explain child sexual abuse spanning from the 1800s to the present day. These partial and, at times, unsupported understandings of abuse have been shaped by socio-cultural and socio-political conditions. This has had serious implications for our collective (mis)understanding of child sexual abuse and the ways in which we respond to abuse with dominant discourse often transcending into policy, law, and the courtroom where social (in)justice occurs. In addition, despite there being three centuries of child sexual abuse research, to-date there has been limited exploration of the phenomenon in residential care settings both globally and within Aotearoa. However, the opportunity to explore child sexual abuse in this setting has availed itself with the New Zealand Government launching a Royal Commission of Inquiry into Abuse in Care in 2018 to better understand abuse across State and faith-based settings between 1950 and 1999. This thesis aims to provide additional insights to the inquiry by exploring the different ways in which child sexual abuse in residential care is understood as well as the conditions which legitimise or silence these understandings.

A Foucauldian Discourse Analysis was used to analyse 47 publicly available documents from the inquiry including statements, transcripts, and evidence briefs from survivors, survivor advocates, counsel, and representatives from institutions that provide care and protection for young people. Analysis found six discourses: *control and punishment*, *fabrication*, *harmful*, *power and oppression*, *shameful*, and *State and institutional failure*. These discourses reaffirm previous findings in sexual abuse research including sexual abuse as shameful and notions of fabrication. New insights were also found and include the use of sexual abuse as a method of controlling and punishing young people; predatory sexual behaviour in young people as a method of self-protection; cultural genocide and intergenerational care placement as victim sequelae; and the development of adaptive survival behaviours in residents in response to the State's failures to protect them. In addition, systemic failures were uncovered including inadequacies in internal and external monitoring, failures in vetting, poor investment in professional capabilities of frontline workers, and a culture of tolerance toward abuse. Overall, the analysis found cultures of sexual violence and cultures of tolerance toward abuse within residential care, which emerge from the young person's status as a State Ward.

Table of Contents

Acknowledgements	ii
Abstract.....	iii
Table of Contents.....	iv
List of Tables	viii
List of Figures	ix
Glossary.....	x
Chapter 1: Child Sexual Abuse in Residential Care	1
International and Local Definitions of Child Sexual Abuse	1
New Zealand Residential Care: Definition, Key Residences, and Purpose	2
Child Sexual Abuse in Residential Care	4
Adverse Outcomes for Abuse Survivors	4
Understanding Child Sexual Abuse in Residential Care: A Parallel Investigation to the Abuse in Care Inquiry	5
Chapter 2: Psychological Theories, Movements, and Perspectives of Child Sexual Abuse	7
Tardieu: Early Recognition of Child Sexual Abuse	7
Freud’s Psychoanalytic Theory: Child Sexual Abuse as Seduction	8
Liberation Perspective: Child Sexual Abuse as Consensual and Beneficial	9
Family Systems Theory: Child Sexual Abuse as Systemic Dysfunction	10
Attachment Theory: Child Sexual Abuse as Suboptimal Maternal Responsiveness	11
Feminism, Gender Roles, and Sexuality: Child Sexual Abuse as Oppression	13
Kempe and Scientific Inquiry: Child Sexual Abuse as Harmful	16
Freund and Kolarsky’s (1965) Courtship Disorder: Child Sexual Abuse as Intimacy Deficits	17
Sexualised Children: Child Sexual Abuse as Observational Learning	18
Sexual Violence Scepticism and Witness Suggestibility: Child Sexual Abuse as Fabrication or Distorted Memory	21
Child Sexual Abuse and Culture: Shame, Norms and Tolerances.....	22
The Current Study: Aim and Research Questions	23

Chapter 3: Methodology and Method – Foucauldian Discourse Analysis	25
The Use of Discourse Analysis in Child Sexual Abuse Inquiry.....	25
Foucauldian Discourse Analysis: A Critical Approach to Discursive Psychology	26
Methodological Principles of FDA.....	31
Four Conditions of FDA.....	33
Ontological and Epistemological Foundations of FDA.....	33
Procedure.....	34
Phase 1: Identification and Collection of Corpus	34
Phase 2: Identifying Discourses	37
Phase 3: Identifying and Analysing Conditions.....	37
Ethical Considerations	39
Freely Available Data: Balancing Risks and Benefits	39
Moving Beyond Pathologising Māori: Producing Culturally Responsible Research.....	40
Research as a Political Tool: Identifying and Acknowledging Positionality.....	40
Chapter 4: Results.....	43
Discourse 1. Sexual Abuse is a Means of Control and Punishment.....	43
A Legislative and Political Focus on Control and Punishment.....	44
A Paradigm Shift: Rangatirangtanga for Māori and Pasifika	45
Labels and Stereotypes Emerge from the Legislative and Political Focus on Control and Punishment: “Little N***er boy”, “Dirty” Girl, and “Worthless” Child.....	45
Sexual Abuse Serves to Control and Punish the “Little N***er boy”, “Dirty” Girl, and “Worthless” Child	46
Discourse 2. Denial of Survivor Truth Claims: Child Sexual Abuse as Fabrication	48
Survivors as “Liar”, “Scammer”, and “Crook”.....	49
Misunderstanding the Realities of Child Sexual Abuse	49
Protecting Reputations.....	51
Inadequate Investigations Compromise Evidence	52
Victim Credibility and Decisions not to Prosecute	53

Reliability and Accuracy of Forensic Interviewing	53
Win-at-all-Cost Mentality Among MSD and Crown Law	54
Obstructed Access to Discursive Resources	56
The Abuse in Care Inquiry Serves as a Validating Discursive Resource	57
Discourse 3. Child Sexual Abuse is a Harmful Form of Violence	57
A Trajectory to Psychopathology.....	58
A Trajectory to Prison	63
A Trajectory to Intergenerational Care Placement	66
Discourse 4. The Nexus of Power and Oppression in Child Sexual Abuse	67
The Materialisation of Sexual Abuse as a Form of Power and Oppression	68
Discourse 5. Shame as a Mechanism of Silence	71
Discourse 6. Child Sexual Abuse as a Symptom of State and Institutional Failure	71
Nature and Scale of Abuse Exemplifies State Failures	72
The Materialisation of Child Sexual Abuse in Residential Care as State and Institutional Failure: Systemic Failures	73
Underinvestment in Professional Capabilities.....	74
Vetting Blind Spots.....	75
Inadequate Complaints and Grievance Processes	77
A Culture of Tolerance	79
Poor Internal Monitoring and Oversight	83
Inadequate External Monitoring Functions.....	84
Negligent Oversight and Monitoring of Third-Party Providers	89
The Development of Adaptive Survival Behaviours in Residents who Protect Themselves from Abuse	91
Chapter 5: Discussion, Conclusion, Limitations and Future Inquiry	95
Summary of Research Findings.....	95
Discourse 1. Child Sexual Abuse as a Means of Control and Punishment	95
Discourse 2. Doubting Survivor Truth Claims: Child Sexual Abuse as Fabrication	96

Discourse 3. Child Sexual Abuse as a Harmful Form of Violence	97
Discourse 4. The Nexus of Power and Oppression in Child Sexual Abuse	97
Discourse 5. Shame as a Mechanism of Silence	98
Discourse 6. Child Sexual Abuse as a Symptom of State and Institutional Failure	99
Overarching Conclusion: State Ward Subject Position Promotes Cultures of Tolerance and Sexual Violence in Residences	99
Limitations and Weaknesses: Threats to Reliability, Internal Validity, and Generalisability	100
Implications for Future Research: Working Toward Cultural Shifts, Identifying Positive Sequelae, and Uncovering Mechanisms of Disclosure.....	100
References	102
Appendix A – Source Documents and Internal Reference Code	111

List of Tables

Table 1: Glossary.....	x
Table 2: The Prevalence of Child Sexual Abuse in Residential Care and the General Population (Data Obtained From MartinJenkins, 2020)	4
Table 3: Analytic Prompts for Exploring the Extra-Textual: The Conditions of Knowledge, Material Effects, and Historical Factors Shaping Discourse	38
Table A1/2: Appendix A – Source Documents and Internal Reference Code	111

List of Figures

Figure 1: Foucault's Conceptualisation of Discourse	27
Figure 2: The Data Selection and Collection Process.....	36

Glossary

Abbreviation	Meaning
ACC	Accident Compensation Corporation
CCTV	Closed circuit television
DSW	Department of Social Welfare
FDA	Foucauldian discourse analysis
HPA	Hypothalamic pituitary adrenal axes
MSD	Ministry of Social Development
PTSD	Post traumatic stress disorder
SCWI	Speciality Child Witness Interview Guide

Chapter 1: Child Sexual Abuse in Residential Care

Child sexual abuse is a deeply disturbing and widely condemned social phenomenon that poses significant threats to the wellbeing and safety of children worldwide. Children and adolescents in residential care settings within Aotearoa and New Zealand¹ are at heightened risk of child sexual abuse, exposing a vulnerable population to repeated harm. In addition, while there is a vast amount of research on the topic, child sexual abuse in residential care settings is an under researched area. Therefore, this thesis aims to explore the ways in which child sexual abuse in residential care is understood which can aid in preventing abuse in this setting for future generations.

To provide context for this research, this first chapter sets out a background of child sexual abuse in residential care. It begins by providing an understanding of the phenomenon under investigation with the presentation of key definitions of child sexual abuse as well as a brief overview of the purpose and history of residential care. Moreover, prevalence data highlights the magnitude of child sexual abuse in residences compared with the general population as well as the adverse outcomes experienced by survivors. The section concludes with a brief introduction to the New Zealand Royal Commission of Inquiry into Abuse in Care (hereafter referred to as the 'Abuse in Care Inquiry'), highlighting how this event provides a unique opportunity to explore child sexual abuse in the residential care. Ultimately, this chapter aims to reveal the significance of child sexual abuse in this setting.

International and Local Definitions of Child Sexual Abuse

Child sexual abuse has been defined by leading international bodies, including the World Health Organisation and the United Nations Committee on the Rights of the Child. Child sexual abuse is defined as "the involvement of a child in sexual activity they do not comprehend, are unable to give consent to, are not developmentally prepared for, and which violates the laws or social taboos of society" (World Health Organisation, 1999, pp. 15-16). It is evidenced by non-consensual sexual activity "between a child and adult or another child who by age or development is in a relationship of responsibility, trust or power" (World Health Organisation, 1999, pp. 15-16). The activity may or may not gratify or satisfy the needs of the abuser or be recognised by the victim as abusive (Committee on the Rights of the Child, 2011; World Health Organisation, 1999). Further, sexual acts may be contact (i.e., fondling) or non-contact (i.e., exhibitionism) and may or may not include physical force.

¹ Aotearoa and New Zealand are the Māori and English names of this country, respectively. Both names will be used interchangeably throughout this thesis.

Locally, section 14AA of the Children Young Persons and Their Families Act 1989 – which is a legislative framework for determining if a young person needs care and protection – stipulates child sexual abuse is a circumstance by which a child or young person may be suffering or is likely to suffer serious harm (Children Young Persons and Their Families Act 1989). The Act provides no further insight into what may characterise child sexual abuse. However, a definition utilised by professionals in the social service sector echoes the definitions provided by the United Nations and the World Health Organisation:

Sexual abuse is any action where an adult or more powerful person (which could include other children) uses children for a sexual purpose. Sexual abuse doesn't always involve bodily contact. Exposure to inappropriate sexual situations or to sexually explicit material can be sexually abusive, whether touching is involved or not. Children may engage in consensual sexualised behaviour involving other children as part of normal experimentation this is not considered sexual abuse (Safety of Children in Care Unit, 2022, p. 10)

In addition to these overarching definitions of child sexual abuse, sexual abuse researchers have worked to define the different variations of the phenomenon. The most common types of child sexual abuse in residential care are harmful sexual behaviour, sexual dating violence, and child sexual exploitation (McKibbin et al., 2021). Harmful sexual behaviour and sexual dating violence are both perpetrated by another young person. Harmful sexual behaviour is behaviour by a child under the age of 18 that is developmentally inappropriate, harmful to oneself or others, or abusive to another person such as indecent exposure or forced sex (Hackett et al., 2016) while sexual dating violence is sexual assault in the context of a young person's dating relationship such as sexting or coercing a partner into non-consensual sexual activity (McKibbin et al., 2021). Child sexual exploitation on the other hand is sexual abuse perpetrated by an adult. It involves a child receiving goods, money, power, or attention in exchange for sexual activity and can include activities such as physical touching or prostitution.

New Zealand Residential Care: Definition, Key Residences, and Purpose

Residential care is defined as a non-family-based group environment with paid or unpaid staff where children live and receive care (UNICEF, n.d). Residences within New Zealand include: Epuni Boys' Home (Lower Hutt), Hokio Beach School (Horowhenua), Kohitere Boys' Training Centre (Honorwhenua), Ōwairaka Boys' Home (Auckland), Kingslea Girls' Home/Burwood Training Centre (Christchurch), Moerangi Treks (Urewera), and Whakapakari (Great Barrier Island) (Abuse in Care Royal Commission of Inquiry, n.d.). Children and young people are placed into these settings under care and protection orders (Lambie, 2014). From the 1980s through to the present day, young

people are placed into the custody of the state via the Child, Young Person, and Their Families Act 1989 and/or the Children's Act 2014 because the young person: is suffering or likely to suffer serious harm; offends against the law; is a risk to themselves, family or community; or because the adult responsible for the young person is unable or unwilling to "control" them (s.14). The placement of a young person into a residence is seen as a last resort with the 1989 Act encouraging the use of family group conferences and kinship placement to address concerns in the first instance (Hyslop, 2022).

The focus of the system between the mid-1950s through to the introduction of the Child, Young Person, and Their Families Act 1989 was to control and correct the behaviour of the child (Hyslop, 2022; Toohey, 2020). This is said to be attributed to behavioural and psychological perspectives of the day (Hyslop, 2022) as well as reports – such as the *Mazengarb* report (1954) – which positioned the young person as out-of-control (Soler, 1988; Toohey, 2022). The *Mazengarb* (1954) report was presented in response to public concern about adolescent delinquency and promiscuity which spurred from high profile cases including a teenage sex ring in Lower Hutt, Wellington, and the Parker and Hulme murder in which two teenage girls murdered Parker's mother (Soler, 1988; Toohey, 2022). The report positioned adolescents as a threat to society and blamed poor and/or absent parenting for adolescent 'delinquency' and 'promiscuity' (Soler, 1988; Toohey, 2022). This influenced changes to a series of legislation including the Child Welfare Act 1954 which emphasised controlling and correcting the young person's behaviour and which broadened the definitions of delinquency to include female promiscuity (Toohey, 2022). From 1954 through to the introduction of the 1989 Act, children and adolescents could be taken into custody for committing an offence, persistent truancy, being out-of-control of his or her parents, promiscuity, from an agreement between the Department of Social Welfare (DSW) and the parents, or neglect or ill treatment (Toohey, 2022).

There was also a focus on the control and correction of young Māori during this timeframe stemming from the *Hunn* (1961) report which drew attention to Māori juvenile offending (Savage et al., 2021) and which attributed offending behaviour among this population to a "cultural deficit" and a perceived failure to assimilate to Western ways of being (Hyslop, 2022, pp. 60-61). The data and perspectives presented in the report fed stereotypes and deficit perceptions of Māori, leading to further moral panic within society and a rapid rise of young Māori in care, including residences, from the 1960s (Hyslop, 2022; Stanley, 2016, as cited in Savage et al., 2021). The ideology of correction and control within the social services sector extended into the 1970s with the DSW releasing a report which again attributed youth delinquency to a child not being under proper "control" of the parent (Department of Social Welfare, 1973, p.10). In efforts to control the juvenile delinquent, the

sector expanded the number of available residences (Savage, 2021) and increased policing powers under Section 12 of the Child and Youth Persons Act 1974 which permitted unaccompanied children in public places to be arrested, delivered to the Children’s Court, and placed into the custody of the State if a parent or guardian could not be found (s12).

Child Sexual Abuse in Residential Care

While the aim of placing young people into residences in contemporary times is to protect them and others from harm, child sexual abuse is more pronounced in this setting than in the general population (see Table 2). As can be seen in Table 2, data summarised by MartinJenkins (2020) for the Abuse in Care Inquiry shows child sexual abuse is significantly greater in residential care than in the general population with rates as high as 38% for residences compared to 12.7% for the general population.

Table 2

The Prevalence of Child Sexual Abuse in Residential Care and the General Population (Data Obtained From MartinJenkins, 2020)

Setting	Secondary Source	Prevalence
Youth justice and care and protection residences	Christchurch Health and Development Study (n.d.)	29.8%
	Alloggen et al. (2017)	38%
	Euser et al., (2013)	28%
General population	Christchurch Health and Development Study (n.d.)	6.4%
	Carroll-Lind et al. (2011)	11%
	Radford et al. (2017)	12.7%

Adverse Outcomes for Abuse Survivors

When abuse occurs in institutional settings, the negative effects are argued to be more profound as the abuse is compounded by the institution’s failure to prevent the abuse and respond when it is reported (Goldsmith et al., 2014; Smith & Freyd, 2013, 2014). Further, evidence suggests that those who experience repeated and sustained abuse by a trusted authority figure or family member are more likely to experience significant negative consequences including psychological, behavioural, social, and physical harms (Mathews, 2019). Psychologically, a survivor may develop post-traumatic stress disorder (PTSD) or related symptomology, eating disorders, dissociative disorders or related symptomatology, psychosis, depression, and low self-esteem (Boney-McCoy & Finkelhor 1995; Chen et al., 2010; Cutajar et al., 2010; Dubner & Motta 1999; Fanslow et al., 2007; Kirby et al., 1993; Spataro et al. 2004).

The effects on behaviour and social functioning are also substantial with research documenting poor economic wellbeing, low levels of employment and educational attainment, and substance use disorders which develop as a coping mechanism but often result in offending behaviour and/or homelessness (Bode & Goldman, 2012; Collin-Vézina et al., 2013; Currie & Widom 2010; Gatwiri et al., 2020). While the outcomes mentioned are largely negative and reflect the severity of outcomes for abuse survivors, the trajectory varies per individual and is moderated by factors such as the persons level of resilience at the time of the event(s) (Mathews, 2019). In addition, some survivors of abuse may experience positive outcomes including post traumatic growth (Hartley et al., 2016). However, despite the possibility of varied outcomes in sexual abuse survivors, the negative impacts of sexual victimisation are profound and impede significantly on the psychological, social, and behavioural functioning of the survivor.

Understanding Child Sexual Abuse in Residential Care: A Parallel Investigation to the Abuse in Care Inquiry

Despite the heightened risk of abuse in residences and the significant adverse outcomes experienced from victimisation, there has been limited research on child sexual abuse in residential care settings. However, the New Zealand Government has taken a critical step toward understanding abuse in this setting. The Abuse in Care Inquiry was launched in 2018, aiming to understand the physical, sexual, emotional and psychological abuse and neglect of children, young people, and vulnerable adults in all State and faith-based care settings from 1950-1999 (Department of Internal Affairs, 2021). While the inquiry is an official and comprehensive investigation, its purpose is to identify the nature and extent of abuse, factors contributing to its occurrence, and lessons learned. This broad-based approach limits the commission's ability to delve deeper into specific areas such as child sexual abuse in residences. However, data from the investigation has been made publicly available² and this provides a unique opportunity to explore alternate research questions that the inquiry may not have fully addressed. In addition, the development of independent insights can complement the commission's work and add to a body of knowledge which enhances our understanding of child sexual abuse in residential care, strengthening the case for change, and providing recommendations to safeguard vulnerable young people from sexual abuse.

In summary, child sexual abuse is a global and local concern with particular relevance to residential care settings. Prevalence studies reveal a high rate of child sexual abuse victimisation in residences, which is argued to have a more profound and enduring impact on survivors whose

² Data available at www.abuseincare.org.nz

experiences of abuse in care are compounded by the institutions failure to prevent and respond to abuse in this setting. The significant psychological, behavioural, social and physical harms suffered by survivors underscores the need to better understand and address this issue. The Abuse in Care Inquiry provides a unique opportunity to explore child sexual abuse in residential care settings, providing fresh and novel insights into the issue in residential care which up until this time has been a neglected area of child sexual abuse research. The following chapter will explore and discuss the historic and contemporary traditions of thought on child sexual abuse.

Chapter 2: Psychological Theories, Movements, and Perspectives of Child Sexual Abuse

This chapter reviews child sexual abuse theories, movements and perspectives from the 1800s through to the present day. It begins with the early ground-breaking works of Amboise Tardieu and Sigmund Freud which recognised the issue as socially detestable and psychologically harmful. Subsequently, it highlights a significant period of repression spanning two centuries which was driven by Freud's theory of infantile sexuality and the liberation perspective and which presented child sexual abuse as beneficial to the child and resultant of the child's unconscious sexual desires. Next, the influence of the family systems perspective and attachment theory are explored with each theory holding the non-offending mother and child accountable. The chapter then makes a notable turn toward the transformative influence of the second-wave feminist movement and increased scientific inquiry from the 1960s. This period powerfully unearthed the true scale of child sexual abuse and, for the first time, attributed culpability to offenders. The chapter concludes with a brief overview of social norms and the ways in which these norms influence responses to sexual abuse. In addition to tracing the evolution of child sexual abuse perspectives, this chapter also illustrates how each understanding only offers a partial account of abuse; has been shaped by socio-political and socio-cultural conditions which either acknowledge or deny the issue as socially detestable; and has had a profound impact on social (in)justices for survivors.

Tardieu: Early Recognition of Child Sexual Abuse

The earliest recorded recognition of child sexual abuse was by French physician Tardieu. He was the first to officially document cases of child sexual abuse and to advocate for social reforms. In his 1857 book titled *Étude Médico-légale sur les Attentats aux Moeurs (A Medico-Legal Study of Assaults on Decency)*, which was published over seven editions, Tardieu provided an analysis of 632 cases of sexual abuse against girls and 302 cases of pederasty and sodomy (Dorahy et al., 2010). His work was comprehensive. For the first time, it provided a detailed view of child sexual abuse with evidence of intra- and extra-familial abuse, with and without clinical signs, with and without penetration (Mathews, 2019). In addition, he detailed the physical and psychological consequences experienced by survivor. This work was influential in establishing the fact that child sexual abuse was a widespread issue, not confined to a social class, and that often there were no clear signs abuse had occurred. Despite the damning evidence Tardieu provided, the topic of child sexual abuse as a socially and morally detestable issue was received unfavourably due to the socio-political climate of the time, which had limited recognition of the developmental needs and human rights of children (Bell, 2011). As such, Tardieu's work was undermined by competing beliefs in false disclosures, holding that children pretended to be abused for secondary gain (Dorahy et al., 2010) and this resulted in allegations of abuse being dismissed without careful investigation (Mathews, 2019).

Freud's Psychoanalytic Theory: Child Sexual Abuse as Seduction

Like Tardieu, Freud recognised the widespread nature and profound psychological impact of child sexual abuse. Between 1897 and 1902 he explored the sexual aspects of human behaviour through an exchange of letters with physician and friend Wilhelm Fliess and through his own clinical research (Rachman, 2021). During this time, he developed the seduction hypothesis which he shared with Fliess in a one of his letters: "Have I revealed the great clinical secret to you either in writing or by word of mouth? Hysteria is the consequence of a presexual [*sic*] sexual shock... "Presexual" [*sic*] means before puberty" (Rachman, 2021, p.31). Within this theory, Freud maintained the cause of hysteria in adulthood was due to traumatic sexual experiences in prepubescent childhood (Rachman, 2021). This hypothesis was derived from 18 clinical cases of incest, which typically isolated the father as the main abuser. He presented the theory to the Society for Psychiatry and Neurology in a paper titled *The Aetiology of Hysteria* (1894). However, as with Tardieu, Freud's work was rejected by his colleagues and, in addition, medical journals refused to publish his ideas. His insights were before his time and the conservative Victorian era was unwilling and unprepared to accept that adult caregivers had molested their own children (Azzopardi et al., 2019).

In response to the rejection of his ideas, Freud reformulated his seduction theory and developed the theory of infantile sexuality (Adams et al., 1992; Azzopardi et al., 2019). He began to doubt the validity of patient reports and to entertain the idea that his patients accounts were not real events but instead repressed, unfulfilled fantasies of their incestuous desires toward their parents, particularly the parent of the opposite sex. His theory of infantile sexuality posits children have an innate unconscious sexual desire for a parent which helps to release inner tension. He argued this is a universal phase of psychosexual development, which he coined the Oedipal complex, that is experienced by all children (Azzopardi et al., 2019). The symptoms of hysteria were also reframed. Instead of being a manifestation of sexual trauma, hysteria was attributed to intrapsychic conflicts related to unacceptable primary desires. This reformulation had profound consequences for survivors. Not only did it silence the issue of child sexual abuse for decades, but children were positioned as having seductive qualities and of being desirous of sexual relations with adults for their own sexual pleasure (Adams et al., 1992; Azzopardi et al., 2019). This shifted the blame onto the child, suggesting they actively sought out or participated in the abusive acts, and removed any recognition of the child as innocent victim of abuse. In addition, the psychoanalytic approach positioned the issue of child sexual abuse as an individualised problem that failed to acknowledge the broader social influences that condone and promote the sexual abuse of children and sexual aggression in males (Adams et al., 1992).

Liberation Perspective: Child Sexual Abuse as Consensual and Beneficial

In alignment with Freud's theory of infantile sexuality, the liberation perspective developed by Kenneth Plummer (1981, as cited in Adam et al., 1992) argues that viewing a child as innocent and nonparticipating in adult sexual encounters is misguided and that children may act on their own sexual desires and interests by seeking the attention of an adult. It is asserted that sexual interactions between children and adults are often consensual and, in addition, can be described as affectionate, playful and willing interactions that foster the emotional development and wellbeing of the child when their parents are unavailable or unresponsive to their developmental demands. Any negative consequences from these sexual interactions are thought to be the result of interventions which take place after the abuse has occurred. This idea extends from earlier works of Kinsey et al., (1953) which concluded the psychological trauma experienced by the women in their study was the result of cultural conditioning rather than the abuse itself. The author's state: "It is difficult to understand why a child except for its cultural conditioning, should be disturbed by having its genitalia touched" (Kinsey et al., 1953, p. 121). They argue a conditioned fear of sex occurs when a child-adult sexual interaction elicits a negative reaction from parents which suppresses the child's sexuality. They also argued that interventions following the abuse can also cause an elicited fear response, stating: "The emotional reactions of the parents, police officers, and other adults who discover that the child has had such contact, may disturb the child more seriously than the sexual contact themselves" (Adams et al., 1992, p. 374).

This viewpoint has been criticised for several reasons including its focus on conditioning as the cause of negative outcomes for survivor and the idea that adult-child sexual relations can be consensual and beneficial to child development (Adams et al., 1992). In respect to the conclusions drawn about conditioning, there is a vast amount of research documenting serious and long-term negative outcomes in adults who have been sexually abused as children. Granted, methodological difficulties make it challenging to infer causality between child sexual abuse and adult psychopathology. However, evidence suggests survivors who have never disclosed their abuse experience the same serious and long-term negative outcomes as survivor who disclose their abuse, including feelings of guilt, betrayal, loss of trust, and longstanding difficulties in adult relationships. This suggests that the outcomes experienced by victims of abuse may not be the result of cultural conditioning processes but instead the result of the abusive experience itself. The second criticism of this theory, which is also applicable to Freud's theory of infantile sexuality, is the assumption that children can consent to child-adult sexual relations. While it is important to acknowledge the sexual curiosity and interest of children and adolescents, it is also important to acknowledge that for consent to occur the child must have the power to refuse involvement in sexual relations with an

adult. This is often not possible considering the power dynamics between adults and children which places adults in a position of advantage. When taking this into account it is more appropriate to characterise adult-child sexual interactions as child sexual abuse which is inclusive of coercion and abuse of power.

Family Systems Theory: Child Sexual Abuse as Systemic Dysfunction

From the 1960s, family systems theory became a popular orientation for conceptualising father-daughter incest. The theory focuses on interactions between family members and the problems that result from these interactions (Azzopardi et al., 2019; Karakurt & Silver, 2013). Father-daughter incest is argued to be a symptom of dysfunctional relationships within the family unit, which manifests when the mother consciously or unconsciously disengages from her duties as a mother and wife (Adams et al., 1992; Finkelhor, 1986). The mother's disengagement results in an impaired sexual relationship between the parents and sexual tension in the father (Finkelhor, 1986). While the father could relieve his sexual tension outside of the family home, he is unwilling to do so because he is motivated to maintain his public image as a stable and competent patriarch. The dysfunctional mother-father dyad creates a fear of family disintegration and/or abandonment amongst all family members and they reach the conclusion that any alternate arrangement is preferable to the family breaking apart. A role reversal is negotiated between the family members with the daughter taking on the central female role in the household which includes the sexual, affectional and nurturing responsibilities of the mother.

This approach paved the way for the recognition of child sexual abuse as a problem which had been neglected and denied for centuries (Finkelhor, 1986). Its premise of family dysfunction served as an important inoculation against earlier theoretical frameworks such as Freud's theory of infantile sexuality and the liberation perspective which promoted the idea of unconscious sexual desires in children and the 'benefits' of adult-child sexual engagements. In addition, it conceptualised father-daughter incest for the first time, aiding family therapists and child welfare specialists to identify cases of abuse. It has also received strong empirical backing for its overarching premise with high levels of family dysfunction found in families with incest. However, the theory is too narrow to describe many cases of child sexual abuse, possessing limited explanatory power with father-daughter incest only accounting for 7% of sexual abuse cases (Russell, 1984, as cited in Finkelhor, 1986). It also inadequately explains offender behaviour. In contrast to the proposition of sexual tension in the marital relationship as a motivator for the abuse, relationship difficulties only occur in 10% of cases and offenders often report sex on demand with their wives (Finkelhor, 1986). In addition, 40% of incestuous fathers reported extra-familial paedophilic behaviours implying deviant sexuality in the father independent of family dynamics.

The prevailing notion that maternal transgression is the root cause of family dysfunction and child sexual abuse has also faced significant critique (Finkelhor, 1986). In efforts to pinpoint negative attributes, family systems researchers often overlooked the loving, supportive, and nurturing qualities of the mother (Azzopardi et al., 2019). As such, non-offending mothers have been unfairly characterised as emotionally distant, childlike, rejecting and vindictive, withdrawn, dependent, psychotic or severely retarded, and negligent in her domestic duties (Furniss, 1983). This theory and research have not only contributed to a persistence of undue blame being placed on mothers but have also influenced family systems-based interventions that encouraged mothers to take responsibility for how her maternal inadequacies fostered incestuous relations between her husband and daughter. Despite the influence of this mother-blaming narrative on intervention, no studies have proven the hypothesis that non-offending mothers are collusive in child sexual abuse (Bolan, 2002). Instead, contradictory evidence has been found with 75% to 95% of mothers reporting they were not aware of the abuse. Furthermore, feminist researchers also argue that when a woman does deviate from her role as a protective mother and opts for denial, this is often reflective of abusive home environments where she holds limited power and is restricted of choices due to sources of stress and oppression such as poverty and violence (Azzopardi et al., 2019; Finkelhor, 1986).

Attachment Theory: Child Sexual Abuse as Suboptimal Maternal Responsiveness

As with family systems theory, attachment theory locates the risk of child sexual abuse within dysfunctional family relationships but, more specifically, the mother-child dyad (Azzopardi et al., 2019). The theory was introduced from the late 1950s by Bowlby (1958, 1969, 1982 as cited in Azzopardi et al., 2019) and Ainsworth (1967, 1973 as cited in Azzopardi et al., 2019) but became popular in the 1990s as a tool for conceptualising multiple dynamics of abuse (Bolen, 2002). Attachment is defined as a biologically based system of behaviour that exists between an attachment figure and a child. This process is evolutionary and ensures the safety and survival of a child through close proximity to the parent. The attachment relationship is intergenerationally transmitted and is reciprocal in nature with the child displaying an attachment behaviour such as crying which draws out a response from the attachment figure. This response may or may not adequately meet the needs of the child and shapes the child's sense of security and their ability to confidently explore the world. It also shapes the child's view of others and self through the development of internalised working models which represent how the child views the attachment figure and themselves, setting a blueprint for future relationships. These working models are dynamic and can change throughout life with the influence of developmental history and current

circumstances. There are four types of attachment, including one *secure* style and three insecure styles (*avoidant*, *resistant*, and *disorganised*).

The intergenerational transmission of risk hypothesis provides insight into the association between attachment style and risk of child sexual abuse. It argues that mothers who have insecure attachment histories, and their own histories of sexual victimisation, are more likely to have children who develop insecure attachment patterns and their own sexual abuse histories (Azzopardi et al., 2019). The lasting impact of sexual trauma on maternal mental health impairs the parenting competencies of the mother resulting in transmission of insecure attachment which results in sexual abuse vulnerabilities. The transmission of risk is presented by Alexander (1992, as cited in Azzopardi et al., 2019) who conceptualised the relationship between attachment style and abuse susceptibility. In *avoidant* attachment styles, the mother rejects the child, is psychologically and physically unavailable, and is less likely to acknowledge abuse. As a result, the avoidant child feels rejected and unloved, and this promotes a strong affiliation with strangers and heightens the risk of abuse (Bolen, 2002). In addition, the child mimics avoidant behaviour of the mother and denies the abuse (Azzopardi et al., 2019). In *resistant* attachment styles, the mother engages in role reversal, is unable to attend to the child's needs, is not cognitively or emotionally available, and is unable to stop the abuse. Due to parentification and emotional neediness, the resistant attachment child is more vulnerable to abuse and may develop a strong attachment with their abuser. In *disorganised* attachment styles, mothers are too disorientated to identify abuse due to their own unresolved histories of abuse and chaotic home environments. Disorganised children lack in feelings of security (Azzopardi et al., 2019), tend to cling and be dependant in relationships, and are at risk of being abused by a trusted other who is viewed as a source of security (Azzopardi et al., 2019; Bolen, 2002).

Substantial evidence supports Alexander's conceptualisation and the intergenerational transmission of risk hypothesis in understanding child sexual abuse (Azzopardi et al., 2019). For example, those with avoidant attachment styles are susceptible to extra-familial sexual abuse, whereas those with disorganised attachment styles are more likely to experience intra-familial abuse (Bolen, 2002). Further, attachment style has also been found to influence maternal responsiveness to the disclosure with guardian support greater in secure-attachment bonds (Bolen & Lamb, 2002). Several other studies have also found associations between insecure attachment and sexual victimisation (Azzopardi et al., 2019; Bolen, 2002). However, attachment does not always transfer directly from attachment figure to the child (Bolen, 2002). In addition, there are several attachment-related variables associated with child sexual abuse discontinuity which refutes the idea that intergenerational transmission is inevitable (Azzopardi et al., 2019). This body of research has also been heavily criticised for the undue blame placed on the non-offending mother (Azzopardi et al.,

2019; Bolen, 2002). The focus on a mother's failure to establish a secure-attachment bond perpetuates mother-blaming narratives of child sexual abuse, which is sustained by other theories focusing on maternal inadequacies including the family systems perspective (Azzopardi et al., 2019). Further, these frameworks do little to hold the perpetrator to account and fail to consider the external, socio-cultural influences of attachment or abuse. Understandably, feminist researchers have worked to break down mother-blaming stereotypes by highlighting environmental and socio-cultural influences which impede on the mother-child attachment bond such as abusive home environments or the use of grooming strategies which can transition the mother and child into a space of insecurity.

Feminism, Gender Roles, and Sexuality: Child Sexual Abuse as Oppression

The late 1960s and early 1970s marked the emergence of a second-wave feminist movement. This movement revolted against earlier works of child sexual abuse and sexual violence which were developed by men, and which often ignored the experiences of females and positioned women, mothers, and children as responsible for sexual victimisation (Rennison, 2018). Several key feminists MacLeod and Saraga (1988) and Sheffield (1987) upturned these taken-for-granted understandings of abuse, replacing these with understandings that acknowledged the role of society and men in abusive experiences (as cited in Adams et al., 1992). These scholars argued child sexual abuse and sexual violence against women is a form of oppression or sexual terrorism in which women and children live under a constant state of threat that acts to control and subordinate. This understanding of sexual abuse extended from the work of Brownmiller (1975, as cited in Adams et al., 1992), a radical feminist who documented the use of rape and other forms of sexual violence as a means of social control through anthropological studies. She concluded: "...rape provides sufficient threat to keep all women in a constant state of intimidation... men who commit rape have served in effect as front-line masculine shock troops, terrorist guerrillas in the longest sustained battle the world has ever known" (p. 373).

According to Brownmiller (1975) and other feminist theorists, the "front-line masculine shock troops" (as cited in Adams et al., 1992, p. 373) are not isolated to the societies of the past that she studied. Instead, the continued promotion of traditional gender ideologies within contemporary society keeps these armies in circulation, acting as a significant contributor of continued sexual terrorism and sexual violence against women and children (MacLeod and Saraga, 1988, as cited in Adams et al., 1992). Within these ideologies, men are deemed inherently aggressive and sexually geared human beings with little control over their sexual desires (Devon, 2003; Fontes & Plummer, 2010; Rajiva, 2021). As such, they learn to think about and express their sexuality as an overwhelming and uncontrollable force, to focus their sexual feelings towards submissive objects

such as women and children, and that their sexual desires should be serviced (MacLeod & Saraga, 1988, as cited in Adams et al., 1992). In contrast, gendered ideologies of females are focused on passivity and restraint. Women are expected to avoid arousing men by keeping their legs closed and by hiding or policing their bodies (Fontes & Plummer, 2010; McCormick, 2010; Rajiva, 2021). In addition, and unlike men, women are expected to restrict their sexual behaviour, particularly outside of marriage (Safilios-Rothschild, 1977).

These traditional gender ideologies have contributed to the acceptance of sexual violence against women within society (Adams et al., 1992). For example, mass media and pornography openly support and legitimize male domination and female subordination in sexual relations (Adams et al., 1992; Edwards, 2020). Further, women and girls are often placed into a good/bad dichotomy (Adams et al., 1992). When women and girls transgress from their role as a female by enjoying sexual relations outside of marriage or dressing in a way that society views as provocative, she is often blamed for her own sexual victimisation while the behaviour of boys and men is excused as an expression of normal male masculinity through public commentary which argues “boys will be boys” (Rajiva, 2021, p.7). These sexually coded tropes also transcend into the courtroom, shaping legal narrative and influencing judicial thinking in favour of the perpetrator, while also reinforcing commonsense misunderstandings of sexual abuse which privileges male patriarchy while blaming female transgression for sexual victimisation (Edwards, 2020). The Grace Millane rape and murder trial is case in point. A rough-sex-gone-wrong defence was presented in which the 22-year-old victim’s sexual history, her enjoyment of rough sex, and alleged promiscuity were used to justify her victimisation. The defence claimed that Millane failed in her obligation to police her own body and, as such, consented to her own rape and murder.

A key development resulting from the feminist movement was a rise in social activism which was incredibly influential in shaping social reform (Mathews, 2019). Several women presented articulate accounts of their childhood. American activists, Louise Armstrong and Maya Angelou, related their experiences of incest in their books *Kiss daddy goodnight* (1978) and *I know why the caged bird sing* (1969) (as cited in Mathews, 2019). Another key figure during this time was women’s rights activist and leader of civil rights movements Fannie Lou Hamer. Like Armstrong and Angelou, Hamer related stories from her childhood. She spoke of how her mother birthed 23 children, 20 of whom were the product of rape, and how both her mother and grandmother taught her that a black woman’s body is never her own. The stories of these women gave voice to survivors who had previously been silenced and to a topic which had previously been dominated by academic (mis)interpretations. In addition, their stories sparked public outrage shaping social reform, changing rape laws, increasing prosecutions, and causing a shift in social attitudes and norms surrounding

child sexual abuse and sexual violence more broadly (Mathews, 2019; Reavey & Warner, 2003). This resulted in increased social justice for survivors which up until this period was largely unheard of.

While second-wave feminist interpretations of child sexual abuse proved powerful in respect to making child sexual abuse visible and taken seriously, it developed conditions for the ways in which females and males were positioned regarding abuse (Reavey & Warner, 2003). Societal perceptions of child sexual abuse and sexual violence became a gendered, heterosexual issue reflecting the male domination of females (Devon, 2003; Mathews, 2019). While some level of female offending has been recognised in the literature, it is often minimised as being of little significance (O'Hagan, 1989, as cited in Devon) or "no great moral harm" (Edwards, 1984, as cited in Devon, 2003, p. 309). These interpretations circle back to gendered understandings of sexuality in which females are submissive non-aggressors and this works to evade the seriousness of female offending, which has been reported by survivors as the "most shameful and damaging form of childhood sexual victimisation they have suffered" (Devon, 2003, p. 310). The evasion of female perpetrated sexual violence manifests in underreporting and under prosecution. Survivor often find it difficult to report abuse due to fear of hostile reactions (disbelief, verbal abuse, dismissal, trivialisation of experience) when presenting experiences that defy traditional gender norms (Devon, 2003). When abuse is reported, this is often dismissed by professionals and this is complicated by the fact that the law often does not recognise female perpetrated sexual violence, making it difficult or impossible to prosecute. This impedes social justice for survivor maintains gendered misunderstandings of sexual abuse through the underreporting and prosecution of female perpetrators, and reinforces traditional gender ideologies that the feminist movement aimed to challenge in the first place.

These gendered, heterosexual understandings of sexual violence have also failed to recognise male victimisation. When men are positioned as sexually aggressive it excludes the image of males as victims or males who are reluctant to have sex (Devon, 2003). As such, male victimisation is understudied compared to female victimisation and science, policy, and society often attends more heavily to female survivors (Depraetere et al., 2020). Most research cites rates of child sexual abuse in males as between 3% and 17% (Barth et al., 2013). However, some studies have found rates of up to 34% (Depraetere et al., 2020). Lower estimates of abuse could be due to underreporting, which is thought to be resultant of traditional gender ideologies that promote men as dominant and sexually charged as well as rape myths that position women as the ideal victim. These societal beliefs of men's sexuality and sexual violence prevent men from self-identifying as victims and inhibit them from seeking help to cope with the adverse consequences of sexual victimisation. In addition, male survivors who disclosed abuse face a legal system that privileges gendered, heterosexual

understandings of sexual abuse (Burrow et al., 2020). Again, the law not only denies social justice for these survivors but also limits understandings of sexual violence to those which were embedded in traditional gendered ideologies reflecting heterosexuality.

Kempe and Scientific Inquiry: Child Sexual Abuse as Harmful

The 1960s marked the turning point in which child sexual abuse began to be considered as psychologically harmful to survivors, and which was morally and socially detestable (Reavey & Warner, 2003). Alongside the second-wave feminist movement, physician Henry Kempe – who recognised patterns of abuse and attempted to conceptualise these in what he identified as ‘battered-child syndrome’ – publicly announced his concerns about child sexual abuse. From here, the scale and patterns of the issue became the focus of scientific inquiry. Through this inquiry, it was discovered child sexual abuse impacts an astonishingly high number of children (17.2%; Pereda et al., 2009) and that there is a heightened risk of victimization in females compared to males with meta-analysis highlighting victimisation in 15% to 20% of girls and 5% to 10% of boys (Barth et al., 2013; Pereda et al., 2009). In addition, the median age of onset is between 9 and 10 years and indigenous and ethnic minority communities, those with intellectual disability, and those who identify as lesbian, gay, bisexual, transgender, queer, questioning, intersex and asexual (LGBTQIA) are more likely to experience victimisation (Euser et al., 2016; Fanslow et al., 2007; MartinJenkins, 2020). Studies also identified that the perpetrator is most often known to the victim and that abuse is often experienced on more than one occasion and over a sustained length of time (Hussey et al., 2006; Smallbone & Wortley, 2001).

As the patterns and scale of the issue began to emerge, researchers focused on documenting the symptomology or sequelae of victimisation. As already discussed, some of the long-term negative outcomes for survivors include PTSD, eating disorders, dissociative disorders, psychosis, depression, low self-esteem, poor economic wellbeing, low levels of employment and educational attainment, substance use disorders, criminality, and homelessness (Bode & Goldman, 2012; Boney-McCoy & Finkelhor 1995; Chen et al., 2010; Collin-Vézina et al., 2013; Currie & Widom 2010; Cutajar et al., 2010; Dubner & Motta 1999; Fanslow et al., 2007; Gatwiri et al., 2020; Kirby et al., 1993; Spataro et al. 2004). The discovery and publication of these outcomes moved the issue of child sexual abuse into a space of psychopathology, requiring psychological intervention with professionals seeking cures for survivor disturbance (Reavey & Warner, 2003). With psychological knowledge informing legal and medical systems, the mapping of negative sequelae in survivors helped obtain positive outcomes in some cases, such as financial redress and access to therapy. However, this negative lens of victimhood has been positioned as a universal story in which those who experience child sexual abuse are damaged and vulnerable throughout their lifetime. This focus

on negative outcomes has created the 'harm story', which stresses that abuse only counts if the survivor suffers, and this suffering does not subside. This has arguably resulted in the rarefication of other possibilities for survivors such as increased resilience and post-traumatic growth and the denial of redress or services for survivors of abuse whose outcomes are not considered adverse enough.

Freund and Kolarsky's (1965) Courtship Disorder: Child Sexual Abuse as Intimacy Deficits

In parallel with research on survivor sequelae, scholars began theorising the psychology of offending behaviour in those with paraphilic tendencies, underpinned by the idea that psychological understandings of criminal conduct are integral for the accurate appraisal of risk and for effective rehabilitation (Andrews & Bonta, 2016). A notable theory in this space is that of courtship disorder by Freund and Kolarsky (1965, as cited in Freund & Seto, 1998). This theory hypothesises paraphilic behaviours (voyeurism, exhibitionism, frotteurism, and preferential rape) are the result of an underlying disturbance in the normal courtship process of males (Freund & Seto, 1998). The term courtship is used to explain the dyadic behavioural interactions between two individuals that lead to and initiate sexual intercourse. The courtship process proposed by Freund and Kolarsky (1965) occurs over four phases: the *finding phase* which involves locating and appraising a potential partner; the *affiliative phase* which consists of nonverbal and verbal advances such as looking, smiling and talking; the *tactile phase* where physical contact occurs; and a *copulatory phase* which comprises sexual intercourse (Freund & Seto, 1998). Each paraphilic behaviour is posited to be a distortion or extreme intensification of one of these courtship phases. Voyeurism is a distortion of the finding phase, exhibitionism a distortion of the affiliative phase, frotteurism a distortion of the tactile phase, and preferential rape a distortion of the copulatory phase. When exhibiting these behaviours, other phases are skipped or retained in a way which loses its initial function. In addition, individuals often possess distortions across multiple or all phases rather than one phase in isolation, signifying an underlying disturbance in the entire courtship process.

The theory has received empirical backing for the perceived relatedness between paraphilias with scholars documenting the co-occurrence of behaviours and identifying exhibitionism as a behavioural marker of later escalation to preferential rape (Jung et al., 2012). In addition, the focus on intimacy deficits informed contemporary treatment approaches which provide offenders with the skills necessary to satisfy fundamental intimacy human needs (Marshall et al., 1991; Middleton et al., 2009; Ward et al., 2006). A treatment framework emerging in this space is the good lives model. According to this model, all individuals have an innate desire to seek 'primary goods' including experiences (such as intimate relationships) (Harkins et al., 2012). Similarly to courtship disorder, sexual offending occurs when goods are obtained in a maladaptive way, out of frustration of being

unable to obtain a good, or out of an improper prioritisation of goods (i.e. sexual gratification over emotional intimacy). The framework is considered a positive approach to psychology, which increases treatment motivation by focusing on knowledge and skills building which leads to the successful and safe acquisition of goods (i.e. consensual sexual relations) which is incompatible with offending (i.e. sexual abuse) (Fernandez, 2006; Harkins et al., 2012; Mann et al., 2004; Marshall et al., 2005). However, a noteworthy limitation of this body of research is the focus on offender characteristics and rehabilitation. This has resulted in the development of theories of sexual offending which neglect situational or contextual aspects of criminal behaviour (Beauregard, 2009). Research in this space could benefit from the integration of etiological factors and a deeper understanding of the context in which sexual abuse occurs. This would aid in generating a more robust explanation of sexual abuse which could inform crime prevention strategies, shifting the focus from tertiary rehabilitative methods to primary prevention methods which tackle abuse before it even occurs.

Sexualised Children: Child Sexual Abuse as Observational Learning

Following the birth of clinical theories which focused on offender profile and motivations for child sexual abuse, the research landscape looked to differentiate between normal, abnormal and abusive sexual behaviour in children and adolescents. This was stimulated by several published case studies in the mid-1980s of children who sexually abused other children and concern from clinicians about the misclassification of 'sexualised' children as offenders, which can have serious consequences such as being listed on a sex offender registry restricting employability, education and access to housing (Cavanagh Jonhson, 2000). As children with sexualised behaviour entered the therapy room, clinicians discovered a spectrum of sexualised behaviours which were not confined to a dichotomy of normal/abusive. Instead, it was discovered sexualised behaviour in children exists on a spectrum ranging from normal to abnormal (but not abusive) to abusive. Various frameworks were developed to describe this spectrum of behaviours. This led to more effective treatment with each category of behaviour requiring a different, tailored treatment approach. It was determined a child or young person only required clinical (i.e. trauma-informed cognitive behavioural therapy; Deblinger et al., 2015) or legal intervention when the behaviour caused harm to another person and/or when the behaviour interferes with the young person's functioning including engagement in developmental tasks consistent with their age (Creeden, 2020). Behaviours outside of this – including consensual sexualised behaviour with another child – are considered normal and not needing of intervention.

Cavanagh Jonhson's (1988, as cited in Cavanagh Jonhson, 2000) spectrum of 'sexualised' behaviours in children became a popular tool for clinicians. It includes four stages of sexualised

behaviour: *natural and healthy sexual behaviour, children who are sexually reactive, children who engage in extensive mutual and sexual behaviours, and children who molest* (Cavanagh Johnson, 2000). As most children who sexually abuse others have been sexually abused themselves (Deblinger et al., 2015), Cavanagh Johnson (2000) argues children progress through each stage of the continuum as they attempt to rationalise and deal with their own sexually abusive experience. While the child's behaviour may be disturbing to those in the child's social circle, their sexualised behaviour is often the first clue that they have been sexually abused. Natural and healthy sexual behaviours are described as an information gathering process. Within this category, children explore each other's bodies and gender roles through play (i.e., playing doctors or playing house). This play-based exploration takes place with children of a comparable size, age, and developmental status and the other child's participation is voluntary and not forced. Embarrassing experiences may occur through play, but this is not damaging to the child. These children may also take part in masturbatory behaviour, experiencing pleasure and orgasm, but this is more common in older children on the cusp of puberty.

In contrast to natural and healthy sexual behaviours, children who are sexually reactive engage in self-stimulating and/or sexual behaviours with other children and/or adults (Cavanagh Johnson, 2000). This behaviour is often exhibited in public spaces and indicates the child has experienced sexual trauma. Many children exhibiting this behaviour have lived in sexually overwhelming environments and, as such, they have not been protected from adult or adolescent sexuality and so they do not understand their own rights or others' rights to privacy. When these children do not receive support for trauma they have suffered or when they continue to live in sexually overwhelming environments, their sexual reactivity is unable to extinguish. As such, the child moves along the continuum and begins engaging in extensive and mutual sexual behaviours. These children use sex to cope with a lack of adult attachment and to meet their emotional and physical needs while trying to cope with feelings of abandonment, hurt, sadness and anxiety. The final stage of the continuum is children who molest. As with adult sexual offenders, the behaviour of children who molest is typically pervasive, violates the rights of others, occurs across time and locations, and is coercive (i.e., bribery, trickery, manipulation). However, it is not common for them to use physical force. Their victims can be younger, the same age, or older. Before reaching this point, children who molest have typically experienced a pattern of sexual behaviour problems and intense sexual confusion.

Similar to Cavanagh Johnson's continuum of sexualised behaviour in children, social learning theory (Bandura, 1986, as cited in Creeden, 2020) has been used to explain why children who have experienced sexual trauma develop abnormal and abusive sexualised behaviours. Based on this

perspective, children imitate the behaviour of others based on observation (Deblinger et al., 2015). When applied to the development of sexualised behaviour in children, social learning theory posits children who are exposed to adult sexual behaviours or who are engaged in child sexual abuse will sometimes imitate these behaviours in the same way that they imitate many other observed behaviours. Such behaviours could include grooming and coercion methods, which the child has experienced as part of their sexual victimisation and then use in their own offending behaviour. There is empirical support for the application of social learning theory to the development of sexualised behaviours in child sexual abuse survivors. Research has shown young people with histories of sexual victimisation replicate their own experiences of sexual abuse in the expression of their harmful sexual behaviour (Hackett, 2014). For example, in a sample of 74 adolescent male sex offenders with histories of sexual victimisation, researchers found similarities between their own experiences of abuse and their offending behaviour (Veneziano et al., 2000, as cited in Hackett, 2014). They found young men who were abused under five were twice as likely to choose victims under five while those who were abused by males were twice as likely to choose male victims. More significantly, a close correlation was found between type of act experienced and type of abusive act perpetrated (i.e. offenders who were sodomised as children were 15 times more likely to sodomise their victims).

However, while Cavanagh Johnson's spectrum of sexualised behaviour and social learning theory have evidential support and clinical utility, neither explain how abnormal and harmful sexualised behaviour develops in children and adolescents who have not been victims of abuse (Creeden, 2020). In addition, both fail to explain why most children who sexually offend are males despite higher rates of female victimisation. In light of these criticisms, researchers have moved towards a developmental approach. This approach attempts to understand the interaction between genetic, environmental, developmental and relational factors in the onset of abnormal or harmful sexual behaviour in children and adolescents. This framework does not deny the role of sexual abuse as a contributing factor, but it also considers how the other components mediate the progression of sexualised behaviours. Other conceptualisations of sexualised behaviours in abuse survivors includes the survivor using sex to take back the control they lost in their own abuse experience (Gold & Heffner, 1998) as well as survivors engaging in frequent sexual encounters and sexualised behaviour as a means of regulating their distress and trauma-related symptoms (Deblinger et al., 2015). In children diagnosed with post-traumatic stress disorder sexualised behaviour is conceptualised as a re-experiencing symptom, which often resolves as the child faces their memories through trauma narration and processing (Deblinger et al., 2015).

Sexual Violence Scepticism and Witness Suggestibility: Child Sexual Abuse as Fabrication or Distorted Memory

The enormous change in societal attitudes from the 1960s and an increased focus on offender accountability led to changes in criminal proceedings which allowed uncorroborated child testimony in the prosecution of child sexual abuse cases (Bruck & Ceci, 1999). This resulted in an increase of children providing statements in legal cases and an increased number of prosecutions. However, several high profile cases in the 1980s and 1990s challenged the credibility of survivor reports due to concerning claims of satanic abuse, pornography, and multiple victims and the absence of concrete evidence such as eye witness testimony or physical evidence despite the children's detailed descriptions suggesting this evidence would be possible. Prosecutors argued that the absence of evidence did not necessarily negate the validity of the children's testimony, as the content described was well beyond the common knowledge and experience typical of children. In contrast, the defence tried to argue children's reports were the product suggestive interviewing. This spurred scientific inquiry into witness suggestibility with researchers confirming the malleability of children's memories and demonstrating how certain techniques such as repeated interview and relentless suggestions, coupled with individual differences such as the child's age, could lead to distortions in a child's account (Ceci & Bruck, 1993; O'Donohue et al., 2018). This research was significant because while the child's report may be true, evidence of suggestibility undermines the accuracy of the testimony, making it difficult for prosecutors to make a safe conviction beyond reasonable doubt (Ceci & Brunk, 1993). This has led to some cases being dismissed or exonerated. For example, Peter Ellis – who was convicted of sexually abusing seven children at the Christchurch City Creche between 1986 and 1991 – was exonerated due to improper interview techniques which compromised the accuracy of testimony and safe conviction (“Supreme Court”, 2022; Van Beynen, 2021).

In addition to highlighting witness suggestibility, defence and investigators have increasingly called into question survivor testimony through other means such as scrutinising the initial report or highlighting survivor dishonesty under Section 13 and Section 10 of the Evidence Act 1908 (Law Commission, 1997). Under Section 13 of the Act defence council can show inconsistencies in reporting which calls into question the credibility of survivors. However, inconsistencies in reporting can occur for a variety of reasons other than fabrication such as modifying or correcting an original statement due to memory lapse. The defence may also present a survivor's criminal history to imply dishonest through Section 10 of the Act, with the permissibility of this technique based on an association found between habitual antisocial behaviour and lying. However, an association has also been found between child sexual abuse victimisation and criminality and this is often resultant of the

survivor's sexual trauma and subsequent substance abuse, mental distress, anger dysregulation, low self-esteem and poor coping skills (Papalia et al., 2018). Therefore, when counsels call on offending behaviour in sexual abuse survivors, they are likely inflating the idea that the survivor is dishonest by erroneously highlighting their criminal history against a backdrop of sexual abuse. While these techniques are used to ensure a fair trial, scholars have argued that they can result in 'manufactured' false reports (Orchowski et al., 2020). Manufactured false reports occurs when the survivor recants their accusations to end accusatory and unsupportive investigative processes.

When cases are dismissed or exonerated due to perceived untruthfulness or evidence of witness suggestibility, or when a survivor retracts their claim, it arguably perpetuates the notion that child sexual abuse claims are fabricated and that survivors are untrustworthy (Orchowski, 2020). This notion persists despite evidence suggesting false reports only make up 2% to 10% of cases, with these cases most likely to occur in the context of child custody disputes (O'Donohue et al., 2018). The perception of fabrication is further exacerbated by disproportionate media coverage of 'illegitimate' cases, where survivors have recanted their accusations or offenders have been exonerated (Orchowski, 2020). Unfortunately, this reporting often fails to emphasise the scepticism and pressure placed on survivors the injustices in the legal system, or the shortcomings of investigative processes. The overemphasis on child sexual abuse claims being fabricated has led to survivors routinely encountering intense scrutiny when reporting abuse, which can result in their claims being unjustly dismissed (Orchowski et al., 2020). This is particularly salient when their account of abuse does not align with public misconceptions about what abuse entails (Randell, 2021; St. George, 2020) and when the survivor's demeanour is deemed unfavourable or because of racial stereotyping (Law Commission, 1997). Common misconceptions include beliefs that child sexual abuse is rare, children immediately report abuse, perpetrators are strangers and societal outcasts, and physical and medical evidence should always be present (Randell, 2021; St. George, 2020). These misconceptions persist despite revelations that child sexual abuse is common, perpetrators are often known to the victim and may be respected members of society, and that physical and medical evidence is typically scarce.

Child Sexual Abuse and Culture: Shame, Norms and Tolerances

The relationship between shame and child sexual abuse has also been explore, which is central to many ethnic-minority experiences of sexual violence (Fontes & Plummer, 2010). Shame has been found to both deter disclosure and perpetuate the continuation of child sexual abuse. In some cultures, sexual abuse is considered so shameful that this can taint the family name through connection with authority figures and/or social stigmatisation from neighbours and friends. Fear of bringing this shame onto oneself or the family and/or fear of violent retribution (i.e. victim murder

to cleanse the family name) often discourages disclosure. In cases when abuse is disclosed this is frequently met without favour and the child learns to suffer sustained abuse in silence because their plea for help is ignored. Shame can also make it difficult for a child to discuss or disclose abuse referring to “something that is happening ‘down there’ without using prohibited words” (Fontes & Plummer, 2010, p. 496). This often occurs when children and adolescents are inadequately educated about their bodies and sexuality because of values of modesty and shame which consider such topics inappropriate and unspeakable (Fontes & Plummer, 2010). Interestingly, shame can also promote the social acceptance and continuation of abuse based on this acceptance (Shafe & Hutchinson, 2014). For example, the shame of being an ‘uncut’ woman who is oversexed, unfaithful, and incapable of regulating her sexual desires, encourages women to undergo female circumcision (Omigbodun et al., 2022). This is despite the procedure being socially condemned as female genital mutilation in Western cultures (Omigbodun et al., 2022; O’Neill & Pallitto, 2021). Desire for the procedure stems largely from the psychological torment by ‘cut’ women who hold a privileged and superior social status (Omigbodun et al., 2020). Once ‘uncut’ women undergo the procedure they report feelings of relief and that, with their newfound social capital, they look forward to joining the socially privileged group who harass and stigmatise ‘uncut’ women, engaging in a cyclical process which continues to promote the practice and acceptance of the procedure within their culture.

The Current Study: Aim and Research Questions

As has been presented, child sexual abuse theories, perspectives and movements from the 1800s right through to the present day offer partial (mis)understandings of child sexual abuse. In addition, these understandings of abuse demonstrate child sexual abuse is a complex issue and that our understanding of this issue is deeply intertwined with and shaped by socio-political and socio-cultural conditions which either prohibit or promote social justice for survivors. This leads to two critical questions: are there alternate understandings of child sexual abuse that exist, and if so, what factors shape, validate, or suppress these perspectives? Understanding the coexistence of multiple perspectives and the socio-cultural and socio-political factors influencing these perspectives is crucial for a comprehensive and sensitive response to abuse. Therefore, the primary objective of this research is to gain insight into how child sexual abuse in residential care is understood as well as the conditions which enable or constrain these various interpretations. The research questions driving this investigation are:

1. What are the different ways in which child sexual abuse in residential care is understood?
2. What are the conditions which legitimise or silence these understandings?

Chapter 3: Methodology and Method – Foucauldian Discourse Analysis

Chapter 3 offers a comprehensive overview of the methodology and method used in this thesis: Foucauldian discourse analysis (FDA). The chapter begins by highlighting the pivotal role of discourse analysis in the space of child sexual abuse research, emphasising the distinct value it brings in diverging from the constraints of positivist inquiry to unveil nuanced, contextually rooted perspectives. In addition, the ability of FDA to draw on publicly available data, with its analytic focus on talk and text, surpasses common ethical constraints faced by qualitative researchers seeking to explore child sexual abuse. After setting out the value of discourse analysis, the chapter moves on to explain what FDA entails, outlining Foucault's conceptualisation of discourse as well as four methodological principles and conditions which serve as a framework to scrutinise discourse. The method is then outlined, focusing on how each research question will be responded to. The chapter concludes with a brief overview of the key ethical considerations of this research including: the harms and benefits of using publicly available data, moving beyond pathologising Māori to culturally competent research, and the importance of positionality when using research as a political tool. This comprehensive overview of the methodology and method serves as a bedrock for the forthcoming chapter where discourses of child sexual abuse in residential care are presented.

The Use of Discourse Analysis in Child Sexual Abuse Inquiry

Discourse analysis plays an important role into the scientific enquiry of psychological phenomenon. It offers an alternate, contextualised, and comprehensive perspective compared with conventional quantitative methodologies (Budde et al., 2017). Traditional scientific inquiry into child sexual abuse has primarily relied on quantitative approaches that have provided valuable insight into prevalence and offender and victim correlates (Briere, 1992; Gibson & Morgan, 2013). These insights have been pivotal in assisting legislators, clinicians, policy makers, and scientists in stimulating law, therapy, policy, and scientific interest in the topic (Briere, 1992). However, there are inherent limitations in quantitative research including underreporting due to nondisclosure, the use of non-equivalent comparison groups, the inclusion of amnesic participants in non-abused groups, and noteworthy variations in the conceptualisation and operationalisation of child sexual abuse (Allnock & Barns, 2011; Briere, 1991; Gibson & Morgan, 2013; Wager, 2011). These challenges have led to substantial disparities in research outcomes and dubious inferences. Further, the objectivist principles which underpin quantitative methods constrain the scope of discovery, relying on predetermined questions and variables based on the positivist tradition of seeking and verifying one objective truth. This has contributed to an incomplete picture of child sexual abuse with quantitative methods silencing perspectives that fall outside of predefined criteria and, therefore, failing to adequately capture heterogeneity in abuse experiences (Maniglio, 2009).

Discursive psychology moves beyond the regulatory straight jacket of traditional positivist psychology and allows for an in-depth exploration of child sexual abuse (Augoustinos, 2013). The development of discourse analysis was in response to the 'crisis in social psychology' in the 1960s and 1970s which criticised psychology for its positivist orientations and individualistic approach and urged the discipline to consider human behaviour within its broader cultural, historical, and social contexts (Budds et al., 2017). This prompted the 'turn to language' and the establishment of discursive psychology within the discipline. Informed by social constructionism, discursive psychology does not consider language as a mere reflection of an individual's thoughts, attitudes, and emotions. Instead, it recognises language as culturally, historically, and socially situated and as a medium which is used to create different versions of social reality. The emphasis on talk and text in discursive work not only moves beyond the limitations of objectivism to provide more contextually rich understanding of social phenomenon, but it also alleviates a common constraint of child sexual abuse research encountered by qualitative researchers, which is gaining access to survivors of child sexual abuse (Allnock & Barns, 2011; Priya, 2021). Ethical obligations require researchers to protect participants from harm and to reduce risk (Taylor-Dunn, 2023). Due to concerns about re-traumatisation, ethics approval is often difficult to obtain. Discursive psychology allows us to overcome this issue through the analysis of readily available talk and text such as the evidence from the Abuse in Care Inquiry, which is publicly available. Within the social sciences there are several approaches to discursive psychology, each including its own conceptualisation of what discourse is, such as Potter and Wetherell (1987), Edwards and Potter (1992), Wetherell (1998), Wetherell and Edley, (2014), and FDA. For this research, FDA was selected.

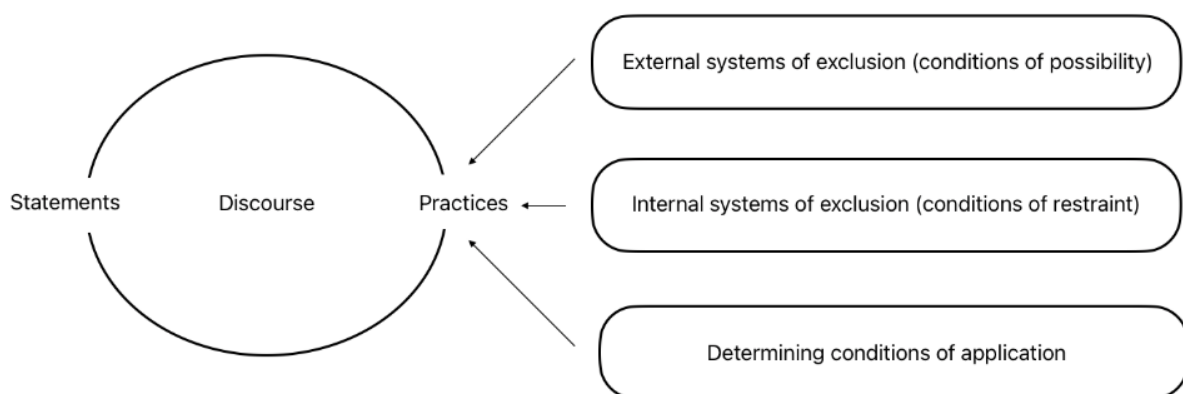
Foucauldian Discourse Analysis: A Critical Approach to Discursive Psychology

FDA is a post-structural discursive methodology. It allows for alternate understandings of child sexual abuse to be uncovered as well as the conditions which silence and legitimise certain understandings of abuse. This qualitative methodology was developed by French philosopher Michel Foucault (Hook, 2007). It encourages the exploration of discourse as he conceptualises across multiple works including *The archaeology of knowledge* (Foucault, 1972) and *The order of discourse* (Foucault, 1981). Foucault's conceptualisation includes three core components: discourse, discursive statements, and discursive practices (see Figure 1). Discursive statements are defined as statements and utterances which have been constructed to provide meaning and which have some effect in society (i.e., "We do not talk about such things"). Logical groupings of these statements are discourse (i.e., child sexual abuse as taboo). Both statements and discourse are regulated by discursive practices, which are the rules, systems and procedures which dictate what can be written, spoken, and thought. Discursive practices are strongly linked to the exercise of power because they

represent a conceptual terrain from which knowledge can be formed and ensures the reproduction of the social system through the promotion or silencing of discourse. The process of promoting and silencing discourse are seen as inseparable with discourses selected and promoted at the sacrifice of discourse which is pushed to the periphery where it is deemed a risk to the social system and the continued authority and materialisation of dominant discourse. As such, FDA is located within the field of political critique, concerned with not only understanding the statements and utterances which encompass discourse but also the broader political and material functioning of discourse in maintaining social systems or phenomenon and the fact that discourse constrains and enables writing, speaking, thinking, and doing and, in doing this, determines what constitutes knowledge and reality.

Figure 1

Foucault's Conceptualisation of Discourse



Foucault's Three Groups of Discursive Practices

A strong focus of FDA is to uncover the discursive practices involved in the circulation of discourse and the maintenance of the social system (Hook, 2007). Foucault (1981) deconstructs the concept of discursive practices with three groups of procedures which are linked to the selection, omission, and dominance of discourse (Hook, 2007). The three groups include external mechanisms of exclusion (conditions of possibility), internal mechanisms of exclusion (conditions of restraint), and determining conditions of application.

External Mechanisms of Exclusion (Conditions of Possibility). External mechanisms of exclusion (conditions of possibility) represent the exclusionary mechanisms of discourse which are the most obvious (Hook, 2007). These include *social procedures of prohibition*, the *opposition between madness and reason* ("the speech of the mad"; Hook (2007) p. 103), and the *opposition between true and false* (our will-to-truth). Social procedures of prohibition manifest in the form of

taboo, ritual, and privileges. For example, discourses of child sexual abuse as unspeakable may be influenced by the fact that the phenomenon is considered taboo (i.e., “It is just not something that is spoken about”) or which brings shame on a family and therefore speaking of the subject is avoided. The opposition between “madness” and reason is drawn from Foucault’s earlier work, *Madness and civilisation* (1965), in which he argues the individual suffers an exclusionary effect reflecting moral condemnation or othering (Gutting, 2005). This occurs when the individual makes a radical choice to do humanness differently by rejecting humanity, normalisation, and dominant discourse. This radical difference is seen as a risk of disrupting the social system and, as such, the individual and their discourse are exiled to the periphery. Discourse analysis aims to uncover multiple truths, particularly those which are oppressed, and so Foucault argues that by looking to the limits of reason – where the “mad” reside – oppressed truths can be discovered (Hook, 2007).

The final external mechanism of exclusion is the opposition between true and false (Hook, 2007). Foucault draws the Nietzsche concept ‘our will to truth’ when articulating his thoughts about this exclusionary mechanism. Here, Foucault refers to how our sense of what is true is contingent on an a historical, modifiable, and institutional constraining system which legitimises, promotes, and distributes knowledge. He exemplifies the work of Greek poets to rationalise his idea. The poets were once considered the highest order of truth “which inspired respect and terror, that to which one submitted because it ruled, and which was pronounced by men” (Foucault, as cited in Hook, 2007, p. 104). However, the truth of these poets was later overturned due to changes and mutations to the institutions which govern legitimate knowledge. While Foucault draws attention to the ways in which power shifts and modifies over time and the flexibility of truth, the focus of analysis is on identifying the institutional supports and practices (such as complaints systems and reporting processes) which govern discourse through the production and legitimisation of truth.

All of these external mechanisms of exclusion (conditions of possibility) aim to displace the will-to-truth with the will-to-power (Hook, 2007). This requires an uncompromising criticism toward statements and knowledge claims which validate themselves as truth. By this, Foucault does not refer to relativism in which multiple truths exist waiting to be discovered. Instead, he refers to the conditions of possibilities (external mechanisms of exclusion) which underly the production and promotion of these truth claims. These conditions are the material conditions (such as institutional supports or social structures and practices) which are historically and socio-politically located, and from which statements come to be seen as meaningful and true. By identifying the conditions of possibilities, discursive researchers can clearly demonstrate the ways in which knowledge is legitimised or silenced and the *power/knowledge complex*, in which knowledge that counts as truth is the product of discourse and that truth is contingent on current forms of such discourse.

Internal Mechanisms of Exclusion (Conditions of Restraint). Internal mechanisms of exclusion (conditions of restraint) point to the creative limitations of discourse which on the surface appears original, innovative, and novel but are restrained by a set of conditions (Hook, 2007). There are three core internal mechanisms of exclusion: *the commentary*, *the author*, and *the discipline*. The commentary refers to the major foundational narratives of a society which are formed through an interchange between primary texts (religious, scientific, juridical) and secondary texts (commentaries). This interchange follows Foucault's principle of recitation in that the commentary provides the opportunity to say something other than the primary text itself but on the condition that the primary text is uttered. For example, when referring to a father-daughter incest a statement like "She wanted it" may appear to be an original utterance or opinion of the speaker but this utterance follows the principle of recitation in that it refers to Freud's theory of infantile sexuality which posits children have unconscious sexual desires towards their fathers. Therefore, the utterances in everyday discourse are not a product of originality, innovation, or novelty but instead a product of recitation, the discursive re-circulation of taken-for-granted understandings and the reappearance of what has been said before.

The author carries an important function of authenticating statements or discourse, and it does this by affirming the status of discourse or statements within society (Hook, 2007). Statements and discourse may only come to be seen as truth through association with authors who are given privileged subject-positions. In *What is an author?* (1977, as cited in Hook, 2007), Foucault highlights how, as with the commentary, the author function is not a creative function. Instead, it is a complex function which points to the existence and circulation of discourse (associated with the author in question) and which affirms their status in society. Instead of analysing what the author is saying, Foucault asserts we should analyse what subject-positions are being made available by asking who is being given the privileged position of speaking and who is being denied the opportunity to speak. Last, the discipline refers to the rules which constrict scholarly creativity and, as such, the production of primary and secondary text (commentaries) (Hook, 2007). Within each scholarly discipline lies a set of rules about what knowledge can be discovered (epistemology) and how this can be discovered (ontology). As such, the bounds of the discipline limits scholarly creativity, and with this the types of discourse and truth claims that can be made or discovered while also rarefying discourse which does not exist within these limits.

The overall aim of interrogating the commentary, the author, and the discipline is to demonstrate the restriction of creative function (Hook, 2007). When exploring this set of conditions, Foucault highlights the principle of recitation as a focal point. This principle posits that while the commentary, the author, and the discipline appear innovative in articulating discursive statements

each is simply recirculating taken-for-granted understandings and truth claims which have come before. In addition, researchers should not just search for truth but also scarcity of meaning by focusing on what cannot be said and what is impossible or unreasonable within certain locations. It is here that the restriction of creativity in knowledge production can be captured and exposed.

Determining Conditions of Application. The final group of discursive practices is the determining conditions of application which aim to highlight conditions of availability and bring into view the broader sociological view of discourse (Hook, 2007). Foucault argues discourse is not equally available. It can be available and open to all subjects, restricted to sit in line with or promote doctrinal or institutional belief, or totally forbidden. As such, in this last set of conditions, Foucault puts forward a set of rules and restrictions which impact access to discourse. These include *rituals*, *societies of discourse*, *doctrine*, and *conditions of social appropriation*. Rituals represent the institutional props which support the verbal performance of discourse, and which accompany and legitimise the qualified speaker. These are most found in political, juridical, religious, and therapeutic locations and take the form of gestures, body significations, and signs. Societies of discourse function to distribute and circulate discourse in a closed space. These societies are marked by various schemas of exclusivity and disclosure and the societies of most interest to Foucault are those which are institutionally bound, that operate their own laws of discretion and exclusion when it comes to what can be said and how this can be said.

Doctrines represent philosophical, religious, or political texts (i.e., the bible, policy or legislation) which represent a set of beliefs (i.e., Christianity) that are circulated and transmitted among individuals who have a shared purpose (i.e., adherence to Christianity) (Hook, 2007). It requires conformity to a set of validated discourse by the speakers which support the doctrine. In addition, it requires congruence between the speakers and the discourse. Therefore, the focus of the doctrine is on double subjectification, which is a dual reinforcing system that holds the shared set of beliefs in circulation by the imposition of discourse on the speaker and the recirculation of this discourse by the speaker. Last, social appropriation reflects the limitations of education. Foucault argues educational systems are locations which do not promote creativity as one would often like to think but instead represent a “ritualisation of speech, a quantification and a fixing of roles for speaking subjects, the constitution of doctrinal groups, and the distribution and appropriate of discourse with its powers and knowledge” (Foucault, 1981, p.64). This is different from the discipline in that rather than looking at the creative limitations of the scholarly work, social appropriation looks at the availability and distribution of discourse within educational systems.

Methodological Principles of FDA

Four methodological principles help guide the exploration of discourse (Hook, 2007). These include: the *principle of reversal (event versus creation)*, *principle of discontinuity (series versus reality)*, *principle of specificity (regularity versus originality)*, and *principle of exteriority (conditions of possibility versus signification)*.

Principle of Reversal. The principle of reversal involves subverting and overturning the origins of discourse (Hook, 2007). This involves challenging the traditional sources of discourse to demonstrate how they limit and restrict discourse. Within this principle, Foucault refers to the ideas of event versus creation. He argues discourse should be viewed as an event, with discourse contingent on certain rules, systems and structures and affiliated with institutions, agencies, classes, academics, corporations, groups, ideologically defined parties, and professions. By bringing these conditions and affiliations to the fore, the analyst can move into a space of political critique by forcibly redefining and reidentifying the interests that discourse serves. In addition, the focus on event rather than creation allows the analyst to demonstrate discourse as an active and occurring phenomenon with performative qualities – made up of both discursive statements and practices – which continually manufacture its own materiality, maintaining its existence and circulation within the social system. This principle aims to connect discourse to power relations and institutions and works towards a broader understanding of discourse as active and performative and as implementing and embodying power.

Principle of Discontinuity. The principle of discontinuity challenges the traditional cause-and-effect patterns of explanation which are more typical in psychological research (Hook, 2007). Instead of looking for coherence and unity, the analyst should destabilise meanings, challenge their authority and reveal discontinuity in discourse. This can be achieved by incorporating historical dimensions into the analysis that highlights discontinuity over time. This enables the emergence of counter knowledges that challenge and disrupt contemporary knowledges. However, Foucault argues the analyst must move beyond the great 'unsaid' to liberate marginalised voices because this process merely reproduces discourse. The incorporation of historical dimensions should focus on examining and revealing the extra-discursive practices which influence the selection, promotion, and exclusion of discourse. This allows the analyst to reveal the power-knowledge complex and keeps the analysis in a space of political critique by tracing discourse to formations of power and control which change and mutate overtime. The principle stresses the need for the analyst to challenge traditional cause-and-effect patterns of explanation, destabilise meanings, and reveal the historical irregularities in discourse, which exposes the power-knowledge complex and enables political critique.

Principle of Specificity. The principle of specificity is concerned with the overgeneralisation of analysis which reduces discourse to a set of pre-existing significations (Hook, 2007). Uncovering hidden meanings will not suffice because according to FDA truth is not out in the universe waiting to be discovered. Instead, we come to know meaning and distinguish truth claims based on discourse. Therefore, the focus of the analysis is not to discover meaning but instead to look further afield to identify the discursive effects which legitimise or silence knowledge. This involves moving beyond textual analysis to identify the materiality of discourse. For example, a discourse of child sexual abuse as harmful must be accompanied by discursive utterances (i.e., “she was traumatised”, “it left scars not visible to the naked eye”) and discursive practices (i.e., the manifestation of psychopathology in survivors and research on long-term negative sequelae) which support, extend, and affirm the textual elements of the discourse. By focusing too heavily on text or, more specifically, with an overemphasis on language the analyst will fail to capture the discursive effects of discourse. Through this principle of specificity, Foucault aims to impart on us the idea that discourse occurs in a multitude of ways, in various forms, and that it can stretch from textual to material conditions. Further, the principle aims to highlight the symbiotic relationship between textuality and extra-textuality, between the discursive and the extra-discursive, in generating knowledge. Therefore, the analyst should not look for what knowledge exists waiting to be discovered but instead how knowledge comes to be.

Principle of Exteriority. The principle of exteriority refers to the limitations of discourse analysis which focuses on analysing text and which aims to uncover a “hidden nucleus” of discourse (Hook, 2007, p. 127). Such analysis is limited by textual relativism, which allows for multiple interpretations or readings of a text to be considered valid. This is further compounded by the fact that the analyst is unable to justify one interpretation over another due to the absence of notions of truth and falsifiability within FDA and by the researcher’s own political position from which certain readings may be privileged or maintained over another. Therefore, the analytic output carries no scientific or political weight – it is merely interpretative. As with the principle of specificity, Foucault argues the analyst should move beyond the textual to the extra-discursive (space, time, architecture, material forms of discourse, discursive effects) to demonstrate not just what knowledge or meanings exists but to the conditions of possibility which give rise to or limit knowledge. This double epistemological focus adds scientific and political weight to the interpretation which is no longer limited by textual relativism. This principle challenges the limitations of discourse analysis with the issues surrounding textual relativism by emphasising the need for exteriority, the extra-discursive, in the analytic process which provides a more robust and politically significant interpretation.

Four Conditions of FDA

Based on Foucault's conceptualisation of discourse and the methodological principles, Hook (2007) suggests researchers must attend to four key conditions of FDA: *historical contextualisation*, *conditions of knowledge*, *materiality* and *the extra-discursive*. Historical contextualisation allows the researcher to produce an analytic output which is not confined by the socio-political context from which it originates. It allows the researcher to explore alternative interpretations, the historical backdrop and systems of thought which have shaped discourse, and through this focus the researcher can strengthen the critical potential of the analysis. The conditions of knowledge allow the researcher to explore how discourse is intimately intertwined with social, historical, and political factors which determine how statements come to be seen as true or false. Neglecting these conditions leads to an analytic output which is isolated to the text being analysed, reducing the findings to textual interpretation, and hindering the generalisability and political relevance of the research. Materiality also allows the researcher to move the focus of the research from text by exploring the material effects of discourse. Through this unique discursive approach, the researcher can demonstrate not just how discourse prescribes meaning but also the complex relationship between discourse and power. Across these three conditions – historical contextualisation, the conditions of knowledge, and materiality – there is one overarching message or condition that Hook (2007) asserts, which is for researchers to move the analysis beyond the textual and beyond language to the extra-discursive or the conditions and material effects of discourse. By doing so, the researcher clearly locates the research within the field of political critique, concerned with not just understanding meaning which has been prescribed through discourse but also the broader political and material functioning of discourse and the fact that discourse constrains and enables writing, speaking, thinking, and doing therefore determines what constitutes knowledge and reality.

Ontological and Epistemological Foundations of FDA

In addition to the methodological principles and conditions set out by Hook (2007), FDA is also informed by the ontological foundations of *social constructionism* and the epistemological foundations of *post-structuralism* and *critical theory* (Leotti et al., 2021). Ontology is concerned with the nature of reality and truth. The social constructionist view of reality is that reality only exists because we attach meaning to it and this meaning is prescribed through our social interactions with the world. As reality emerges from social interactions it is subjective, contextual, and dynamic, changing according to time and place. Epistemology is concerned with how we know what we know, or where reality can be found and how we can analyse it. Post-structuralism views language as a resource which represents social reality and therefore where reality can be found, deconstructed, and challenged. It is not just the talk or what is said that can be found here in language but attitudes,

values, assumptions, acts, beliefs, social structures, and social identities which comprise social reality (Mason & Clark, 2010). Critical theory is complementary to post-structuralism (Leotti et al., 2021). It is explicitly political and has a specific agenda in advocating for social change or social justice which can be achieved through a post-structuralist deconstruction of language and the identification of taken-for-granted understandings and power relations that construct, maintain, or subvert these understandings.

Procedure

While Foucault was heavily influential in the birth and expansion of discourse analysis, a strict FDA method does not exist (Parker, 1992). Instead, there are a variety of discursive frameworks which explore discourse including approaches by Parker (1992) and Potter and Wetherell (1987). However, while these methods are popular among discursive researchers including those who claim to conduct FDA, both have been heavily criticised by Hook (2007) for failing to explore Foucault's conceptualisation of discourse and failing to align with the principles and conditions of FDA. As such, a new method was developed for this research. Hook's (2007) critique of Parker (1992) and Potter and Wetherell's (1987) discursive failures, his explanation of Foucault's conceptualisation of discourse, and his articulation of FDA principles and conditions were used as the foundation for this method. As such, the method allows for the exploration of discourses of child sexual abuse in residential care through a Foucauldian lens encompassing statements, utterances, and discursive practices while meeting the methodological principles of reversal, discontinuity, specificity, and exteriority as well as the methodological conditions of FDA including historical contextualisation, materiality, knowledge, and moving beyond the textual to the extra-textual. The method was crafted into three phases: sampling and data collection, identifying discourse, and analysing discursive conditions. Each phase is explained in turn.

Phase 1: Identification and Collection of Corpus

The first phase involved *identifying* which text would be studied. Specification and collection of the data required treating the object of study (child sexual abuse in residential care) as text because fragments of discourses are found in text and it is from these fragments that inferences about discourse can be made (Leotti et al., 2021; Parker, 1992). While Hook (2007) stresses FDA should move beyond the textual to the extra-discursive to adequately analyse discourse, extra-discursive elements can still be found within text along with meaning and language. Therefore, publicly available textual evidence – transcribed testimonies, statements, and evidence briefs – from the Abuse in Care inquiry were downloaded from the inquiry website³. Purposive sampling was used to

³ www.abuseincare.org.nz

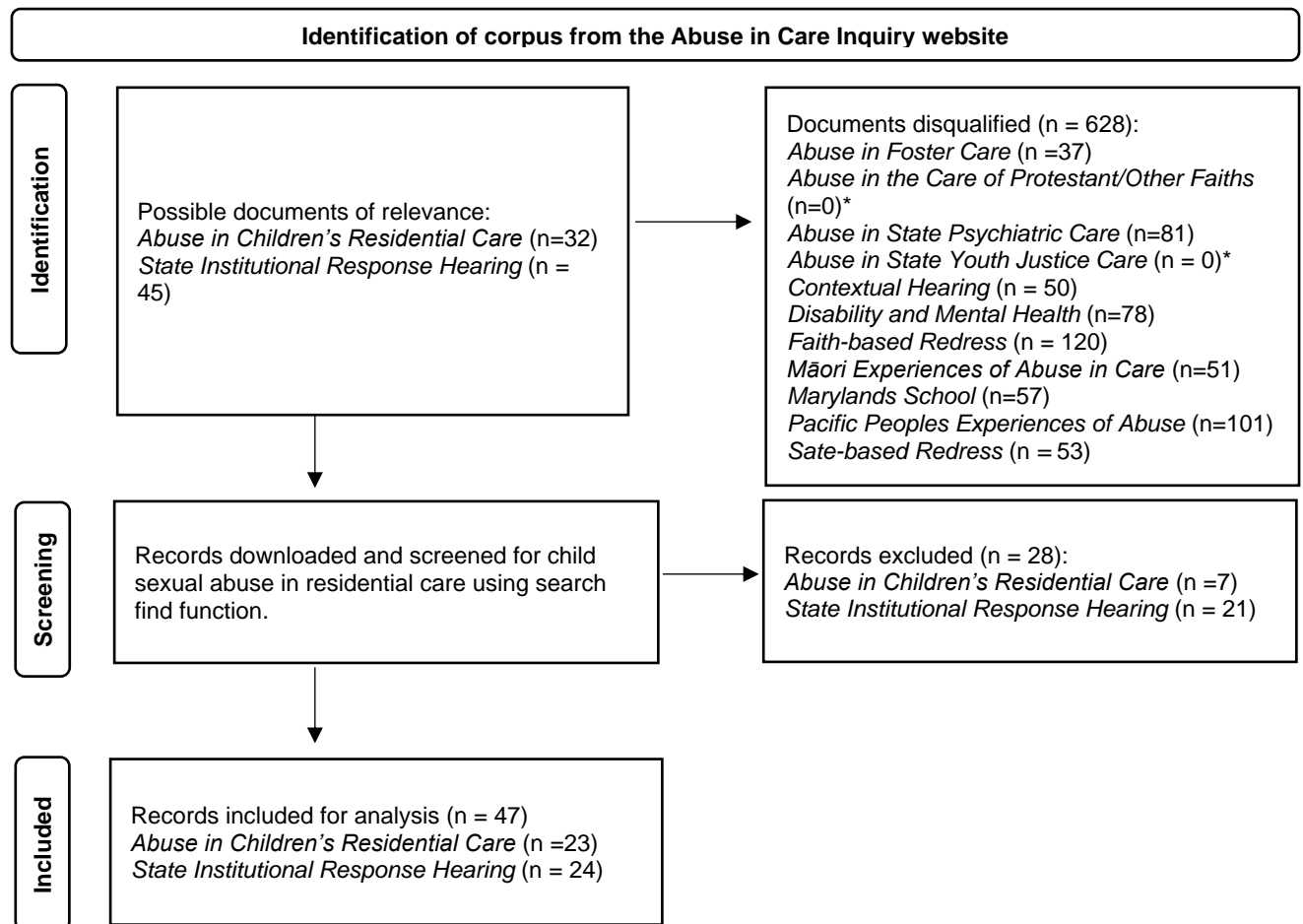
identify data sources of relevance to the research aim and questions. The sampling and data collection process (see Figure 2) included: identifying hearings of relevance, scanning documents within these hearings for text related to child sexual abuse in residential care, and uploading the Word documents to Nvivo for analysis⁴.

When identifying hearings of relevance, it was discovered two lines of investigation within the inquiry examined child sexual abuse in residential care settings: the *abuse in children's State-run residential care* hearing and the *State institutional response* hearing. The abuse in children's State-run residential care hearing examined the abuse (sexual, physical, emotional and psychological) of children and young people in State-based residential care in New Zealand (Abuse in Care Royal Commission of Inquiry, 2021). Settings included within this inquiry were: children's homes and institutions which provide care and protection residential facilities including social and family homes; institutions which provide remand or secure facilities such as care and protection residential and/or training facilities; and residential programmes or facilities provided by third parties but excluding those provided by faith-based institutions. Specific residences include: Epuni Boys' Home (Lower Hutt), Hokio Beach School (Horowhenua), Kohitere Boys' Training Centre (Honorwhenua), Ōwairaka Boys' Home (Auckland), Kingslea Girls' Home/Burwood Training Centre (Christchurch), Moerangi Treks (Urewera), Whakapakari (Great Barrier Island), and State-owned family homes (nationwide) (Abuse in Care Royal Commission of Inquiry, n.d.). The State institutional response hearing examined the institutional responses of selected State-based organisations in respect to failures of these organisations to provide adequate care and to prevent and respond to abuse in care (Abuse in Care Royal Commission of Inquiry, 2021). It included the extent of the abuse and neglect in care, how institutions responded to or prevented abuse, and failures of these organisations to provide adequate care and to prevent and respond to abuse in care.

⁴ <https://portal.mynvivo.com/>

Figure 2

The Data Selection and Collection Process



NOTE: Data not publicly available*

Documentation from both hearings were retrieved (n = 77; abuse in children's State-run residential care, n = 32; State institutional response, n = 45). The documents were large, averaging 42 pages. Each document was scanned for relevance to the research aims and questions through the 'search find' function of Adobe. A list of search terms for residential care was developed based on the scope of investigation for the inquiry and included: residential, family, homes, secure, Epuni Boys' Home (Lower Hutt), Hokio Beach School (Horowhenua), Kohitere Boys' Training Centre (Honorwhenua), Ōwairaka Boys' Home (Auckland), Kingslea Girls' Home/Burwood Training Centre (Christchurch), Moerangi Treks (Urewera), Whakapakari (Great Barrier Island) (Abuse in Care Royal Commission of Inquiry, n.d.). Search terms related to child sexual abuse were based on common terms that may be used to describe child sexual abuse, harmful sexual behaviour, and child sexual exploitation and included: sex(ual), abuse(d/ing), molestation, incest, naked, bed, rape(d/ing), force(d/ing), fondle(d/ing), touch(ed/ing), naked, nude, assault(ed/ing), harrass(ment/ing), attack,

coerce, coercion, exploit(ation), strip(ed/ing), prostitution, groom(ed/ing), trick(ed/ery), brib(ed/ery), pornography, porn, humiliat(ion), and reward. Documents which were identified as potentially relevant were read line-by-line for true relevance. If the record spoke to child sexual abuse in the context of residential care it was included in the corpus. However, if the text described child sexual abuse which occurred prior to entering residential care, after the individual was discharged from care, or in another care setting this was excluded. Once all relevant documents were identified these were uploaded to NVivo for analysis. The final sample size was $n = 47$ (abuse in children's State-run residential care $n = 23$; State institutional response $n = 24$).

Phase 2: Identifying Discourses

This phase focused on addressing the first research question by investigating the ways in which child sexual abuse in residential care is *understood*. Statements and utterances related to child sexual abuse in residential care were identified. This process focused on identifying connotations, allusions, and implications related to child sexual abuse in residential care because discourse is not reducible to the explicit meaning of a sentence but instead suggestive of the ways in which individuals or groups come to understanding reality (i.e. "You can't run away naked" = child sexual abuse as a form of control) (Parker, 1992). Once statements and utterances were identified and coded these were then assigned to coherent and logical groupings of meanings (themes; i.e., child sexual abuse as control and punishment, child sexual abuse as power and oppression, child sexual abuse as harmful, child sexual abuse as state and institutional failure). Statements and utterances were assigned to these logical groupings or themes based on how groups of statements and utterances painted a picture of the world.

Phase 3: Identifying and Analysing Conditions

This phase focused on addressing the second research question by identifying and *exploring the conditions* which legitimise or silence different understandings of child sexual abuse in residential care. As with the identification of statements and utterances, the occurrence of conditions within the data is not explicit but suggestive. For example, when a speaker says "He told me not to nark" and there is a collection of similar statements or utterances this can suggest a 'no narking culture' which is a social procedure of prohibition that restrains the speaker. To aid in the identification and analysis of discursive conditions a list prompts was developed (see Table 3). These prompts were based on the conceptualisation of the discursive conditions outlined by Hook (2007) as well as the conditions of FDA which aim to move the research beyond the textual to the extra-textual in order to examine the conditions of knowledge and the material effects of discourse. This focus on the extra-textual elements of the data allowed the method to respond to the second research question

and to meet the principles of exteriority, reversal, and specificity, by moving the analysis past the search for meaning to instead explore how meaning comes to be through discursive conditions and materiality which enables or constrain writing, speaking, thinking, and what comes to be seen as true or false or what counts as reality. Prompts were also added to ensure the principle of discontinuity and the condition of history were met. This encouraged the exploration of historical factors and systems of thought which have evolved overtime and shaped discourse. By doing this, the critical potential of the analysis was strengthened through the signification of how discourse is not stagnant, but instead how it is dynamic, changing according to time and place, and according to the socio-political climate or the systems of thought which change and mutate over time.

Table 3

Analytic Prompts for Exploring the Extra-Textual: The Conditions of Knowledge, Material Effects, and Historical Factors Shaping Discourse

<i>External Mechanisms of Exclusion (Conditions of Possibility)</i>	
<i>The Will to Power</i>	Identify institutions which are reinforced or attacked when discourse is used. Identify how institutional structures and policies shape the production, circulation, and dissemination of discourse. Identify how social structures within the institutions create unequal access to discursive resources which enable or constrain certain voices and perspectives.
<i>Social Procedures of Prohibition</i>	Identify social procedures of prohibition (taboo, rituals, privileges) which may be hidden in the text. Speculate how these may reinforce or subvert discourse.
<i>Oppositions Between Madness and Reason</i>	Identify terminology, labels, diagnostic categories used to define the speaker as mad or reasonable. Speculate about the implications this has in respect to power, stigmatisation, and exclusion of the speaker and their discourse.
<i>Internal Mechanism of Exclusion (Conditions of Restraint)</i>	
<i>The Author</i>	What types of people are talked about in the discourse. Speculate about their rights to speak and how through the circulation of discourse their status in society is affirmed.
<i>The Commentary</i>	Identify commentary which appears to be an original statement or utterance but is the recitation of a primary text or taken-for-granted understandings or systems of thought and what has been said before.

<i>The Discipline</i>	Identify the discipline the speaker belongs to. Critically examine the boundaries of the discipline and how these may influence the production of knowledge and the truth claims being made.
<i>Determining Conditions of Application</i>	
<i>Rituals</i>	Identify gestures, signs, and behaviours which accompany or extend the warrant of the qualified speaker. Speculate about how their discourse is more pronounced, available, or true compared with speakers who are denied such privileges.
<i>Doctrines</i>	Identify key terms, phrases, or symbols which are commonly associated with doctrinal beliefs. Speculate about how these doctrines (political, religious, or scientific) may influence or provide a framework for understanding and structuring discourse.
<i>Societies of Discourse</i>	What do institutionally bound societies say or not say? Speculate about how they restricted by what can be said within their laws of discretion and exclusion and why.
<i>Historical Contextualisation</i>	
<i>Historical Factors</i>	What is the historical backdrop, the historical factors, or systems of thought (i.e. controlling and punishing the delinquent) that have evolved overtime and that have shaped the discourse?

Ethical Considerations

Freely Available Data: Balancing Risks and Benefits

Utilising freely available data presents ethical considerations regarding participant wellbeing. This research used publicly available data without recourse to additional human involvement (e.g., interviews, surveys, etc.), as such, the study was not required to be reviewed by a human research ethics approval committee. However, I acknowledge that the dissemination and publication of the research findings through academic mediums and the media poses the risk of participants negatively evaluating the use of their data and experiencing a range of emotions such as shame and anger (Court, 2018). Those individuals whose statements and ‘voices’ have been recorded for the Inquiry contains *difficult knowledge* (i.e., knowledge that bears a history of trauma – Pitt & Britzman, 2003) and so the responsibility to analyse and communicate this research requires care. In addition, there are concerns about employees of the institutions suffering unwarranted blame or reputational damage due to their participation in the inquiry. There is the risk that employees involved in the inquiry may be unfairly vilified due to their participation or employment within the institutions

despite not being involved in these institutions during the scope of the inquiry or directly involved in abusive experiences. To mitigate these risks, an internal referencing system was created to anonymise the data and protect participant identities (see Appendix A). Although measures have been taken to minimise potential harm, it is also worth noting that the research benefits significantly outweigh any of the identified risks. This research is the first opportunity of its kind in New Zealand, providing a discursive understanding of child sexual abuse in residential care.

Moving Beyond Pathologising Māori: Producing Culturally Responsible Research

Research continues to be a persistent feature of colonisation with researchers and society continuing to perceive Western worldviews as superior to indigenous knowledge systems (West-McGruer, 2020). This has resulted in the marginalisation and denial of indigenous knowledge while Western researchers have maintained power and control over resource allocation. In addition, an abundance of research focuses on pathologising Māori as inherently diseased or deficient. This research, which often lacks in scientific rigor, emphasises negative social outcomes and positions Māori as deficient or lesser, welfare dependant, intellectually inept, and in possession of a criminogenic warrior gene. This erroneous pathologising lens detracts from the social, cultural, and environmental influences which result in negative social outcomes for Māori, particularly the devastating consequences of colonisation (Gillett & Tamatea, 2011). The legacy of colonisation is that Māori suffer increased exposure to a variety of risk factors such as poverty which are correlated with negative social outcomes such as higher rates of offending behaviour and poorer educational attainment (Engle & Black, 2008; Hsieh & Pugh, 1993; Khalid Anser et al., 2020). The correlation between risk factors and negative social outcomes often occurs regardless of ethnicity. In response to this historical backdrop, this thesis consciously avoided the use of deficit-based narratives. Instead, it endeavoured to present more a contextually rich understanding of the experiences and outcomes for Māori to counter and move beyond the pathologising lens traditionally found in Western research. In addition, this thesis equally embraces indigenous solutions to issues of abuse in care. These solutions are presented alongside Western worldviews, recognising the parity and value of Māori and Western worldviews in addressing societal challenges.

Research as a Political Tool: Identifying and Acknowledging Positionality

Research inherently reflects the values and interests of the researcher (Gillies & Alldred, 2012). As such, this research dismisses a neutral, objective stance and offers a transparent acknowledgment of positionality as an integral part of qualitative research, acknowledging that researcher bias influences the results, to establish the trustworthiness of research, and to justify actions aimed at effecting change (Gillies & Alldred, 2012; Mullet, 2018). The ongoing issue of abuse in care is,

fundamentally, a matter of power with institutions in a place of privilege, denying voice to survivors, and maintaining abuse in care settings through inaction. The political nature of this topic is reflected in the choice of methodology and method; a Foucauldian discourse analysis which aims to uncover unjust power relations, ideologies, and social structures which contribute to the maintenance of social (in)justices. As such, this thesis focused on amplifying survivor voices and as a result the presented findings may be confronting. However, while there is a strong focus on liberating survivors, this research does not seek to condemn residential care workers or care providers, which hold an important role in protecting young people from abusive home environments. Instead, the focus lies in shedding light on the issue, amplifying silenced voices, improving the quality of care for young people living in residences, and protecting an already vulnerable population from repeated harm. In addition, despite analysing a substantial data set (n = 50), this research does not claim to have privileged access to the only truth of abuse in care or to be presenting the only possible interpretation of events. The understandings of abuse presented throughout are limited to the understandings which were discussed within the Abuse in Care inquiry. Other truths are there to be uncovered, which exist outside of this medium.

Chapter 4: Results

This chapter outlines the results, presenting six identified discourses of child sexual abuse in residential care which were found in the children’s State-run residential care and State institutional response hearings:

- Control and punishment
- Fabrication
- Harmful
- Power and oppression
- Shame
- State and institutional failure

Documents in the corpus that are cited as supporting evidence throughout this chapter will be referred to by code (e.g., ‘12a’). For fuller details, the reader is directed to Appendix A. In this chapter, identified discourses – including encompassing statements, utterances and conditions – are discussed in turn.

Discourse 1. Sexual Abuse is a Means of Control and Punishment

Within the discourse of *child sexual abuse in residential care as control and punishment*, the terminology used to describe residences and experiences in residences are reminiscent of prison culture (8b). An ideology and philosophy (16a) is said to exist within residences which focuses on restraint, control and punishment (1a, 2a, 3a, 4a, 6b, 8a, 10a, 13a, 14a, 15a, 16a, 21a) rather than care and wellbeing (10a, 11a, 12a, 15a, 16a, 19b). The child or young person is viewed as “out-of-control” or a “threat” (6b, 7b) due to great moral panic within society (5b). These young people were placed into residences with other prisoners or inmates [young people] (9b) which were referred to as prisons or the pound (1a, 2a, 8a, 8b, 17a, 21a) and which functioned under a harsh (9b) prison-like model akin to adult prisons (22b). The treatment young people experienced in these settings was inhumane (9b). Survivors describe being locked up (2a, 4a, 10a, 12a, 14a, 15a, 17a, 21a, 22a, 23a) in the secure unit (secure) which was like a jail cell (2a, 4a, 6a, 7a, 9a, 9b, 10a, 12a, 14a, 15a, 16a, 17a, 18a, 21a, 22a, 23a) where sexual abuse served as tool for punishment. While in the secure unit or on their arrival or their return to residences, female survivors were often subjected to forced internal examinations (1a, 2a, 4a, 6a, 7a, 8a, 11a, 15a, 17a, 18a, 22a) to check for venereal or sexual diseases (1a, 4a, 6a, 7a, 11a, 15a, 18a, 21a, 22a) for their perceived “promiscuity” or sexual activity (1a, 15a). Similarly, boys describe routine strip searches while in secure or on their arrival or return to residences (2a, 9a, 13a, 14a, 16a, 20a, 21a) from which they are threatened (2a, 14a) and humiliated

(16a). Horrifically, Māori and Pasifika were subjected to sexual abuse in secure as a form of punishment and humiliation for their race (10a, 21a).

A Legislative and Political Focus on Control and Punishment

Reports and legislation from the 1950s through to the mid-1970s are described as standardising the control and punishment of “delinquent” youth, “promiscuous” young girls, Māori, and Pasifika. These include the *Mazengarb* (1954) report, the Child Welfare Act 1954, the *Hunn* (1961) report, the Children and Young Person’s Act 1974, and the Oranga Tamariki Act 1989 (1a, 5b, 6b, 7b, 11b). Survivors describe being taken into custody and being made a Ward of the State (2a, 10a, 11a, 12a, 13a, 14a, 15a, 16a, 21a, 22a) under the Children Act 1954 and the Children and Young Person’s Act 1974. Consistent with the discourse of control and punishment, many young people did not enter the custody of the State for mistreatment in the home but instead for perceived “delinquency” (6b, 7b). The State is said to have exercised its power liberally under Section 12 of the Children and Young Person’s Act 1974 during the scope of the inquiry (7b) under the naïve belief that enforcement and punishment this would prevent young people from misbehaving in the future (5b). As such, many young people entered care for what was characterised as “delinquent” behaviour (including promiscuity) and not being under the “proper control” of their parents (6b, 7b). The types of issues or offences that were characterised as “delinquent” and “out-of-control” are said to be low level offending such as stealing milk money against the backdrop of poverty (7b) or for social issues such as truancy and homelessness (5b).

The powers of police under the Children and Young Person’s Act 1974 are said to have disproportionately affected young Māori (5b, 6b). Individuals describe how police would send tamariki and rangatahi Māori to the Children’s Court with a disproportionate number prosecuted compared with non- Māori, resulting in an inflated crime rate (5b, 6b). This behaviour is said to have been encouraged by racist attitudes and stereotyping among police, perpetuated by the *Hunn* (1961) report, which positioned young Māori as “criminals” and “aggressive/uncivilised” (1a, 5b, 6b). As a result of these racist views, Māori were denied involvement in the decision making and there was little consideration for alternate care arrangements (7b) or embracing whānau to prevent future offending (5b). Instead, police exercised their powers under the Children and Young Person’s Act 1974 to bring a young Māori to court to gain access to services that would “civilise” and “save” them (5b, 6b). Pasifika communities experienced similar racist attitudes and discriminatory practices during the scope of the inquiry (1a). Speakers describe how challenges from both migration and the dawn raids resulted in increased exposure to poverty, drug and alcohol use, family harm, and sexual violence (6b). This bought the same negative attention to young Pasifika, with the perception they needed to be “saved” and “civilised” (6b). These racially biased attitudes are said to have resulted in

a disproportionate number of young Māori and Pasifika being taken into care where they experienced forced assimilation/cultural genocide through the denigration of their culture, identity, and language (1a, 5b, 6b, 7b, 11b, 12b, 13b).

A Paradigm Shift: Rangatirangtanga for Māori and Pasifika

This political and legislative focus on the control and punishment of Māori and Pasifika is legitimised, and reinforced, by speakers who iterate the need for a paradigm, cultural, and mental shift which moves away from presumed European superiority and the idea that young Māori and Pasifika need to be “saved” from bad whānau to a more nuanced understanding that whānau from these communities are struggling due to Crown inaction and the legacy of colonisation, the dawn raids, and the challenges of migration (6b). Speakers describe how requires a shift away from the removal of children to a system which values Te Ao Māori and Pasifika worldviews and to a system which focuses on prevention, early intervention, and wraparound services that address the legacy of colonisation, migration, and the dawn raids (6b). In addition, it requires power sharing whereby the decision-making is transferred back to Māori – back to whānau, hapu, and iwi – and back to Pasifika so these communities can have rangatirangtanga over the care and protection of their own young people through 7AA treaty partnership agreements (Māori) and 396 third-party partnerships (Pasifika) (6b). Works are currently underway to put this paradigm shift into practice, and this is said to have been encouraged by the introduction of the Te Reo Māori Act 2016 which requires all Government agencies to revitalise te reo Māori in policy and legislation and the Public Sector Act 2020 which requires agencies to begin a “cultural journey” (6b).

Labels and Stereotypes Emerge from the Legislative and Political Focus on Control and Punishment: “Little Ner boy”, “Dirty” Girl, and “Worthless” Child***

As can be seen, the overarching focus during the scope of the inquiry right is the control and punishment of the “delinquent”, the “promiscuous”, Māori, and Pasifika. This discourse of control and punishment permeated residences, directly influencing the discursive materialisation of stereotypes or diagnostic labels which justified the use of sexually abusive behaviours which served to control and punish. Young people were often assigned the diagnostic label Ward of the State or State Ward (2a, 4a, 5a, 6a, 8a, 10a, 11a, 12a, 13a, 15a, 16a, 21a, 22a, 23a) when taken into care which included embedded stereotypes of the “diseased” or “promiscuous” girl and the “delinquent” (1a). Survivors often speak of the dehumanising (21a, 23a) nature of being made a Ward of the State describing how they were: not spoken to but ordered to do this and do that (18a); “numbered” (21a); “owned by the government” (10a); “treated like cattle or animals in a zoo” (2a, 6a); viewed as “manipulative” (6a, 17a), “sly and cunning” (10a, 21a); and made to feel “worthless” (11a, 21a). Those in direct contact with these children and adolescents had little regard for their care and

wellbeing (10a, 11a, 12a, 15a, 16a) and instead focused on punitive approaches (22a) in alignment with the view that these young people in care must be controlled and punished (1a, 2a, 3a, 4a, 8a, 10a, 13a, 14a, 15a, 16a, 21a).

The “diseased” and “promiscuous” girl was denied voice and was subjected to forced internal examinations with little to no explanation of the purpose and with the aim of controlling diseases (1a, 4a, 6a, 7a, 11a, 15a, 18a, 21a, 22a). These girls were treated by staff and depicted in their records as “diseased” (1a, 6a, 11a, 15a, 22a), “dirty” (4a), “uncouth” (4a), “disgusting” (11a), “unhygienic” (4a), and “to blame” for their abuse (4a). Wāhine Māori were subjected to dual stereotyping for their intersectionality as an indigenous child with perceived promiscuity:

The girls to whom I refer are in the main the dull, backwards, affection starved Māori girls who cannot produce anything near a reasonable day's work and who try and get their needed affection from any male who is handy (6b)

This degrading stereotype allowed for the mistreatment of these young women who had histories of sexual victimisation and/or who were exhibiting what was arguably normal adolescent sexual experimentation. Finally, speakers describe how racism toward Māori and Pasifika from the *Hunn* report (Hunn, 1961) and the dawn raids transcended into care facilities where children and adolescents who identified with either ethnicity were seen as “lacking in intelligence and language ability” (6b), “native savages”, “belonging to the floor” (10a), and “worthy of punishment because they had brown skin” (10a). Staff referred to these young people as “little n***er boy”, “little black bastard”, “bloody coconut”, “bunga”, “lowest of the low”, and “piece of shit” (10a, 21a) and speakers describe how when these young people were abused it was to “teach them a lesson” (10a, 21a).

Sexual Abuse Serves to Control and Punish the “Little Ner boy”, “Dirty” Girl, and “Worthless” Child***

The diagnostic labels and stereotypes assigned to young people in care facilitated their mistreatment and the discursive materialisation of sexual abuse which served to control and punish. The abusive acts described by survivors include forced internal examinations for disease identification and control, sexually abusive surveillance tactics, and the use of sexual abuse as a means of punishment.

Forced Internal Examinations Control Diseases. Females were subjected to compulsory vaginal examinations (7b) which served to control for venereal diseases (1a, 4a, 6a, 7a, 11a, 18a, 22a). These examinations were conducted on admission to or return to residences (1a, 7b) and were

described by speakers as “nonconsensual” (7a, 11a, 18a), “humiliating” (18a), the “worst thing” about being in care (7b). One survivor describes how from experiencing these examinations she learnt adults had rights to her body (4a), demonstrating her learnt powerlessness as a child in care. Survivors also describe how they were spoken about during the exams while staff ignored them (4a, 15a), how they were subjected to invasive medical examinations (7b, 18a), and how they were restrained during these examinations to force compliance (4a, 6a, 7a, 7b, 15a, 17a). Senior health officers recognised these practices as a form of control and abuse:

We have had extensive discussion with senior health officers and accept their advice that medical examinations and any part of a medical examination cannot be compulsory, nor can punishments ensue from a refusal to undergo an examination. I appreciate this may appear to be contrary to the good care and control of the children admitted, but I must accept the legal and medical opinion that where a child or young person is capable of giving informed consent but withholds that consent, an enforced medical examination is in fact assault (7b)

In addition, survivors describe how male doctors engaged in inappropriate sexual contact with patients during examinations (4a, 7b, 11a, 15a, 22a):

He was touching parts of my body down there that he should not have been. Looking back, I knew it was wrong [...] It wasn't until years later I learned that it wasn't a necessary part of the procedure (7b)

Intimidation and Surveillance Tactics Control and Contain Risk. Various sexually abusive surveillance tactics were also identified. Young people were denied privacy during showering and toileting (3a, 7a, 13a) while two survivors recall being deprived of pyjamas (6a, 14a) with one citing a requirement to sleep naked as a tool to avoid absconding because young people “can’t run away naked” (14a). Boys were often strip searched on arrival to a facility or after visitation from whānau and this practice is described as a mechanism for containing risk and threat from contraband and weapons (9a, 20a). This “dehumanising” and “inhumane” (7b) practice was also used as a form of “humiliation”, “intimidation”, and violence with boys “threatened” during strip searches to control them and obtain their compliance (2a, 7b, 14a, 16a). Strip searches continued to be a function of residential care until September 2021 when they were discontinued in care and protection residences and replaced by walk through scanners within youth justice residences (7b). However, the practice remains permissible today under law (Residential Care Regulations 1996, s384E; 7b).

Sexual Abuse as Punishment. Sexually abusive acts are also said to be a form of punishment which took place in the “barren”, “austere”, “prison-like” secure unit which is “worse than seclusion

cells in prisons or psychiatric hospitals” (7b, 10b). Children and adolescents were often sent to secure for “speaking out”, “running away”, or being disobedient. One of the punishments received in the secure unit involved being hit on the backside and scrotum with a paddle (10a, 21a). Another punishment included a young girl being made to change in front of male staff and to eat her food naked while sitting next to the toilet:

Secure unit was like a jail cell. You had the bed, the toilet, that's it. You know, there was staff there but in their own little office – male staff in particular. If you didn't abide by anything that they said down in that secure unit, it was your word against theirs. And the Pākehā male staff that was there that made me undress and sit down by my fuck'n toilet and eat my food while I'm naked (17a)

Racially Targeted Sexual Abuse. In addition to the control and punishment of “delinquency” and “promiscuity”, Māori and Pasifika reported racist elements to their experiences. One survivor described the use of “rotating turns” where children were taken out of their cell, one-by-one, and sexually abused because of their ethnicity or because the guard disliked them (10a, 21a):

Yeah, the thing is you got to understand about this, I call it the prison, the prison, is you were numbered. You were down there and they were going to teach you a lesson and – but it went by numbers, and what I mean by numbers, everybody had a number and that was because if you had the number, I don't know – oh sorry, yes, if you had the number 1, if two or three of you were number 1, you were the most hated ones by these guards and the most hated ones were always, always myself and Māoris and any other Islanders. So, we were done by numbers, we were raped, we were physically abused, we were mentally abused by numbers because they didn't like us, they didn't like our colour [21a].

Discourse 2. Denial of Survivor Truth Claims: Child Sexual Abuse as Fabrication

Within the discourse *child sexual abuse in residential care as fabrication*, survivors describe how their opinions and thoughts did not feature (6a); how they were not believed (6a, 6b, 10a, 11a, 12a, 16a, 17a, 19a, 21a), heard (6a, 15a, 17a, 23a), or listened to (5b, 6a, 7a, 10a, 15a, 17a); and how they were “turned away” (17a), told to “go away” (11b), ignored (5b) or dismissed (3a, 5a, 11a, 11b, 13a, 16a, 22a) when reporting allegations of abuse. They were also told they were “lying” (6a, 12a, 17a) or “making things up” (6a). Because they were not believed, they often did not receive the support they needed (6b, 11a, 16a) and incidents were not appropriately recorded (1a, 5a, 6a) or investigated (4a, 6b, 5a, 16a). As a result of this inaction perpetrators were not held to account and abuse often continued (6b). This is said to have caused additional trauma and distress to the abuse already suffered (6b).

Survivors as “Liar”, “Scammer”, and “Crook”

Various authors hold the privileged position of deciding what is truthful and what is untruthful, including residential staff members, catholic church figures, principal facilitators, officials, police officers, social workers, Crown Law lawyer, Ministry of Social Development (MSD) redress case officers, and doctors and psychologists who worked independently or who were hired by Accident Compensation Corporation (ACC) or Oranga Tamariki. Survivors try to “convince” (17a, 19a) these individuals of the abuse suffered and describe how they are often “turned away” (8a, 17a), disbelieved (6a, 10a, 11a, 12a, 16a 17a, 19a, 21a), or “denied” (3a, 12a, 17a). This disbelief or denial of survivor truth claims occurs because of: misunderstandings of child sexual abuse (5b, 6a, 6b, 7b, 8a, 10a, 17a, 19a, 21b); to preserve the institutions or employee’s reputation (5b, 6a, 7b, 8b, 16a); because of delays or errors in investigative processes caused by policing bias and inadequate investigative policies (5b, 14b); an overreliance on corroborative evidence in the perceived absence of “survivor credibility” (5b, 6b, 7b, 14b); constraints in the law including the need for valid and reliable forensic interviewing to ensure safe conviction (14b); and a “win-at-all cost” mentality by the MSD and Crown lawyers (2a, 3a, 5a, 6a, 8a, 10a, 12b, 13a, 13b, 16a, 19a).

Misunderstanding the Realities of Child Sexual Abuse

The speakers describe how institutional employees often misunderstand the realities of child sexual abuse. This is said to be perpetuated by improper definitions of child sexual abuse which leads to erroneous interpretations of allegations as fabrication (5b, 6a, 7b, 8a, 10a, 19a). Common misconceptions of child sexual abuse described include delayed disclosure being perceived as an indication of fabrication (5b, 6a, 8a, 10a, 19a), the “ideal victim” versus the “ideal perpetrator” (5b, 6a, 8a, 10a, 19a), and the equalisation of adult-child sexual relations (5b, 7b).

Inadequate Definitions of Child Sexual Abuse Causes Confusion. Despite child sexual abuse being legally unacceptable during the inquiry timeframe, speakers describe how a lack of understanding and conversations within society about child sexual abuse and young people’s rights led to poorly defined practice standards (i.e., Child welfare field officer manuals, 1950-1984; *Care and protection handbook*) and regulatory and legislative functions (Child Welfare Act 1925; Children Young Persons and Their Families Act 1989) (7b, 19b) that aim to protect against abuse. This is said to have provided “confusion” around what behaviours constitute child sexual abuse and an under identification of incidences (7b, 21b).

Delayed Disclosure Undermines Credibility of Survivors. Delayed reporting is viewed as a lack of credibility in survivor accounts and as such when survivors do not immediately report abuse,

they are often misbelieved (5b). This is despite sexual abuse victims often taking years or decades to disclose abuse (5b).

The Ideal Victim Versus the Ideal Perpetrator. Awareness of the risk of sexual offending by people in positions of authority during the scope of inquiry did not reflect the realities of child sexual abuse (5b). Perpetrators of abuse who ran the institutions or who were employed by the institutions were in positions of power and, as such, were viewed as “pillars of society”, “more credible”, and as “people who do not commit crime” (i.e. doctors, teachers, priests, Pākehā, psychiatrists) (5b). This is compared to victims who are viewed as “liars” (6a, 8a, 10a), “scammers” (8a, 19a), and “crooks” (8a) and, due to their status as an offender group in State care, survivors struggled to get “cut through” (5b) because they were thought to be “troublemakers” (5b), “promiscuous” (5b, 6b) and “less credible” (5b):

When you had what they saw as a bad boy accusing housemasters, who are they going to listen to? Who are they going to believe? They would say you're a loudmouth and a liar — that's what is on my records (10a)

The assignment of these subject positions (“*pillars of society*” versus “*liars*”, “*scammers*” and “*crooks*”) meant the true extent of abuse was rarely recognised (5b) and that victim discourses were exiled to the periphery where they were deemed unreasonable and untrue compared to their abuser who was seen as more credible:

Many police would not listen or act due to the reason that they were in care, that they wouldn't believe a young person who might otherwise be seen as a bit of a troublemaker... for some who did make allegations to the police they felt the police did not listen (5b).

In addition, societal attitudes of the “ideal victim” often resulted in police decisions not to prosecute (5b). This occurred when corroborative evidence was not available to substantiate claims because the perceived unreliability of the victim in the courtroom is thought to compromise successful prosecution:

Difficulties arose in this inquiry because none of the allegations were recent and there was no corroboration of the statement by the sister. In my own mind, I feel that he has committed the offences, but the girls he has committed them on would not make good witnesses, character wise, and there is nothing to corroborate their statements (5b).

Even when damning evidence was available, the subject positions of “liars”, “scammers”, and “crooks” was so powerful survivors were still not believed over “pillars of society”:

No-one was listening again, and I went out and the sperm that was still coming out of me, I went to tell the staff and I put my hands down there, I said to them what the fuck is this? I'm telling the fuck'n truth and I got dragged down to the secure unit, kept telling me I'm lying, that "How can you say that about your father the man of the cloth?" Holy fuck (17a).

Perceived Mutuality Between the Victim and Perpetrator: "A Meeting of Equals"

Inappropriate and predatory sexual behaviour towards young people was viewed as "mutually consensual" and relations between adults and children were "equalised" (5b, 7b). The young person was viewed as "akin to the adult", "at fault", and "equally culpable" for a sexual encounter and activity (7b). Survivors as young as 12 were described as having a "promiscuous temperament" (5b) and acts were often characterised as "consensual" or a "meeting of equals":

Acting on rumours 'from several pupils', it was alleged that some boys had been indulging in sexual activities with a staff member. These include mutual masturbation, anal intercourse, and other forms of sexual misbehaviour. Most of these incidents occurred in the home of the staff member, which is approximately a mile away from the institution. On occasions, that staff member would make improper suggestions and advances to the boys in concealed areas of the institution (7b)

This characterisation of young people as akin to the adult and as "promiscuous" is described as failing to recognise the backdrop of sexualised behaviour among young people which can be a consequence of sexual abuse and the power imbalances which exist between an adult and young person (5b).

Protecting Reputations

Survivor truth claims are also denied by institutional employees who appear to be protecting the reputation of the institutions, employees, and the Crown (5b, 6a, 7b, 16a). Abuse allegations often resulted in employees being transferred to other institutions instead of being appropriately investigated (5b). Speakers describe various instances where the overarching concern appeared to be heavily focused on the reputation of DSW, the institution, and the employee rather than the safety and wellbeing of the children (5b, 7b, 8b, 16a):

He did so by touching them in the genital area and although there is no evidence he actually masturbated those boys, it would seem that this was his intention [...] I felt in the absence of any real corroborative evidence that this would only serve to bring opprobrium on the institution and possibly give rise to considerable speculation on the part of the public (7b).

I have discussed today the possibility of the perpetrator's request that he should go to Hokio rather than to Kohitere. We agree this would be much more practicable both in terms of the apparent need there is in that institution for relief staff and in terms of it not being inconsistent with a move that he could have made anyway without disadvantage to his career (7b).

The official from Social Welfare, in my presence and at district office, revealed to the perpetrator the nature and extent in general terms of accusations made against him. He was told, among other things, that a transfer would be absolutely but not immediately necessary and that he himself would be given the opportunity of requesting it (7b).

While the focus largely appeared to be the reputational maintenance of the Crown, the institutions, and employees, one survivor also describes how they were dismissed by staff who were understaffed and too busy to address the concerns raised (6a):

They were annoyed because they were understaffed and I remember one of them saying something along the lines of "Look Loretta, you little bitch, you always want everything. We're understaffed" and they more or less just pushed me into the visiting room where they closed the door [...]. When my father raped me the next time I told them to test him to prove that he was abusing me. They didn't do anything to him, and instead they sent me to the secure unit for speaking up (6a).

Inadequate Investigations Compromise Evidence

Individuals report "failed" or "delayed" investigations which compromised the ability for police to generate appropriate and reliable evidence to prosecute and therefore denied the validation of truth claims (5b, 14b). Widespread "failures" to investigate abuse in care are attributed to the volume of abuse allegations police investigate annually (5b). At the time of the inquiry, police were investigating 9000 sexual abuse cases (5b). It is argued that despite the best efforts of police, there are occasions where "failures" in investigations occur due to the volume police are dealing with (5b). However, concerns were also raised about the fact there is no universal policy governing the receipt of allegations of abuse of children or young people in care (14b). All reports of child sexual abuse, regardless of who made the complaint or the setting by which the abuse occurs, is investigated in accordance with the *Child Protection Investigation Policy* and *Adult Sexual Assault Investigation Policy* (14b). Investigations are prioritised based on "perceived risk of ongoing offending, the resources required to investigate, and the seriousness of the allegations" (14b). When there is an indication of multiple victims and repeated patterns of offending, a *Mass Allegation*

Investigation may be initiated (14b). While police state they are committed to ensuring conscious and unconscious bias are not factors in decision-making and have introduced training accordingly (5b), a lack of policy for investigating the abuse of children and young people in care environments is argued to lead to “lower levels of priority for investigation” due to the young person's subject position as a State Ward who is viewed as an “untrustworthy troublemaker” (5b). This low-level priority is described as similar to the treatment of family violence investigations in New Zealand until family harm policies were introduced that changed policing attitudes toward the issue (5b).

Victim Credibility and Decisions not to Prosecute

Individuals also describe the constraints of the law which sets a high bar for prosecution (in order to obtain safe conviction) but which make it difficult to bring a case to court which would validate survivor truth claims (5b, 6b, 7b). Decisions not to prosecute are made in conjunction with Crown solicitors in line with the Solicitor-General’s prosecution guidelines (5b). When a prosecution does not proceed, this is said to indicate a gap between the evidence available and the evidential standard required (5b, 14b). Police argue it does not indicate the survivor has not been believed, a failure in police to investigate, or that the offending has not been treated seriously but challenges with the law which sets a high bar for conviction (5b, 14b). In deciding whether to move ahead with prosecution, one of the core features of decision making for police is the assumed credibility of the victim (5b). When a victim is “not articulate” or “has issues in their own background”, this can undermine their credibility and the success of conviction in the courtroom (5b). As has been presented, the credibility of the cohort within the inquiry has come under significant scrutiny due to their State Ward status (5b). Despite the ability to use expert testimony to generate a point of confidence in survivor testimony by combatting negative societal attitudes towards victims and misconceptions of sexual abuse, police describe how they rely heavily on corroborative evidence to bolster victim credibility despite corroboration not being a legal requirement (5b). This evidence can be hard to find, particularly in historical abuse cases, and often results in police decisions not to prosecute and a failure to validate survivor truth claims (5b). Decisions not to prosecute are reviewed by the National Adult Sexual Assault and Child Protection team to ensure consistency in decision making and survivors of abuse can request that decisions not to prosecute be reviewed (5b).

Reliability and Accuracy of Forensic Interviewing

Another constraint of the law discussed includes the reliability and accuracy of forensic interviewing (14b). Compromised forensic interviewing - which has been found as recently as 2014 -

can undermine the credibility of the investigation and the ability to prosecute due to concerns of unsafe conviction (14b). Forensic interviewing continues to be a work-in-progress in recognition of failures in this area (14b). From 2007, speciality interviewing was introduced using the *Speciality Child Witness Interview Guide* (SCWI) which is said to be aligned with international best practice guidelines and interviewing protocols (14b). These guidelines and protocols were introduced to increase the reliability and accuracy of interviews and to reduce survivor re-traumatisation (14b). An evaluation of forensic interviews with children in New Zealand between 2012 and 2014 and published in 2016 found factors that may influence interviewing practice and affect interview accuracy (14b). Opportunities for improvement were identified with adherence to SCWI and this was used to benchmark the practice of interviewing practitioners with the New Zealand Police and Oranga Tamariki to increase further increase the accuracy and reliability of interviewing which in the past may have compromised the ability to successfully prosecute (14b).

Win-at-all-Cost Mentality Among MSD and Crown Law

Survivors face continued scepticism in their adult lives through the historical claims process. Speakers describe how MSD's redress system has not always worked in the best interest of survivors when assessing and setting claims (12b, 13b) and the system is described as fostering a "win-at-all-cost" culture that is "suspicious" and "sceptical" toward claimants (2a, 5a, 8a, 10a, 13b, 16a, 19a). Survivors describe the process as trying to "catch them out on lies" or "fabricating stories" (19a) with the institutions trying to "wear them down", "juggle them around" (8a), and "throw them around in circles" (19a) by making them "repeat their abuse" (8a) during multiple medical and psychological assessments by ACC registered professionals (10a, 19a). They are also subjected to extensive cross-examinations (2a) and surveillance techniques which aim to "vilify" them and bring their credibility into question (5a, 16a):

This response confirms that private investigators were engaged by the Crown to assist with the preparation for the White trial. This was around the exact time that I felt that I was under surveillance [...] And what do you think investigators do? And the fact of the matter is, is why did you hire them in any capacity against us in the first place? You are attempting, essentially, to vilify and undermine people who have come forward because they've been victims of serious sexual abuse as children (5a).

This "win-at-all-cost" process is described as "degrading", "gruelling" (6a), "nothing but grief" (8a), an "uphill battle", and "very hard to deal with" (6a). Some survivors settle their claim rather than going to trial because they are anxious about the experiencing further accusatory

investigation techniques (2a). In addition, their claims are often dismissed due to: thresholds which are “unreasonable”, “very legalistic” (16a), and “mathematically calculated” (6a); the Limitations Act (2010) which sets timeframes on filing claims and the limitations of this law with the nature of delayed reporting in sexual abuse survivors (3a); and because survivors are often unable to provide corroborating evidence such as a location where the abuse happened (16a). When survivors are unable to provide corroborative evidence, they report their claims are rejected due to “spurious grounds” (16a):

They want times and dates of all the assaults, but it was over 40 years ago. The abuse carries on through this process. They say they understand it has been a long time when they ask — but then why are they asking? Of course I don't have a diary with all the times and dates of when all the abuse happened. I was a kid (10a).

MSD accepted only a reasonably small part of my claim and rejected most of it. This was for reasons including that my uncle was not working at Epuni when I said he was, and the records did not support that I was in secure, and so on (13a).

Through survivor stories of the redress process, it has been found that both Crown Law and MSD did not comply with the Crown litigation strategy which “requires meritorious cases to be settled swiftly” (13b). Instead of settling cases as required by the strategy and validating survivor truth claims, both the Crown Law and MSD became overly focused on “minimising the Crown’s liability through a win-at-all cost manner which was unnecessarily adversarial, legalistic, and aggressive” (13b). The Public Services Commissioner describes how Crown Law and MSD lost sight of the human beings at the centre of the claims; they did not behave as a model litigant; they did not provide adequate settlements; they failed to disclose previous criminal convictions of the perpetrator to the survivor; they failed to investigate employee transfers between residences; they failed to investigate the relationship between residences, the Catholic Church, and abuse; they tried to resolve claims through alternate resolution process; they had outdated ideas about sexual abuse including sexual abuse reporting; they failed to facilitate restorative justice processes; they instructed private investigators to seek personal information about survivor witnesses in an overly broad way which did not rule out surveillance and which was in breach of the code of conduct under the State Sector Act; and they caused additional trauma through the wrongful handling of claims (5a, 13b). Due to inadequacies in the process, many survivors are still pursuing their claims (13b). In response to these failings in the redress system and improvements identified through the *He Purapura Ora, he Māra Tipu* report from the inquiry’s redress hearing, work has begun on developing a new independent redress system (12b, 13b).

Obstructed Access to Discursive Resources

Institutional employees often denied access to valuable discursive resources which would prove survivors claims as truthful while promoting the discourse of fabrication. Survivors complaints were often censored by staff (3a, 4a, 6a) and they were denied medical care which would provide evidence of abuse (10a, 11a). This denial of discursive resources for survivors contributed to a lack of accountability for perpetrators and resulted in the continuation of abuse (6b).

Censoring of Abuse Allegations. Survivors describe attempts to “cover up” and “deny” truth of facts through “lost”, “destroyed”, or “incomplete” paperwork in the name of the “institutions agenda”, making it difficult to validate truth claims (1b, 3a, 4a, 6a, 10a, 11b, 13a, 21a). Survivors describe how: incoming and outgoing mail was censored by staff (3a); their letters of complaints were never sent (3a, 6a); their complaints were never recorded on their files (3a, 4a, 6a, 11b, 19b); nothing was ever done about their complaints (4a, 6a); they never had replies to their letters of complaints confirming receipt (3a); and their files were often blacked out (4a):

I wrote a letter of complaint to the Director-General of Social Welfare while I was at Kohitere. This was about the sexual abuse and violence I was being subjected to by other boys and staff. I am still unsure to this day if the letter was ever sent. I certainly never had a reply to my letter. I don't believe it was ever found on my file. I am also fully aware that all incoming and outgoing mail was censored by staff (3a).

I also told the psychologist about my father continuing to abuse me during his visits to me at Bollard however this is not recorded in the report. The report states that I told him that my father had visited me and that I "expressed neither positive nor negative feelings about these visits and appeared to have suppressed any reactions." I do not know why he said that given what I told him (6a).

The practice of censorship occurs despite young people alerting adults within their ecosystem who have ethical and legislative obligations to report and address allegations of abuse through activation of child protection protocols including social workers, police, educational employees, and psychologists (8b). A loophole which allows for the censorship of mail is also described and attributed to facilitating complaint censorship (8b). The practice was permissible under the field manuals for social welfare in 1965 (8b) and while currently not permissible at Oranga Tamariki residences there are provisions in the 1996 Residential Care Regulations which allows employees to search a young person's property when they are concerned about the risk of mail to the young person (8b). In addition, third-party providers have their own complaints systems and

regulations for censoring mail (8b). Within these providers there are examples of staff censoring complaints up until 1998 (8b).

Denial of Medical Care. Residential staff also refused to provide medical care for survivors when required or requested. Access to medical attention would have provided discursive evidence for survivors' complaints of abuse. One survivor describes how he was denied access to medical care for a sexually transmitted disease which was contracted due to an abusive experience because "questions would have been asked about how it happened" (10a). This individual was held in the secure unit until he recovered and due to the extensive damage of the infection he was unable to conceive children later in life (10a). Another survivor speaks of a similar experience, she was denied access to medical care when suffering a miscarriage which was the product of rape by the principle of the residence (11a).

The Abuse in Care Inquiry Serves as a Validating Discursive Resource

The Abuse in Care Inquiry served as a "historic" (12b), liberating, and validating discursive resource which represented survivors and gave them "hope" that something tangible will happen (11b). It allowed them the opportunity to "speak" (21a), "have a voice" (15a, 22b), be "heard" (3b, 12b, 17a), "listened to" (3b, 6b, 12b), "believed" (3b, 12b), and "supported" (17a, 21a) for the first time. The inquiry is described as a "catalyst for change" (11b, 12a, 22a, 22b, 23a), an opportunity to draw together the lessons from those who have been "let down by the system" (22b) and to confront agencies with their failures (11b, 12a), raise awareness, shed light on the "shameful history" of abuse in care (12b), and to eliminate current and future harm (22b).

Discourse 3. Child Sexual Abuse is a Harmful Form of Violence

This discourse of child sexual abuse in residential care as harmful emphasises the harm caused by demonstrating the profound impact of abuse in care on tamariki and rangatahi. Survivors describe how child sexual abuse had a "profound impact" (1a, 3a, 5a, 8a, 11a, 19a, 21a), "invaded", or "ruined" (8a) their lives causing considerable damage (2a, 3a, 13a, 16a). They call out care and protection services as "care and damage" (4a) and both survivors and witnesses from the institutional response hearing describe the "pain" (5b, 12a, 13b, 17a, 21a, 23a, 24b), "despair", "frustration", "heartache" (12b), "loss" (21a), "sadness" (21a), "trauma" (8b, 13b, 24b), "corrosive and traumatic intergenerational impact" (6a, 9a, 12a, 12b), and "hurt" suffered (1b, 5b, 7b, 11b, 12b, 13a, 13b, 14a, 14b, 16a, 17a, 17b, 19b, 23b). Survivors speak of how they "cannot let go of the things that happened in those places" (10a) and that the abuse they suffered is "there for life" (10a), "stays with them", "does things to a person" (10a), and means "healing is not possible" (13a). Some say the "pain is tattooed right through" them (13a), that they are "left with scars not visible to the naked

eye” (17a) and that they “cry all the time because of the pain” (10a). Witnesses acknowledge the “horrific” physical and sexual abuse suffered (12b); disturbing and atrocious stories of “pain, loss, sadness” (12b); deeply personal and “distressing” information (6b, 7b) and “harrowing experiences” (9b) that survivors shared; how these stories of abuse were “uncomfortable” to hear (14b); and how they were “speechless”, “tearful”, and “struggling to comprehend and express the utter sadness felt” (12b). These statements and utterances from the Crown, the Royal Commission and the institutions strongly recognises the harm suffered. Survivors seek an unqualified apology for the wrongdoing of the institutions and the harm caused by and the impact of abuse in care (1a, 3a, 6a, 10a, 12a, 14a, 17a, 21a, 23a). This discourse of child sexual abuse as harmful is materialised through accounts of psychopathology (1a, 2a, 2b, 3a, 3b, 4a, 5a, 6b, 7b, 8a, 9a, 9b, 10a, 11a, 12a, 12b, 13a, 14a, 16a, 17a, 18b, 19a, 21a, 23a,), criminality (1a, 2a, 2b, 2b, 5b, 6a, 7b, 8b, 9b, 10a, 19b, 19a), and the intergenerational transmission of placement (6a, 6b, 7b, 12b, 13a, 15a, 19b).

A Trajectory to Psychopathology

Individuals describe the materialisation of this discourse in the presentation of severe psychopathology in survivors of abuse (3b, 12a). Survivors are described as having suffered “psychological ups and downs” (17a), PTSD (1a, 2a, 3a, 9a, 10a, 21a), pain, loss, and sorrow (12b), generalised anxiety disorder (2a), conduct disorder (2a), antisocial personality disorder (2a), social avoidance (3a), depression (2a, 9a, 10a, 12a, 21a), substance abuse and dependence (2a, 3a, 8a, 9a, 12a, 17a), suicidal ideation and attempts (4a, 10a, 17a, 21a). In addition, they also experience interpersonal (1a, 2a, 10a, 13a, 17a, 21a), employment (10a, 19a), and emotional dysregulation (2a, 10a, 17a) and loss of identity (6b, 10a). Survivors also speak of how their experiences shaped who they are and how they react.

PTSD. Many survivors suffer from PTSD (1a). One survivor who suffers from PTSD describes difficulty sleeping, feeling guilty and inadequate, “like a loser” or “underserving of everything good” in their lives (2a). They have chest pains, butterflies in their stomach, shakiness, feelings of heat and tightness in their head, and are depressed, panicky and agitated (2a). Survivors describe how they can still “hear the screams and cries from the other boys” (10a) and how nightmares and flashbacks are common and debilitating (2a, 10a, 17a, 21a):

You don’t know what it’s like to wake up now and jump out of bed sweating, tears in your eyes and think you’re still in that shithole. I still get that. I damn well still get that. And I’m angry and I’m pissed off (21a).

I had problems falling asleep and staying asleep. I would be jolted awake with surges of anxiety or a racing heart, hyperventilation, and shakiness. I would then be scared about

going back to sleep. I was worried that I would die. I would have similar, although less intense, panic symptoms when I was awake. This would last a few days and then I would start to feel really low, sluggish, and heavy and I would again focus on my problems and how I was feeling about it. I would think about how much of a loser I was and how I was underserving of everything good in my life. This would make me feel aggro and feel like isolating myself (2a).

Avoidance of Painful Memories. Survivors are unable to disclose some of the sexual abuse (3a) they suffered or are unwilling to share (11a). Some describe how they try to keep their experience confined to a “small place inside themselves” (17a) or try to “hide in their head what had happened” (8a). Their tendency toward non-disclosure is said to be from the impact of the abuse (3a), “not being in a good headspace” (2a), “not being able to handle the thought of dredging up the painful memories” (2a), “not being able to go back to that time and really feel the true feelings” (19a), and “fearing people would not understand or be disgusted and judgemental” (17a). When they do speak of their experiences, they describe this as “tough” (14a), “hard” (2b, 16a), “emotional” (2b), “painful” (18b), and “extremely challenging” (1a). No matter how much they talk about their experiences, “it never gets any easier” (2a). This sentiment was echoed by counsel for the Royal Commission, who acknowledged the difficulties survivors faced when speaking their testimonies and how this came at a great personal cost (16a). Counsel describes them as “brave” while reiterating that the pain they were experiencing during their testimonies was for a greater cause (21a). Revising case files, which show what happened to a person while they were in care including abuse, is also “very painful to go through, extremely traumatic and triggering” (9b).

Self-Medicating. Survivors drink heavily and use drugs to forget the “painful memories” (3a), “nullify” or “erase the pain” (17a), or “avoid the thoughts” (2a). Their alcohol and substance use are a coping strategy which was both “numbing and comforting” (12a) and helped them with “feelings of anxiety” and “feeling low” (2a). However, while they used substances to avoid their thoughts and emotions related to the abuse suffered in care, they developed “horrible addictions” (3a) and their substance use impacted many parts of their lives with some reporting their drug abuse having a massive impact on their family who have been absent from their lives (9a).

Emotional Dysregulation. Survivors struggle with emotional regulation, with “little things” triggering them like behaviour and attitudes and if people remind them of the staff members at residences (2a, 16a). This triggers feelings and thoughts of “rage”, “anger”, “depression”, “self-loathing”, “distrust”, “paranoia” (2a). One survivor said whenever he was involved in fights he

pictured the face of his abuser (5a). Two survivors describe how their experiences of abuse in care led to anger issues and violence toward women:

I become depressed and I cannot talk to anybody, which means that people do not want to be around me. I become anxious and paranoid and I cannot sleep. Then I take things out on the people I love the most, verbally, and physically. I have been aggressive and violent in relationships with women (2a).

I went to an anger management course myself because I was violent with women. When I think about it, it's because I am frustrated. Everything from when I was younger is still there for me. I didn't want to go down the road my father and grandparents went down. So I went to anger management (10a).

Interestingly, one survivor describes a unique coping mechanism, tattooing his body, to avoid violence against others and to cope with the pain he feels:

Even though I'm tattooed from my face to my feet, my tattoos are my pain in my life. Every time something happened, I was in getting tattooed up. That was my way of not going out hurting anybody. I hurt, I feel the pain that I'm feeling, that I want to inflict on somebody. I put that on me. No-one deserves to be treated like that (17a).

Interpersonal Difficulties. Abuse has impacted the interpersonal relationships of survivors. Whānau members describe their painful experiences of living with loved ones “damaged” by their experiences (3b). Survivors struggle with trust which makes relationships difficult (3a, 4a, 3b, 6b, 10a, 13a). They are unable to trust partners, whānau, police, medical professionals, authority figures, social workers, other social welfare people or the historical claims process (3a, 4a, 3b, 10a, 12b, 13a). This distrust that survivors learnt in care and from their abuse has meant that they have been unable to develop healthy relationships with others, because they are on “guard”, “investigating their surroundings”, and “questioning peoples' motives”:

Whakapakari taught me that bad things can come with smiles. Just because someone is smiling at you doesn't mean they're nice. I have been taught to see beyond a smile. This reasoning has cost me a few friendships along the way. I have wiped a lot of people out of my life because of not taking smiles at face value. It has taught me to really investigate my surroundings and to question people's motives (8a).

They coped the brunt of my frustrations. But as an adult I went to the school reunion and lucky enough to meet some of them. I apologised for my behaviour but it also gave me the opportunity to tell that I wasn't a normal kid and that I just didn't know how to tell anybody

what was going around in here [gestures to head]. I still wonder how the State thought a 14-year-old boy could fit into a normal school and live in a community after being in State care. I was angry, bitter, and twisted (12a, 23a).

Survivor distrust also impacts intimate relationships, with one survivor describing how trust was a huge barrier for them to overcome, that their relationships suffered, and that they have never known what it is like to be in love with somebody (6a, 17a). Other survivors describe how they “fly off the handle” or “lash out” if touched (2a), how they run from relationships because they are “scared” to be intimate (12a), and how it took them years to feel comfortable in a relationship:

I have found relationships and intimacy to be very difficult. I had a big problem with that. The intimacy thing was like taboo for a very long time. It took me many years to feel comfortable with these sorts of situations... It was a terrible feeling (8a).

Another survivor, who suffered extensive damage to his reproductive system from a sexually transmitted infection from abuse, was unable to father children (10a). This too impacted on his ability to form relationships in his adult life:

My fatherhood was taken away from me after the sexual abuse at Owairaka. I couldn't have children after I contracted that disease. I went to get tested after trying for a family with my partner. I believe that's why I can't have children. I am the only one in my family who can't have kids. If you look through my medical history, I've never had a disease or anything since then. I have lost a lot of relationships because of my inability to father children. I also have been unable to adopt children, which I looked into, because of my criminal history. The family I have now, I love them dearly and they love me like a father, grandfather and great grandad. But they aren't my true blood. I hear people talk about their kids and I used to get embarrassed and walk away. They took a lot from my life. To this day no one has ever given it back to me (10a).

Employment Difficulties. Survivors also face employment difficulties consistent with the discourse of child sexual abuse in residential care as harmful. One describes his struggles in maintaining employment (8a), while he wants to be at work it is too dangerous due to the mental distress he was suffering:

I felt overwhelmed I had opened a can of worms. I had to stop driving trucks toward the end of 2020 because I wasn't coping with the pressures of driving such heavy trucks and I was unable to concentrate... I pretty much had a nervous breakdown and I was a danger on the roads. I was driving drunk and I found myself at intersections, not knowing which way to go

or even drive into the intersection. It was dangerous for me and others. I couldn't concentrate... My mind was on the abuse and that box... just came open (8a).

Suicide and Self-Harm. Suicide and self-harm are also commonly spoken about as an impact of abuse in care (3a, 8b, 10a, 17a). Survivors speak of how they “tried to commit suicide” on multiple occasions (10a, 17a), suffered suicidal ideation (12a), “didn't really care if they lived or died” (3a), how they wanted to be in a place where “everything would go away” (17a), that they were low and suicidal (2a), they were a “mess” and “wanted to end their life” (17a), and how they wanted to end it “because there was nothing there for them and nobody wanted to help” (10a). One survivor describes how they thought they were “not worthy of living”, that they were “not meant to be” in this world (17a). Suicidal ideation and behaviours would manifest not only in adulthood but also while the young person was in residence (4a, 21a):

Sorry, yes, at some stage I, in my earlier years, I couldn't cope with life anymore, I couldn't cope with the disappointments, the turndowns, so I tried to commit suicide because I wanted out of this world because I had enough of the abuse. So yeah, many times in my life when I was in borstals, even the boys' home I wanted to end. I just wanted some peace and clarity in my life. Yeah (21a).

The first time I ever properly thought about suicide was when I was at Kingslea [...] I thought everything was my fault. I didn't understand what was going on with me. And what I had done wrong. I didn't know who I was, and I just didn't want to be here. I was being punished all the time (4a)

Underachievement. Within this discourse of harm survivors describe how they find it difficult to fit back into the community (23a) and speak of how they were “robbed” of their innocence (12a) and of their ability to reach their full potential or who they could have become because of their histories of abuse. They ponder about *what ifs*: what if their cries for help were believed or heard, what if their words were taken seriously (17a), and what if they have been properly cared for (10a, 13a):

If I had been treated properly in care with no abuse, I would feel no need to run. I would not need to give this statement. Who knows what my life could be now [...] The way it has affected my life has taken all my chances away in life of what I may have been able to become (10a).

It still hurts that if I had not gone through what I did, I could have achieved a lot better. It is clear from my qualifications that I had some ability. But because of my past, I struggle all the time. I have nothing to show for my life (13a).

Cultural Genocide: Tarnished and Lost Identity. Some survivors also describe a loss of identity (4a, 6b, 10a). This was significant for Māori and Pasifika whose experiences of racism and discrimination in care significantly impacted their ability to express their identity and which forced assimilation to Western ways of being (6b). The degradation of Māori and Pasifika in care – including racially targeted sexual abuse – is described as cultural genocide, stripping away the young person’s culture, traditions, values, language, and therefore their identity (6b, 7b). A Pasifika man says he learnt to hide his identity and culture, and that he wished he was white (10a):

They pounded that into me, that we were no good, we were dog shit. You lose your identity. I would think 'no I'm not Samoan because this is what happens, Islanders are no good'. As a child that's how you think, and that it must be right. Bad things happen to Islanders. Bad things happen to Māori. Sometimes back then out on the streets I used to cry sometimes and wish I was white. That's how bad it was for me. I lost everything. I had no identity, I had no belonging, I had no respect (10a).

When you go into a home, you lose your culture, and you lose your identity. You don't think of yourself as an Islander or a Māori, because you start to believe what they are saying about you. I recall that staff told me that I should go and kill myself because no one wanted me [...] the staff made it clear that Islanders didn't belong to this world (10a).

The loss of identity, culture, belonging, and family was not something this survivor was able to recover from. He says this left him to “wander aimlessly” throughout life “wondering what part of the world he fit in to or where he belonged” (10a). Many survivors of this cultural genocide describe not knowing who they are (7b). In addition, they experience distress and shame from not being able to impart identity and knowledge onto their family (7b).

A Trajectory to Prison

The connection between victimisation and offending behaviour is also described as one of the harmful impacts of abuse (5b, 6a, 7b, 8b, 9b) with one person arguing abuse in care “underpins the New Zealand prison population” (2b). This association is centred around the high percentage of individuals from care and protection who go on to have offending histories and through a focus on linking trauma and criminality (8b, 9b). Oranga Tamariki contests the association between care and protection and offending, arguing involvement in the care and protection system does not heighten

risk for involvement in the criminal justice system (19b). However, other individuals highlight an association between care and protection involvement and entry to prison by comparing the percentage of individuals from care and protection population with offending histories to a matched cohort in the general population (8b, 9b). They demonstrate between 20% and 33% of people in State residential care enter prison compared to 1.6% and 7.7% of a matched cohort in the general population of gender, ethnicity, and age who did not enter State residential care (8b). The rates for Māori were much higher, with 30% to 42% of those in State residential care ending up in prison compared to 4.5% and 12.6% of a matched cohort in the general population who are Māori but did not enter State Care (8b). What these statistics show is that those in residential care are “five to nine times more likely” to end up in prison than the general population and that Māori in residential care are “15 to 24 times more likely” to end up in prison than Māori in the general population (8b, 9b). Speakers link this relationship between care and protection involvement and criminality to the abuse and trauma experienced (8b, 9b) by referencing brain structure abnormalities (8b, 9b), conditioned responses from repeated exposure to violence (8b), gang membership as a form of self-protection (9b), and untreated or unresolved trauma as a correlate of offending behaviour (9b).

Traumatic Brain Injury. Speakers describe how many New Zealanders who have criminal histories (9b) and many tamariki in care and protection or youth justice residential care settings have histories of abuse victimisation (8b). They highlight how brain structure abnormalities caused by abuse and maltreatment have been linked to an 11-fold increase in the likelihood of being arrested for a violent offence (8b):

Brain structure abnormalities have been reported in those experiencing childhood trauma, extremely common as part of the background history of tamariki children in both care and protection and youth justice residential settings, as well as functional differences, which are themselves linked to violent crime, with some studies showing an 11-fold increase in the likelihood of being arrested for an aggressive offence for young people traumatised early in life (8b).

The increased risk of violent offending can also be linked to changes to overactivity in the hypothalamic pituitary adrenal (HPA) axes in maltreated children which causes increased aggressive tendencies and decreased responsiveness to punishment rendering prison ineffective and potentially resulting in recidivism or life course persistent presentations (8b):

Mistreatment is also associated with psychological problems and with changes in the hypothalamic pituitary adrenal axes. Overactivity of this hormonal axis can result in an

increase in impulsive aggression, while underactivity can result in non-responsiveness to punishment and increased instrumental aggression (8b).

Conditioned Responses to Violence. Individuals also describe an association between criminal behaviour and abuse in care as the outcome of conditioned or learned violence in response to self-defence (2a, 6a, 8b, 9b, 19a). Survivors develop justice seeking or defensive safety behaviours in residential care facilities to protect themselves or others from harm. One survivor describes how they took matters into their own hands, violently assaulting a man who was abusing two young boys in her local neighbourhood (6a). They associated this behaviour with their own history of abuse, seeking retribution for other victims:

I have some offending history although I have not been in trouble for a long time and I have the clean slate now. One offence that was linked to what happened to me as a child was when I assaulted a man in the late 1980s. I was told that children were being abused at a property on Holly Street in Auckland and that they were being given alcohol and solvents. I went around there and all I could smell was glue. I saw two boys in a bed there and I went crazy. I assaulted the man there with a knife[...] I was arrested but did not make a statement. They discussed charging me with attempted murder [...] I was eventually charged with aggravated wounding with intent to injure and kidnapping (6a).

Another survivor describes how he spent 18 years of his adult life, in and out of prison, because while in residential care he learned no one would protect him and he had to protect himself:

Since my discharge from Social Welfare care in 1990, I have basically been in and out of prison. I have spent about 18 years in prison [...]. All of the violence and beatings that I was subjected to have made me extremely violent and battle headed. I learned early on that no one would help me. When I reported incidents of violence, beatings, and sexual abuse to staff members, this just resulted in me being told not to nark and being beaten and bashed. I am the only person in my family to do extensive prison time. My father and his brothers when to prison once. I have been repeating this for over 34 years (2a, 8b).

Similarly, another survivor describes how living in on Whakapakari was “fight or flight” and how through continued exposure to sexual violence from elders in the “rape club” young people learn to become sexual predators:

When you see your peers and your elders doing these things to you, I mean young people [...] mimic their elders, they do what they done, monkey see monkey do. Now that was really

brutal and that set my pathway in life. I mean just dealing with things, confrontations [...] it's fight or flight. [...] It thickens your skin up so hard. [...] rapists and murderers were born on that place, they got their training out of there. It was a rape club and I'm aware that murderers and rapists have come off that island. I mean I feel like – I just thank God that I made it this far without doing anything really bad [...] I'm just so grateful that, you know, I'm not doing 30 years in jail for killing someone. Because when you get exposed to that sort of stuff [...] your forte is a whole lot different than someone who hasn't experienced them things. [...] I mean I'm struggling to find words to explain what sort of person you become after that place (19a).

Gang Membership. Evidence presented throughout the inquiry also demonstrated abuse in care as a trajectory to gang affiliation (1a, 2b, 8b, 9b). The increased institutionalisation of young people in care during the early 1970s is argued to have “given rise to New Zealand gangs” (2b) and the “expansion of gang activity that is seen in contemporary society” (9b). Gang membership is said to be an attractive option for self-protection due to the level of violence experienced by young people in care (9b). Others say gang membership offers a place of belonging and formation of a new identity: “A lot of survivors turn to gangs, because gangs have treated them like family. They lost their history and mana and identity, just as I have. It didn't matter which institution you went to, it's lost” (10a).

Unresolved and Untreated Trauma Contributes to Criminality. Unresolved and untreated trauma is said to be a significant contributor to mental health issues, addiction issues, and antisocial behaviour that drives criminality (9b). Unresolved and untreated trauma is strongly recognised by the Department of Corrections as key to addressing offending behaviour (9b). Those identified as having experienced trauma are given the opportunity to work with mental health clinicians which takes on a one-on-one approach and tailored intervention to resolve the individual's trauma-related distress (9b). This trauma-informed approach is said to have some risk mitigating effect in terms of reoffending as well as being generally beneficial to the individual in terms of overall personal functioning (9b).

A Trajectory to Intergenerational Care Placement

Abuse in care is described as causing “long-term and corrosive”, causing a “traumatic intergenerational impact on victims, survivors, their families, whānau, hapū, iwi, and communities” (6b, 7b, 12b, 19b). “Generations of whānau” are said to have experienced care placements (9b). Survivors of abuse in care are at “increased risk of three of five risk indicators of care placement”: “correctional involvement”, “alcohol and substance abuse”, and “family violence” (6b, 7b, 19b). They

are also more likely to experience a range of other social factors which increases the risk of harm or abuse to their children and, as such, increase the risk of intergenerational placement. These social factors include “poverty, poorer health and mental health outcomes, poorer educational outcomes, and poorer housing outcomes” (6b). Survivors are aware of the risk of intergenerational care placement and some take active measures to avoid care placements for their own tamariki:

I have adopted out three of my kids. This is because I do not trust the state to look after children safely. Rather than going through the state adoption process, I followed my own process so that I could make the decisions and feel that my children would be safe (6a).

My adult girls are doing well, as are the two children who live with me. None of the children has ever been in care. It has been important for me to not repeat the cycle. I have taught my children to be law abiding citizens. I am so proud of them and feel blessed that I had the opportunity to be a good father and parent (13a).

This avoidance of care and protection services was detrimental at times. A lack of trust in authority figures and a fear of care placement resulted in death from family violence for a young mum who feared seeking help:

Āe, so one of the things is because my daughter was too scared to ask for help through her domestic violence because she was scared she would lose her boys, to then Child Youth and Family [Oranga Tamariki], she never seeked help and she died (15a).

Discourse 4. The Nexus of Power and Oppression in Child Sexual Abuse

The discourse of *child sexual abuse in residential care as power and oppression* focuses on the inherent power imbalance or abuse of power which exists within the institutions and between individuals within these institutions (5b; 23b). Abuse is attributed to an “inherent violence” within the institutions that results from the power structures that exists within “large institutional arrangements when young people are placed into large groups under the care and supervisions of adults without the right training and skills” and who “exploit their positions of power” (7b, 23b). This issue of power can be seen in the way that survivors describe their abuse. They speak of how the acts were “non-consensual”, that they had “no control” (4a) over the situation and that they “did not agree” (10a) and “were not a willing participant” (21a). However, due to their size and age, combined with the use of physical force, grooming or authority by adults or more powerful young people they were often subjected to sexual abuse. Survivors speak of how they were “small” (2a, 12a, 16a, 23a), “young” (4a, 5a, 8a, 15a, 16a, 17a, 19a, 22a, 23a), “vulnerable” (16a) and how they were “unable to protect themselves” (19a) against their abusers who were “older” (4a, 8a, 12a, 14a,

15a, 19a, 23a), “taller” (10a), “bigger” (12a, 21a, 23a), “in groups” (12a, 23a) and who “forced” (3a, 6a, 8a, 12a, 13a, 23a) and “dragged” them (12a, 23a). In addition, their abusers “made them” do things (9a, 10a, 11a, 12a, 13a, 17a, 19a, 21a, 22a, 23a), “ripped” their clothes off (19a), “beat” them (19a), tied their hands behind their backs (10a), and covered their mouths so no one could hear them screaming (10a).

The Materialisation of Sexual Abuse as a Form of Power and Oppression

The discursive materialisation of this discourse identified in the data includes a hierarchical culture among young people which encourages sexual abuse as a way of exerting power over others; patriarchal expectations of sexual servicing; the use of threat and violence to intimidate or force compliance; the abuse of power by staff members; and grooming practices which exploit developmental weaknesses.

The Pecking Order. A kingpin culture was found as one of the key understandings of abuse perpetrated by other children or young people in care:

The culture of a kingpin hierarchy that maintained physical violence and dominance, which was also highly damaging. Physical assaults by children reflected battles for power and this institutional hierarchy (the kingpin system) was used to designate some children as dominant and others as subordinate. Kingpins controlled others (7b).

Survivors acknowledge their sexual victimisation was often the product of the “kingpin system”. It was a way that older and bigger young people could assert their dominance over young people who were smaller (1a, 12a, 13a, 14a, 23a). The abuse exerted by other young people took two forms: frequent, routine sodomy that occurred four to five times a night for those at the “bottom of the pecking order” (23a) and “initiations” for those who were new to residences (3a, 4a, 15a). Children and adolescents who were bigger, older, or who had power, were able to “fight off abuse” and “say no” (2a). One survivor speaks of the horrifying nature of initiations, during which girls would be violated using broomsticks (6a). Another describes how they were knocked unconscious on at least three occasions by other young people (9b). Despite the harm and traumatisation experienced from being sexually abused, young people who have been victims of abuse go on to sexually abuse others as a means of gaining social capital. By doing this they engage in a complex habitus which maintains the kingpin culture and sexual abuse by residents:

Lots of the older boys at Hokies were also survivors of abuse and so they were angry. They would just line up someone else to take out their anger on and the abuse was often just passed down the pecking order, food chain (23a)

The culture is further encouraged by staff who “use the system to their advantage” and as a means of “controlling the behaviour of other children” (7b) and who legitimised the status of kingpins within residences using reward:

The kingpin culture at Kohitere was very big and used by staff positively and negatively. I challenged [a senior staff member] at one stage about him legitimising the kingpin structure by making some of the more violent kingpins members of the student council and that legitimised their power [...] I believed it was inappropriate (7b)

Patriarchal Expectations of Sexual Servicing. Survivors also describe patriarchal understandings of sexual abuse with men selecting young boys and girls “for the taking” (5a, 11a, 16a). One survivor describes how Alan Moncrief-Wright was prostituting boys from Epuni to the Catholic Church where they were “selected” by Church officials to be sexually abused (5a, 16a). Clergy would walk around the van which transported boys to the location of abuse, look inside, and “choose” who they would take (5a, 16a). Another survivor describes how every time her father came to visit her, he wanted his “needs serviced” (6a) while another detailed how the principle of a facility “had the right” to hand pick girls to rape:

If you behaved yourself, you got the privilege of cleaning his house. He would come around and hand pick who would get to clean his house. One day I got chosen to clean his house. I was raped by him at his home (11a).

I had a principal who thought it was his right to take me over to his home and make me feel like I was the one that was privileged while he raped me, I got pregnant and then miscarried in his facility where he was in charge (22a).

Threats of Violence Used to Force Compliance. Survivors also discuss how the use of threat and violence was used to intimidate them and force compliance (6a, 8a, 13b, 19a):

He's got his gun, wielding his gun around and he's indicating to the older kids to – he's telling us to get our clothes off and then telling the other kids to rip our clothes off and beat us up, and then – and I'm thinking, you know, like I mean I was okay with the beating, but then the other boys at the back took their clothes off and got their penises out, I'm thinking, you know, he's like "Fuck them", and I'm thinking fuck'n what?" (19a).

One survivor describes being “petrified” and “frightened” for their life (8a, 19a). He also highlighted how the supervisor used his gun to tell them not to go anyway and what to do including to take their clothes off and “get on the fucking bed” (8a, 19a). The presence of the gun was intimidating; the survivor speaks of being so scared that he and a fellow peer stayed in the bed all

night where they were subjected to repeated and violent sexual abuse (8a, 19a). Another survivor describes how threats of violence towards others, or the actual punishment of others would force their compliance:

If we refused to sleep with our father then our father would punish our brothers, he would refuse to take our brothers to rugby and they'd be annoyed at us. All they knew was that the door opened and then closed, not what went on inside (6a).

Directed Coercion and Abuse. The abuse of power by those in positions of authority was also highlighted. Survivors discuss how they obeyed the direction of those in positions of power - the supervisor (8a, 19a), "head guy's wife" (20a), doctor (4a, 6a, 7a, 11a, 15a, 22a), or father (6a). For example, one survivor says he bathed with a supervisor's partner on request because she directed him to and he felt he should comply (20a). Another details how during a medical examination – for an abscess just above her knee – the doctor directed her to take her clothes off, bend over and reach down, touch her toes and pull her buttocks apart while he stood behind her (22a). He then asked her to lay down on the bed with her legs together and her feet apart (22a). She followed his direction, knowing the examination was inappropriate, and arguably due to his position of power as a medical professional (22a). Another describes how she did not complain, scream, or yell out because her abuser was making threats and that she just did what she was "expected" to do (6a).

Young people in care also abused by fellow residents under the direction of those in positions of power (7b, 8a, 19a) who were created cultures of sexual violence: "There always seemed to be two or three older kids that were under his direction... He created a sick culture at Whakapakari like a fight and rape club" (7b). Survivors describe how young people complied with the direction to abuse others because of the power imbalances which exist between adults and young people: "He told the older boys to fuck us.... I don't think that the older boys even knew what to do, they were doing what the supervisor told them to do" (8a). In addition, directions to abuse others were sometimes reinforced by threats of violence further encouraging compliance: "It seemed as if the older kids were quite willing to go along with what the supervisor wanted. He was always wielding that gun" (19a).

Exploiting Developmentally Vulnerable Young People. Adults and young people in positions of power offer items, experiences or privileges that the young person does not have regular access to in order to lure them into abusive situations. Young people were given special privileges and were taken to the movies (5a, 16a), Les Mills gym (8a, 19a), and fishing (12a, 23a) which eventuated into abuse. In addition, they were offered their first piece of connection to normality and the outside

world through the gifting of lollies, music, and friendship, and the sexual abuse “progressed from there” (12a, 23a).

Discourse 5. Shame as a Mechanism of Silence

The discourse *child sexual abuse in residential care as shameful* sanctioned oppression over three alternate discourses: child sexual abuse in residential care as control and punishment, child sexual abuse as State and institutional failure, and child sexual abuse as power and oppression. In each of these discourses, survivors speak of their inability to disclose the abuse suffered because of the “embarrassment” or “shame” they felt (8a, 6b, 19a) from experiencing “disgusting” and “heinous” acts of abuse (19a). Some survivors described how they or their family feared disclosure would “humiliate” their whānau (6a, 17a), “make matters worse” for their loved ones (17a), or harm other survivors of abuse (14a). One survivor describes how being wrongfully labelled as sexually active, when she was being sexually abused, stopped her from speaking:

It was then said between the doctor and the staff member "She's sexually active." I was sexually abused and that sits with me every day [...] I couldn't understand, I was 12 years old, 12. How can anyone at 12 years old be sexually active? And the assumption was I was sexually active, and why no-one actually asked had anything ever happened to me because I would have just went blah and told them what happened. But that statement sat with me and stopped me from talking about it to anyone, I was too scared, yeah (15a)

There were also incidences when abusers used the power of shame to silence survivors with survivors describing how being labelled a “homo” was a way to silence them (12a, 23a):

After the first check I would wait for my door to open and the first boy would come in and rape me. I often was raped about 4-5 times a night by different boys. They too told me not to tell anyone or people would think I'm a "homo" (12a)

Discourse 6. Child Sexual Abuse as a Symptom of State and Institutional Failure

Within this discourse of *child sexual abuse as State and institutional failure* it is stated the abuse which occurred in care was “unacceptable” (3b, 6b, 9b, 18b, 20b), “not okay” (14a), “abhorrent” (3b, 6b, 20b), “appalling” (8b), “should never have happened” (8b, 24b). This “monumental tragedy” (2b) occurred due to “failures of the State and its institutions” (4b). The State and its institutions failed to meet its “moral and professional obligations” to “love”, “care”, “support”, and “protect” young people in care (1b, 2b, 3b, 4a, 4b, 5a, 5b, 6a, 6b, 7b, 8b, 9b, 10a, 10b, 11a, 11b, 12a, 13a, 13b, 14b, 17a, 18b, 19b, 20b, 21a, 22a, 22b, 23a, 23b, 24b). This included the failure to “adequately respond” to abuse (3, 4b). Young people entered care expecting the abuse

they were experiencing to stop but this was often not the case with “widespread, persistent, and extensive” abuse reported (2b, 5b, 6b). They were often abused “by the very people responsible for caring for them who held positions of power and authority over them as well as other residents in care” (4a, 5b, 6b). One survivor describes how the system got her raped (8a). In response to lessons learned (3b, 4b, 6b, 9b, 12b, 13b, 14b, 18b, 19b, 20b, 22b, 24b) about the State’s failure to protect young people from abuse in care, the State and its institutions are committed to: “a better future” (2b); “a posture of learning” (5b); “ongoing changes and improvements based on the Royal Commission’s recommendations to address the failings of the past and minimise risk of future harm” (1b, 3b, 6b, 19b, 20b, 23b). The failure of the State and its institutions is considered so significant that a formal government apology is requested (3b).

Nature and Scale of Abuse Exemplifies State Failures

The State’s failure to protect was evidenced throughout the inquiry by a large number of sexual abuse incidences across a range of settings controlled by State (1b, 8b, 13b), which were committed by the “very people and institutions responsible” for keeping tamariki and rangatahi safe (20b). The extent of all forms of abuse in care, including sexual abuse, is said to have impacted 300,000 to 400,000 people across the scope of inquiry (2b). One survivor notably highlights that the inquiry is the “biggest of its type in the world” which is reflective the “massive impact” abuse in care has had on New Zealand (2b). A series of case studies further demonstrated failure of the State and the magnitude of the issue (1b). For example, Kohitere had 228 complainants with 134 sexual abuse allegations, Whakapakari had 40 complainants and 21 sexual abuse allegations, and Moerangi Treks had eight complainants with four sexual abuse allegations (1b). Further, prolific offending by staff members were found across a range of institutions over lengthy periods of time. For example, a staff member was found to have 48 allegations of abuse over a forty-year period (1949 to 1988). Similarly, four other staff members had abuse allegations, including sexual abuse allegations, spanning ten-year periods or more – one at Ōwairaka from 1988 to 1999, one at Epuni from 1968 to 1978, one at Eastland from 1998 to 1999, and one at Whakapakari from 1988 to 2003 (1b). The scale of abuse was not confined to the scope of inquiry with speakers indicating “continued failure of the State and its institutions” in contemporary times (8b). In example, the prevalence of all forms of abuse in care has risen from 6% to 8% (2b) despite efforts from Oranga Tamariki and other institutions to make improvements. In addition, 43% of girls in youth justice and care and protection residences are engaged in child sexual exploitation in the form of prostitution (8b).

The Materialisation of Child Sexual Abuse in Residential Care as State and Institutional Failure: Systemic Failures

The failure of the State and its institutions was legitimised through the materialisation of social structures and systems which permit abuse to occur, and which exemplify failures of the State and its institutions in its obligation to protect young people in residences and other care settings from abuse. Individuals describe the “dreadful way” agencies conducted themselves over decades (2b) and how the care and protection system is a “fully funded failure model” (8b, 13b). They highlight systemic, structural, and practical failures (3b, 4b, 5a, 6a, 8b, 11b, 13b, 16a); inadequate handling of complaints (1b, 4b, 5b, 7b, 8b, 10b, 12b, 21b); insufficient reporting and inadequate investigations (3b, 4b, 5b, 7b, 8b); inadequate resourcing of the care system (4b, 5b, 13b, 19b, 21b, 22b); failures in vetting and staff training (1b, 5b, 6b, 8b, 12b, 14b, 16b, 24b); employee transfers across institutions despite accusations of abuse (5b); instability in care placements (19b); “negligent” oversight, monitoring and accountability (3b, 5a, 11b, 13b, 21b, 22b); a tolerance for abuse (5b); and a failure to implement recommendations from earlier reports and inquiries (4b) or a failure to reduce abuse in care despite implementing recommendations to policy, practice and legislations from the 1950s to the present day (19b).

The failures of the State and its institutions are said to be consistent, continuing from 1950 through to the present day (8b, 11b). Interestingly, one survivor also describes an occasion when a staff members responded appropriately to abuse, preventing abuse from reoccurring (6a). Through this statement, the survivor reinforces the discourse of child sexual abuse in residential care as State and institutional failure by demonstrating a time when abuse was prevented through an adequate institutional response:

There was one staff member who did listen. She was this gypsy looking woman, she wore velvet skirts and she had a good āhua. I told her about what was happening and she sat with me one time during a visit. But she wasn't always on when the bad stuff was happening and there was no one else to tell (6a).

In addition to the statements and utterances used to describe the failures of the State and its institutions which lead to abuse in care, seven major themes were identified from the data which exemplify the social structures and systems that permit abuse to occur: underinvestment in professional capabilities, vetting blind spots, inadequate complaints and grievance processes, a culture of tolerance, poor internal monitoring and oversight, inadequate external monitoring structures, and questionable accreditation and monitoring of 396 providers.

Underinvestment in Professional Capabilities

Underinvestment in Social Workers. The social worker is seen as a “pipeline into the complaints system” and an important function which fosters the “engagement and monitoring of the young person in care” (8b, 19b). While the young person usually has others within their ecosystem who can act as trusted adults (i.e. lawyers or community partners) the social worker is seen as the “primary safety net” for the child who – through qualification and employment standards – is obligated to establish and maintain a relationship with the young person (8b). When these obligations are appropriately met, and the social worker effectively establishes a high-trust relationship with the young person, this is said to encourage the disclosure and detection of abuse (8b). However, it is highlighted how children and adolescents in care report difficulties in establishing this relationship with their social worker (8b). While some young people report a good relationship, a larger portion report “poor relationships” and attribute this to inadequate social worker visitations (8b). This issue is said to be widespread with 62% of young people not visited at the frequency specified in their *All About Me*⁵ plan (8b). In addition to infrequent visitations, young people report inadequate social worker relationships stem from poor communication, multiple social workers/discontinuity of care, disinterest from the social worker (i.e., not listening, not asking questions), social worker disorganisation (loosing information), not being assigned a social worker, and never meeting their social worker (8b).

The inability for social workers to build a high-trust relationship is also attributed to a “devaluing of social worker practice” within Oranga Tamarik and its predecessor and an “underinvestment in the professional capabilities of the social worker” (8b, 19b). Social workers are said to have unmanageable caseloads (15 to 20 clients per social worker) and inadequate training and supervision, including Te Tiriti based training and supervision (8b, 19b). In addition, there has been an underinvestment in information systems which can ease workload and the use of in-house supervision training in place of professional qualifications in supervision (8b, 19b). These factors are said to have contributed to a “diminishment” in social worker capabilities including the social worker’s ability to deliver professional engagement and practice with young people that can foster high-trust relationships (8b, 19b). A workload and casework review by the Office of the Chief Social Worker in 2014 found effective leadership, support systems, and processes make a difference to the professional capabilities of social workers and the delivery of high-quality practice (19b). In addition, Oranga Tamariki recognises the need to enhance the mana of social workers across the sector to

⁵ An *All About Me Plan* indicates the minimum frequency of social worker visits to meet the young person’s needs based on a social worker assessment (8b).

better support young people in care through the development of a new accreditation programme which will move the workforce from a “light-touch approach” to a “deep and sustained bi-cultural approach” that will facilitate the formation of trusted-relationships and which focuses on reworking the purpose of social work practice toward child wellbeing and child safety (8b, 19b).

Underinvestment in Frontline Workers. Frontline staff within residences are also “not well supported” or “adequately trained” prior to placement within residences (8b). Speakers say the consequence of this is the “harm and abuse of young people in care” which was evidenced throughout the inquiry (8b). Unlike social workers, the Chief Executive has no statutory obligations to train and supervise frontline staff including residential care workers who have a high degree of intensity to their work (8b). This is argued to have led to “negligent training and supervision” in frontline workers (8b). There was a Residential Training School in place from 1970 to 1984 (19b). However, the programme was unable to meet demand and sometimes employees were placed into residences without undergoing the curriculum (19b). In addition, the training and supervision of frontline workers outside of this period is unknown and suggests an underinvestment in frontline worker capabilities (19b). Again, Oranga Tamariki recognises its failure to protect young people from harm through the provision of adequate staff training and supervision (8b). Despite not having a statutory obligation, it is planning to introduce a core curriculum for residential staff which is role specific (i.e. team leader, case worker, youth worker) and which includes aspects of trauma-informed practice (8b). The curriculum is designed for staff to complete before they have contact with young people in care (8b). However, the challenges in training existing employees with limited capacity to supplement the existing workforce while they undertake this training was also highlighted (8b).

Vetting Blind Spots

Weaknesses of the Vulnerable Children’s Act (2014). The Vulnerable Children’s Act (2014) was introduced on 1 July 2014, coming into effect on 1 July 2015 (18b, 19b). It requires all Government agencies with contact to children and young people to develop and implement safety checking of employees with contact to children as well as comprehensive child protection protocols (18b, 19b). The Act includes a definition for people who work with children (‘children’s worker’) and workforce restrictions that prohibit people with certain criminal convictions from working in core children’s worker roles (18b, 19b). Safety checking of workers is required every three years (18b). Oranga Tamariki’s police vetting processes are in line with these mandatory requirements (19b). However, despite these statutory obligations the speakers describe how the vetting process is “not a fail proof system” (18b). Blind spots within the Act mean young people are still exposed to risk

through exposure to volunteers (i.e. canteen workers, clergy), non-core workers who do not have direct access to children (i.e. maintenance workers), and those who work in the residence with children but who are not employed by Oranga Tamariki or the care providers (i.e. doctors, speech therapists, dentists), and site visitors (i.e. parents) (18b). In addition, while there is a requirement for three-year re-vetting cycles, this is “not enforced or audited” to ensure compliance (5b) and, as per an Oranga Tamariki employment policy, prospective employees with criminal convictions can receive an exemption that allows them to work with children (19b).

Police Vetting Oversight: Limitations of the Policing Act (2008). The Police vetting service exists under Section 9 of the Policing Act 2008 (5b). However, individuals explain how there is no clear statutory framework for vetting which creates uncertainty about what information should be considered as part of the vetting process, suggesting at times police may disregard important information including allegations of abuse which do not result in conviction (5b).

Internal Vetting Vulnerabilities: Oranga Tamariki Personnel Fail to Identify Abusers. Oranga Tamariki's vetting process includes checking its own database for employee histories of abuse or harm in addition to police vetting for convictions (8b). However, monitoring of its own database was found to be vulnerable to employee error (8b). Counsel described a case where a man accused of raping two girls in the mid-1980s at Dunedin Girls Home was reemployed at Epuni Boys' Home in the early 2000s regardless of his file clearly stating “not suitable for employment” (8b). This employee abused several young people when reemployed which was identified by the historical claims unit in 2011 (8b). He is now serving a 13-year prison sentence for the rape of female children aged 10 to 15 years at Dunedin Girls Home in the first half of the 1980s and, at the time of the inquiry, he had recently been denied parole (8b).

Poor Interagency Oversight: Counsel Call for a Centralised Register of Complaints. Concerns are raised about the ability of employees who have unsubstantiated abuse allegations to transfer across agencies “undetected” (8b). There are currently no protocols in place for interagency information sharing and there is no centralised register of abuse allegations (8b). Information about allegations of abuse, subsequent investigation and assessment, and outcomes are held on individual case files (8b). Unsubstantiated claims are recorded only on the young person's file while substantiated claims are recorded against the employee's file (1a, 8b). This is said to be a major risk in terms of safeguarding children with unsubstantiated claims not searchable or identifiable during the vetting process (1a, 8b). It also limits the ability of Oranga Tamariki to monitor the number of allegations of abuse against a single staff member (1a, 8b). At present, the agency only monitors substantiated claims rather than allegations of abuse (8b). This is considered problematic due to the

high number of unsubstantiated claims which have been found to be truthful through the course of the inquiry (8b). Under the current measurement approach, if various children at different times are raising unsubstantiated complaints about the same person this will go undetected and, in addition, Oranga Tamariki is unable to identify the scale of abuse allegations (1a). In response to this issue, counsel for the Royal Commission call for a centralised register of complaints against employees (both substantiated and unsubstantiated) which is accessible by all agencies and where employers and authorities can see when multiple allegations of abuse are being made against an employee across multiple care settings and/or agencies (8b).

Inadequate Complaints and Grievance Processes

A Poorly Communicated Complaints System: Young People Unaware of Their Rights. Young people describe “not knowing they can complain” or “how to make a complaint” (6b, 19b). This trend is not limited to the scope of the inquiry and is a persistent issue in the present day (8b). Data from 2020 to 2021 shows of 7056 young people in care, 1400 complaints were received but only 1% (14) of these complaints were made by young people themselves (8b). This included young people in third party residential care settings, whānau care arrangements, and those who had left care but who remained in the custody of the State (8b). Young people were also unaware of VOYCE, which is an advocacy group for young people in care (8b). Only 46% of young people knew about the service and only 26% knew how to contact the service (8b). This is despite Schedule 2 of the Oranga Tamariki (National Care Standards and Related Matters) Regulations 2018 (National Care Standards) specifying young people in care must understand their rights to care and support and despite VOYCE having the ability to make direct contact with young people in care to connect them with the organisation (8b). In addition, while there is an anonymous complaints box accessible in all residences which is clearly communicated on admission and which are referred to VOYCE, issues arise when anonymous complaints are made and/or when staff members are not named because complaints of this nature cannot be investigated (8b).

An Untrustworthy Complaints System: Power Dynamics Prevent Disclosure. Individuals also describe the complaints system as “untrustworthy” and young people in care are said to repeatedly describe the system in this way (10b, 21b). One young person states: “...I don’t use it ‘cause I don’t see the point. Nothing’s ever done. Have put them in. Don’t waste my time doing it” (21b). There are specific concerns raised about “who they can trust”, “if they will be kept safe”, or “if their complaint will be appropriately managed” (10b). This distrust is said to stem from the power imbalances which exist in the care and protection space and in the complaints system itself (10b, 21b). Young people describe how they are “frightened” to make a complaint when their welfare is

dependent on the people who they are complaining about and who provide their care (10b, 21b). To activate a complaint, a young person must ask a staff member for a paper-based form and by asking for this form they “forego any anonymity in the complaints process” (10b, 21b). This distrust in the system and the power dynamics which exist is said to prevent disclosure with “allegations of physical or sexual abuse rarely brought to light, resulting in false positives within quarterly reports where no complaints are recorded yet substantial abuse has occurred” (10b, 21b).

Other Issues of Concern: VOYCE, Dual Pathways for Complaints, Remote Locations, Inaccessible Complaints Systems. Other issues of concern were raised about the complaints system. Individuals describe how VOYCE is not available in all locations and how staff working in this agency are often “not adequately trained” to build rapport with the young person discouraging disclosure (10b). The system is also described as “confusing” with a dual pathway for complaints depending on the care setting, making the complaints system “difficult to navigate” (21b). Further, remote locations discourage frequent visitations by authorities which would identify abuse in these settings and the use of complaints lines or websites are described as “unrealistic” for young people who do not have access to phones or computers (1a). Another criticism includes the classification of complaints as either “justified” or “unjustified” (10b). When a young person’s complaint is marked as “unjustified” this acts as a deterrent for future disclosures (10b).

Whānau Oversight Safeguards Young People from Abuse. Whānau, hapu, and iwi are seen as providing an important level of oversight for young people (8b). The Independent Children’s Monitor (ICM) found 79% of complaints received by Oranga Tamariki were made by whānau (8b). Connecting the young person to these people within their ecosystem provides an opportunity for disclosure with a trusted adult (8b). However, it was illustrated by speakers how access to whānau visits or communication are sometimes restricted or “treated as a privilege rather than a basic human right” (8b). Tamariki and rangatahi report they do not have regular visitations with their parents, siblings, and whānau, including their grandparents, aunties, uncles, and cousins while others report a complete disconnect from whānau (8b). The main reasons given for infrequent visitations include the social worker “not following through on arranged or supervised visits” or “whānau dealing with trauma” which prevents them from visiting (8b). When interactions with whānau do occur, these are often monitored with care workers who read communication or supervise visitations to protect the young person from unsafe adults (8b) and this can provide a barrier to disclosure: “When I went for day visits or home on the weekend, I didn’t tell Dad what was happening. When Dad used to come and visit staff would be sitting there” (4a).

Repeated Calls for a Child-Centric Complaints System. Individuals describe how a child-centred complaints system has “never existed” and how one is “urgently needed” to prevent abuse in care (8b, 21b). The current system is said to be “confusing”, “cumbersome”, “not child friendly”, “overly bureaucratic”, “not fit-for-purpose”, “untrustworthy”, “risks re-traumatising young people”, and “inadequate” at identifying young people who are experiencing abuse in care (21b). It is argued a child-centric complaints system would “draw out abuse as it happens” and this would “act as a deterrent” for perpetrators (8b). A child-centred complaints system is described as “child and family friendly”, “accessible”, “independent”, “timely”, “trauma-informed”, and subject to “robust oversight” (21b). In addition, it would address the “power imbalances which exist within the current system” by allowing the child to make direct contact with the complaints system rather than having issues “pass through staff who are charged with providing their care”, who may be concerned about employment consequences if abuse allegations come to light, or who “may be responsible for the abuse the child is suffering” (10b, 21b). In addition, it also needs to be “accessible” through multiple mediums with survivors describing various preferred mechanisms for seeking help including a phone call, text messages, and social media messages which may be to trusted adult or a trusted advocate who is independent from the system (10b).

A Culture of Tolerance

A culture of tolerance toward abuse from which employees and agencies turn a “blind eye” is discussed (3a, 15a). Speakers describe how employees and institutions “let it happen” (4a), “enable staff to get away with abuse”, and how this culture of tolerance plays an effective role in “fostering abuse” (5a, 16a). The culture of tolerance materialises through the non-compliance of child protection protocols, non-compliance with complaints systems, non-compliance with the Public Service’s code of conduct, and a no marking culture.

Non-Compliance with Child Protection Protocols. Child protection protocols are living documents which outline the process and procedures that services must follow to keep children safe, ensuring potential abuse and neglect as well as concerns about general wellbeing are identified and appropriately responded to (18b). Under the Vulnerable Children’s Act (2014) Government agencies must have a child protection protocol in place (19b, 23b) and under Regulation 69 of the National Care Standards any complaints or allegations of abuse or neglect should trigger the child protection protocol where a report of concern should be lodged (5b, 8b, 19b). The report of concern may result in police investigation including a Mass Allegation Investigation which is prompted when there are three or more victims of abuse linked to a setting such as a residence (5b, 8b, 19b). The child protection protocol also sets out joint operating procedures which describe the working

arrangements or responsibilities across agencies when dealing with allegations of abuse in care (5b, 19b). Despite these protocols being in place, the Office of the Children’s Commissioner (OCC) commonly receives “complaints of non-compliance with these protocols” and has had to use the “threat of investigation to compel parties to act in accordance with their own policy and standards for the best interest of the child or adolescent” (21b).

Issues with non-compliance with protocols and failures to respond to abuse have extended throughout the scope of the inquiry to the present day. Individuals describe how despite the presence of policies (i.e., Field Officer’s Manual Child Welfare Division 1965) which clearly articulate the responsibilities of employees to respond to allegations of abuse, including the involvement of law enforcement, these policies were often “not acted upon” (8b). One survivor described how abuse allegations were not appropriately investigated and instead how employee resignations and transfers were used to address the issue which allowed perpetrators of abuse to “slip away quietly” or for abuse to continue (5a). The Royal Commission echoed this sentiment, highlighting how the safety of children and adolescents in care were “not at the centre of the decision-making process” and how Oranga Tamariki has, at times, transgressed from its responsibilities under the child protection protocol (8b). At the time of the inquiry (2022), 10 current employees of Oranga Tamariki were found to have serious allegations of abuse, including sexual abuse, lodged against them through the historical claims process in 2006 (8b, 11b). The allegations are of a “serious nature” including a staff member forcing boys to perform oral sex on another staff member, a staff member forcing a boy to rape another boy, and staff member massaging and raping boys (8b). The historical claims unit paid out 18 claims for abuse by one of the staff members alone, which signifies the truthfulness of the claims (8b). As per the *Child Protection Protocol: Join Operating Procedure* for historical abuse claims:

Consideration must be given to whether the alleged offender still has access to children and/or young people and may still be offending [...] Action must be taken to mitigate risk to any children and/or young person who may currently have contact with the alleged offender (19b).

Despite the information provided about the nature of the allegations, the decision of Oranga Tamariki was that the allegations of abuse “were not of a serious nature”, there were “no active concerns” of staff having day-to-day contact with young people, and that an investigation “was not required unless further information came to light” (8b). One of the employees continued to work for Oranga Tamariki, with access to children, from 2009 until the Monday of the State institutional response hearing in August 2022 when Oranga Tamariki came under scrutiny for its failures to

protect young people in care and its failure to adhere to child protection protocols (8b, 11b). Oranga Tamariki was unable to confirm at the hearing if the other nine staff members were still employed within the institution (8b).

Non-Compliance with Complaints Processes. In addition to non-compliance with child protection protocols, speakers discuss substantial “deviation” from complaints processes (21b). Young people can make complaints about the grievance process to the OCC and the Grievance Monitoring Oversight Committee about the complaints and grievance system (10b, 21b). In 2020/21 the Child Rights Line (facilitated by the OCC) received 352 phone calls of complaints about the complaints and grievance process along with hundreds of other emails and enquiries (21b). Non-compliance with the complaints system has also been “consistently highlighted” in quarterly reports which are disseminated to the Deputy Chief Executive and other decision-makers in Oranga Tamariki (21b). Despite this evidence, there is no statutory provisions which allows for the enforcement or accountability of agencies or employees who do not comply (21b). Flawed reporting from non-adherence to complaints protocols provides “scant evidence of abuse which occurs in residences, undercounting and minimising the issue” (1b). Further, when staff do act on complaints this is sometimes through alternative means other than the internal complaints process with “the media seen as a more trusted source of action than senior leaders within the institutions”, suggestable of a culture of tolerance which exists throughout the agencies, among the institution’s leadership, not just within residences (8b).

Non-Compliance with Public Service Code of Conduct. The minimum standards of integrity and conduct for public servants are set out in the Standards of Integrity and Conduct (the Code of Conduct) under the State Sector Act 1988 (24b). The code applies to all public service employees and Crown entities (24b). It requires public service employees are fair, impartial, responsible, and trustworthy and that they act in the “spirit of the service to the community in which they serve” (24b). However, public servants have not always acted in accordance with the code of conduct and this is said to have “failed in the safeguarding of children in care” and has “perpetuated abuse in care” (24b).

No Narking Culture Discourages Disclosure from Survivors. A strong “no narking” culture is described as discouraging disclosure (2a, 3a, 8b, 10b, 12a, 23a). When reports of abuse were made this results in punishments such as: a young person’s privileges being revoked (6b, 8b); the young person being sent to the secure unit (6a, 8b); the young person being “beaten” and “bashed” or “stomped” by staff or other young people (2a, 3a, 8b, 23a); and being labelled a “nark” which encourages alienation from the group (2a, 12a, 10b, 23a). A fear of consequences (2a, 3a, 8b, 21a,

23a) for speaking out or reporting abuse developed from these punishments and threatening conversations (19a), which discouraged disclosure, or which minimised the extent of disclosure (8b). Survivors learnt they had “no voice” and that they had to “adhere to a code of silence” (8b, 21a). This became so ingrained that even when a young person was with a trusted adult, they were unable to disclose abuse (12a, 23a). One survivor even speaks of how he himself promoted the code by protecting younger residents from the consequences of code transgression, telling them to “shut up, say nothing, back off” (21a). An Independent Children’s Monitor report from June 2021 found this culture still acts as a barrier to disclosure and is deemed to be a more significant barrier to disclosure than the complaints procedure (8b).

No Narking Culture Discourages Disclosure from Employees. Individuals also discuss how no narking cultures are also found among employees (24b). Similar to young people, the consequences or disadvantages of disclosure including punishment or reprisal can deter employees from speaking out against abuse (24b). In addition, fear of loss of employment can also act as a deterrent and has been a “very real consequence” for employees of some residences who have spoken out about abuse in the past only to have a residence “closed and their employment ceased as a result” (8b). To encourage public service employees to “speak up about wrongdoings” by other employees safely and without “fear of consequences” the Speaking Up Model Standards were introduced by the Public Service Commission in 2017 (24b). The model standards outline the expectations for public service agencies to support staff who speak up about concerns and it comprises what is said to be key elements of a speaking up culture: organisational commitment and operating good processes including timely investigation and keeping employees safe. When reports are made about a serious criminal activity these must be reported to the police (24b). In addition, the Protected Disclosures Act 2000 was amended to strengthen protections for whistleblowers (24b).

Calls for a Call out Culture. Individual’s discuss the need for a “call-out-culture”, which is said to be the most effective way to minimise inappropriate behaviour in the workplace (5b, 8b, 13b). In contrast to the culture of tolerance which currently exists, a call-out-culture puts the child at the centre and moves away from safety in care “being an assumption to safety in care being an expectation” (8b). A call-out-culture must be “headed by the management and leaders” of residences and institutions who encourage the disclosure of complaints from both young people and employees through good policies and processes that give “direct lines to senior leaders” and which make “people feel safe to say when things are not right and without fear of repercussion” (8b, 21b, 24b). It also requires a workforce strategy that lifts the quality of practice and responsibility of the care and protection for the child across the child’s ecosystem (social workers, youth workers, youth advocates, VOYCE advocates, teachers, health providers) (8b).

Poor Internal Monitoring and Oversight

Oversight and monitoring is considered one of the “strongest safeguards the State has to ensure the safety of children in care” (8b). However, significant failures in the oversight and monitoring practices of Oranga Tamariki is said to have contributed to children not being kept safe from harm (3b, 8b).

Annual Reports: Scepticism Toward True Transparency and the use of Preservation Data.

Oranga Tamariki produces a series of annual reports including the rates of abuse for children in care (19b). The rates of abuse have been reported since 2010 however inconsistencies in methodology mean reports are not comparable (19b). The Safety of Children in Care Unit was established in 2018 to improve reporting in this space, including the use of a consistent methodology that would allow for a more comprehensive understanding of abuse overtime (19b). The Unit has published annual reports for the 2018-2019, 2019-2020 and 2020-2020 periods; bi-annual reports for the period July to December 2020 and July to December 2019; and quarterly reports for Q4 April to June 2019; Q3 January to March 2019; Q2 October to December 2018; and Q1 July to September 2018 (19b). In addition, the measurement team reviews all findings of harm for young people in care to understand how this occurred, how the agency responded to the young person's needs, how the safety and wellbeing of the child was managed, and how prevention of future harm is being considered (19b). Annual reports are also submitted to the Minister of Children about Oranga Tamariki progress in respect to the Future Direction Plan⁶ (19b). However, while there are a series of annual reports or internal monitoring processes in place, the use of this mechanism comes under scrutiny of some speakers who are sceptical of annual reports which are “not produced independently” from the agency, which arguably produces preservation data that protects the institution, and which “bears little resemblance to what actually occurs in the institutions” (8b).

National Care Standards: Methodological Difficulties Limit Ability to Measure Quality and Assurance. Speakers describe how there have been continued failures by Oranga Tamariki (and its predecessor) to measure quality and assurance, including abuse in care. Oranga Tamariki (National Care Standards and Related Matters) Regulations 2018 were introduced as a monitoring function in 2018 replacing the Residential Care Regulations 1996 (19b). Section 69 of the care standards stipulates duties in relation to allegations of abuse or neglect in care. The new care standards require each residence to be inspected annually to ensure they are being met alongside obligations under the Oranga Tamariki Act 1989 (19b). The standards were implemented through codes of practice and were introduced because Oranga Tamariki’s predecessor (Child, Youth, and Family) was

⁶ The Oranga Tamariki Future Direction Plan sets direction for Oranga Tamariki for the next two to five years.

failing in the care and custody of young people based on evidence within various reports including the *Rebstock* report (2015), *Death of a Child* (1988), *Poweo*, the *Mason* report, the *Brown* report and the *Mel Smith* report (1b). Prior to these standards there was “no framework for monitoring the quality of care provided to young people” (1b, 8b). The standards provide a “minimum benchmark for care that must be provided and can be monitored” (1b). The Chief Executive is required to self-monitor compliance with the standards and have systems in place for continuous improvement (Regulation 86) while the ICM must assess compliance with the standards (8b). However, due to methodological limitations Oranga Tamariki is only able to produce data for 5% of the 199 measures within the care standards (19b) and is therefore “unable to satisfy it is meeting its care requirements” (1b, 8b).

Secure Unit Blind Spots Expose Young People to Risk of Sexual Abuse. In addition to poor oversight and monitoring from a reporting perspective, individuals also highlight poor internal oversight of the secure unit which “exposes young people to risk” of sexual abuse (7b). The remote location and “out-of-sight nature of the unit” is said to increase risk and dangers of being sexually abused through lack of oversight and “disconnect from the rest of the residence” (7b). While in the current day there is closed circuit television (CCTV) footage of the secure unit which is monitored 24/7 in real time, the young person’s bedroom, toilet, and bathroom are not monitored which is where survivors describe abuse taking place within the secure unit: “A lot of things happened down in the secure unit. I can still hear the screams and cries from other boys when they get taken into the shower block. That's where the abuse happened in the secure shower block” (7b; for more examples see *Sexual Abuse as Punishment*, *Child Sexual Abuse as a form of Control and Punishment*).

The use of secure exposes the young person to risk of abuse and is said to still be a prevalent practice in most care and protection and youth justice residences today (7b, 10b). Between January 2015 and March 2021 young people in youth justice residences were placed into secure 6,518 times while those in care and protection residences were placed into secure 2150 times (10b). This is despite the use of seclusion being banned and characterised as abuse by other Government departments like the Department of Education (7b, 10b). While facilities are “phasing out” the use of secure it has not been banned and is still permissible under current regulations (7b, 10b).

Inadequate External Monitoring Functions

Divided External Monitoring Functions Runs Counter to Effective Monitoring. The ICM, OCC, and Office for the Ombudsman are said to be responsible for monitoring the “highly intrusive, and coercive powers” of Oranga Tamariki (24b). These entities are responsible to ministers and parliament for providing information and identifying issues (19b, 24b). Changes have been made to

the monitoring and oversight system through the Oversight Bill, which is argued by some speakers to “run counter to effective monitoring” (2b). Through the former system the OCC, under the Children’s Commissioner Act 2003, had the three key areas of responsibilities in representing young people in care: advocacy work, complaints monitoring, and monitoring processes and practices (10b). However, the three functions are now split among three agencies – the OCC, the ICM, and the Ombudsman (10b). The Ombudsman will address complaints and grievances, the ICM will monitor the processes and practices of Oranga Tamariki, and the OCC will carry out an advocacy role and maintain its Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) monitoring function, which is a monitoring role under United Nations obligations ensuring young people in places of detention are not harmed or tortured (10b). Concerns are expressed by individuals about the system becoming “divided with the advocacy function separated from the monitoring function” (10b). Those who work in advocacy argue “evidence informs advocacy therefore the two monitoring functions should work together rather than in isolation” (10b). Survivors of abuse and young people within the system voice similar concerns about the decision to divide through the Oversight Bill, stating it causes difficulties in “navigating the system” and will cause frustration in having to “repeat concerns across three agencies” (10b).

Under Resourced OCC Fails to Deliver on Independent and Broad-Based Monitoring Functions. Under the previous monitoring system, the OCC had “broad-based monitoring functions” which would allow for “robust monitoring” of the care and protection system including residential care (10b). It was established in 1989 as an independent advocate for young people in response to criticism that the system was “Eurocentric and did not meet the needs of and discriminated toward Māori” (19b). The functions of the OCC are set out in the Children’s Commissioners Act 2003 and the Oranga Tamariki Act 1989 (19b). The Children’s Commissioner’s Act 2003 specifies the OCC can “investigate issues, but it does not specify what the OCC must investigate, to what extent, and how” (22b). This has maintained the independence of the OCC to set its priorities and allocate resources to different functions (22b). The Act stipulates the OCC can “investigate any decision or recommendation made, any act done, or omitted in relation to any child or young person which enables the children’s rights advocacy role” (19b). It also stipulates the OCC can “assess the policies and practices of the department and the policies and practices of any other person, body, or organisation that relate to the performance or exercise by the person, body, or organisation of a function, duty, or power under the Oranga Tamariki Act 1989” (19b). The OCC is also mandated under the Crimes of Torture Act 1989 to give effect to OPCAT monitoring (19b). OPCAT obligations were delegated to the OCC to make good use of public funds with OPCAT and Oranga Tamariki Act

monitoring functions to be undertaken together through a blended approach (10b). Through its OPCAT mandate the OCC monitors the treatment and conditions in Oranga Tamariki places of detention including care and protection, youth justice, and youth justice community remand homes (19b). In executing this role, it has the same powers in its monitoring function of Oranga Tamariki under the Children’s Commissioners Act 2003 (19b).

Despite having these “independent and broad-based powers”, individuals describe how the OCC has never received “adequate funding” to carry out its duties and iterate how if the OCC were adequately funded “all monitoring requirements would have been achievable” (10b, 21b). In exemplifying the inadequacy of its funding allocation, the OCC explains how it was only allocated \$3.157 million per year to complete its broad-based monitoring functions (10b). This is compared to the newly established ICM which has an operating budget of \$44 million over four years to exclusively deliver systems monitoring (10b). Unlike other independent crown entities, the OCC does not have a direct relationship with treasury (21b). Instead, the OCC’s funding is controlled by MSD with MSD seeking funding on behalf of the OCC in its vote to parliament (21b). The OCC has found it “difficult to have budget bids considered seriously” by MSD with the agency “managing back” expectations of the OCC due to its own funding priorities and because of the OCC’s tikanaga Māori approach, which encourages high rates of participation from young people in the monitoring process, but which is not seen as an “efficient or effective use of public funds” by MSD (10b, 21b). Repeated submissions have been made to successive Governments, ministers, MSD chief executives, select committee hearings, and the media advising how funding limitations have impeded the OCC’s ability to deliver on its monitoring functions (21b). Due to the funding structure, the OCC has “never been able to execute its statutory duties and functions including its monitoring mandates” (21b) and because of this the OCC has had to “prioritise monitoring functions” based on areas deemed most important – for children most at risk – and based on international OPCAT obligations (10b). This has resulted in the neglect of other care arrangements and despite a focus on places of detention the OCC was “not able to complete the required annual oversight of all places of detention” (10b). Even with changes to its monitoring mandates and reduced responsibility, the OCC has still not received adequate funding to complete its monitoring mandates (10b, 21b).

Monitoring Without Action: Limited Capacity to Influence and Enforce Change. External monitoring functions were also scrutinised for having “limited powers in influencing and enforcing change” (10b, 22b, 24b). The OCC has had the power to make recommendations based on the findings from its monitoring functions since 2003 (10b, 22b). However, there is no corresponding requirement for these recommendations to be applied into policy or practice (10b, 22b). Speakers describe how successive commissioners “have not been responded to by the Government of the day

or responsible agencies despite significant concerns raised” (22b). In addition, the current ability to enforce change is limited to the Public Service Commission which provides policy briefs to relevant Ministers for consideration in policy agenda setting (24b). The Public Service Commissioner is responsible for holding chief executives of government departments and agencies to account for resolving any issues identified by the three monitoring agencies (OCC, ICM, Ombudsman) in respect to breaches of existing systems or employment obligations (1b, 24b). However, any recommendations to change systems are escalated from the Public Service Commissioner to related ministers through policy advice, which includes technical advice on how the structures of government can be arranged to support desired outcomes (24b). The Public Service Commission is “reliant on Government ministers for developing policy in alignment with these recommendations in order to improve the system based on feedback from external monitoring systems” (24b). However, the uptake of policy advice is said to be heavily dependent on the “policy agenda of the Government which is set by public opinion, to maximise the vote, and which makes it harder to enforce change” (24b).

The State-Run (Independent) Children’s Monitor. The importance of independence in external monitoring functions is iterated as an important function of effective and transparent monitoring (10b). The ICM was established in 2019 in response to the *Beattie Report* which was commissioned by the MSD to identify ways in which the independent oversight of Oranga Tamariki could be improved (1b). The report made recommendations for a systematic monitoring system which provides credible and independent evidence-based assessment (1b). For independent oversight to be achieved, the report recommended “two full time statutory commissioners” – a Children’s Commissioner and a Commissioner of Care and Protection – each with separate roles and statutory requirements who would be publicly notified (1b). However, the ICM has been established as a government departmental agency with its monitoring framework designed by MSD in alignment with the with the National Care Standards, information disclosed on abuse and neglect, and how Oranga Tamariki is responding to National Care Standards 69 and 86 (1b). This is said to remove the “independence” of the monitor (21b, 22b).

Speakers argue the ICM “cannot be independent of the Government as it is a government department with public servants as employees who cannot speak truth to power, who are employed to implement the decisions of ministers who are elected to represent the will of the people, whose responsibility is to the government and the Crown, and who cannot criticise the government as per the Public Services Act” (10b, 24b). In addition, the role of the ICM is viewed as a “data compilation” and “monitoring” function rather than an advisory role (10b). This sits in contrast to an independent crown entity which is “a step back from the government, which does not have the same obligations

to ministers as public servants, and which has the power criticise and provide advice” (10b). In addition, the monitoring function of the ICM does not sit independently from Oranga Tamariki (9b). The ICM is reliant on the provision of self-monitoring data from Oranga Tamariki in order to monitor compliance with National Care Standards. At the time of the inquiry, Oranga Tamariki was only able to provide data for 5% of 199 measures of National Care Standards and this is said to “limit” the way the ICM can conduct its external monitoring function (8b).

Overall, a lack of independence in the ICM is said to bring about issues of “trust in the quality of evidence being presented”, “how complete it might be”, and “how it has been informed” while the lack of advisory capacity is said to be a “natural limitation of the structure of the ICM as a government agency but a major oversight in the monitoring of the system” (10b). Individuals iterate that “the State cannot monitor itself” (10b) and that changes to the Oversight Bill were “offensive and insulting to survivors”, “not representative of progress”, “detrimental to gaining public trust”, and “a consolidation and retention of power and control” (10b, 11b): “There are fears about the deliberate steps taken by the State to remove the checks and balances for a system which has the most feared powers of them all, that is the ability to take you child away” (10b).

The Ombudsman and Oranga Tamariki: Suspicious Working Relationships. The working relationship between the Ombudsman and Oranga Tamariki raises “suspicion among survivors” and other speakers (8b). The Ombudsman has jurisdiction to receive complaints about the State care system including Oranga Tamriki (19b). It tries to resolve problems with the system and can investigate and make recommendations, if necessary (19b). Like the OCC, it is independent and not part of the Government. However, when addressing complaints, the Ombudsman works with Oranga Tamariki to “access information held by the agency” in relation to the complaint (8b). The interactions between the two agencies are said to be “transparent and discoverable for public accountability” and there is regular liaison between the offices to ensure timely and accurate information is provided as per each parties’ obligations (8b). However, given Oranga Tamariki’s “strong hold on data”, speakers argue “consideration should be given to other ways that this monitoring process could function which is completely independent from Oranga Tamariki” (8b).

Calls for a Well-Resourced Independent Oversight and Monitoring System. Across all of the criticisms of the external monitoring functions – the OCC, the ICM, and the Ombudsman – speakers reiterate the importance of an “independent oversight and monitoring system which addresses advocacy, complaints, and systems and practices” (10b) and which has “the powers to investigate, recommend, and enforce action” (22b) to prevent and eliminate abuse in care (10b). In addition, they state the system needs to be “child-centred”, “easily accessible”, has “speciality insight for

supporting whānau” in need, and appropriately applies the principles of Te Tiriti (10b). Without this, they argue the system will remain unchanged (22b).

Negligent Oversight and Monitoring of Third-Party Providers

A “significant portion of abuse” which occurred in the 1990 happened under the care of third-party providers, specially 396 providers (8b). Third-party providers (or 396 providers) are agencies which provide the day-to-day care of young people in State care (19b). 396 refers to part of the Oranga Tamariki Act which allows for an organisation to receive funding from Oranga Tamariki given they have received a 396-accreditation status (8b). The Family Court can make a custody order or sole guardianship order placing the child or young person in the legal custody of these organisation (as an alternative to placing in the legal custody of the chief executive of Oranga Tamariki) (19b). The parent, guardian, or person having the care of the child or young person may enter into an agreement with these organisations (19b). Oranga Tamariki can also place Tamariki with 396 providers but retain custody of the child, in these cases the 396 provider may be referred to as a ‘care partner’ (19b). Oranga Tamariki can place a child or young person with a care partner without the organisation being approved as a section 396 provider, provided that Oranga Tamariki has assessed the organisation is suitable to provide for the child or young person’s care, control, and upbringing (19b). These partnerships are said to bring “special skills and expertise to facilitate the care of young people who are high needs or for iwi-based care for young Māori” (8b). Approximately 20% of all care arrangements are facilitated through third party providers and this number is expected to increase in future years as Oranga Tamariki encourages a shift to iwi and community-led organisations (8b). Individuals argue that due to current inadequacies and an increased need for 396 providers in the future there needs to be improvements to how 396 providers are accredited and monitored through a process which provides greater clarity and assurance (8b).

Suitability and Accreditation of 396 Providers. The accreditation process is described as a “warrant of fitness” which provides “assurance that organisations can safely deliver services and that the organisation has strong and safe business practices” (1b). The accreditation process has evolved overtime and speakers describe a “robust” accreditation process (1b). However, they also highlight how accreditation failures have resulted in “unfit organisations” being accredited and “real-world consequences” occurring including the sexual abuse of young people in care, iterating the need for robust approval, monitoring, and oversight of these providers (1b). Accreditation failures were found with two 396 providers where abuse was considered extensive (1b). Moerangi Treks was given an initial accreditation which was later found to be “inappropriately administered” and Whakapakari was given a re-accreditation which was also found to be “inappropriately administered” and which resulted in “extensive abuse to young people” (1b). In addition, individuals

also highlight the risk of 396 directors, who managed residences that tolerated abuse, reapplying for funding and 396 accreditation (1b). There is currently no database or system to screen for this risk when accrediting a new 396 provider (1b).

Independent Complaints System for Third Party Providers. 396 providers have their own complaints system which is seen as a “risk to safeguarding young people from abuse” (8b). 396 providers must satisfy Oranga Tamariki through the accreditation and review process that they have a good complaints system in place which is evidenced by “how these processes are described in policy” (8b, 19b). In addition, third-party providers must notify Oranga Tamariki of any incidences of harm and may also have an agreed escalations pathway with Oranga Tamariki as part of a relationship management plan (8b, 19b). They must also ensure young people know how to make complaints (19b). The monitoring of the complaints process for third party providers is largely reliant on “reviewing the policies and procedures of the system rather than reviewing its effectiveness in flushing out complaints” (8b).

Negligent Oversight and Monitoring of 396 Providers. A series of concerns regarding the oversight and monitoring of 396 providers was discussed. Oranga Tamariki monitors 396 providers through a quality assurance function (19b) which involves an annual cycle for regionally-led quality assurance and a two year cycle for nationally-led quality assurance (8b). During quality assurance processes care partners are required to share insights and information (8b). However, the quality assurance process is criticised by a “lack of involvement from the service-user” in the design of this process and a lack of involvement from “young people, whānau, and iwi in the monitoring process” (8b). In addition, while 396 providers are supported to establish National Care Standards into policy and practice and adhere to care standards, Oranga Tamariki is “unable to assure” whether 396 providers are meeting these standards and whether the providers would be able to produce adequate data for assurance purposes (8b). This is complicated by differing data collection methods and IT systems which exist across providers (8b, 19b). In acknowledgement of this shortfall, work is currently being completed to improve data exchange and monitoring of standards in third party providers (8b).

Individuals also highlighted gaps in the monitoring of these providers through the ICM. The ICM lacks statutory mandates to monitor majority of these providers (10b). The ICM’s current monitoring powers include Bernardos, Open Home Foundation and Dingwall Trust (19b). However, other third-party providers are not currently monitored, and reports produced by the ICM at the time of the inquiry did not include any 396 providers (1b, 8b, 19b). The ICM is exploring ways of improving monitoring of 396 providers in the future but, as with its monitoring of Oranga Tamariki,

the ICM is reliant on self-monitoring data of 199 measures from the National Care Standards (8b). In addition to negligent oversight of 396 providers by the ICM, the OCC's admits "inadequate monitoring" due to its funding model (10b). The gaps in the monitoring of 396 providers is said to be a significant failing and unacceptable with a large portion of the system currently unmonitored, leaving uncertainty around whether or not young people are safe and well cared for within these providers (10b).

Inadequate Funding of 396 Providers. A consistent theme throughout the inquiry was the inadequate funding of 396 providers (8b). Some argue that as a natural consequence the quality of care was compromised (8b). However, others say under resourcing is not an excuse for the abuse that occurred (8b).

The Development of Adaptive Survival Behaviours in Residents who Protect Themselves from Abuse

In addition to the systemic failures described, a compelling discursive materialisation of the State and institutions' failure to protect is the development of adaptive safety behaviours in survivors. Survivors report having "no one to fall back on" (10a), "no one they can trust" (2a, 6a, 10a, 11a, 12a, 17a, 19a, 21a, 23a), and how they need to "learn to survive" (3a, 4a, 6a, 10a, 21a). As such, they developed various safety behaviours to protect themselves and others from sexual abuse. Taken together, these self-defensive and protective behaviours demonstrate the creativity, courage, and resilience of children and young people who are faced with extreme adversity. They also demonstrate the need for young people to protect themselves from harm because of the State and institutions failure to do so. Unfortunately, while these behaviours served a purpose while in care settings for many survivors these behaviours became ingrained and maladaptive in adult life.

Protecting Self. Survivors use a range of avoidance behaviours aimed at self-protection. For example, several young people were found to run away from the residence to avoid being raped and beaten (6a, 8a, 9a, 10a, 11a, 14a, 15a, 17a, 21a). One survivor describes his time away from the residence and the abuse he was suffering as bliss:

I think for a lot of boys that kept running away from that place, it was – for me it was – I was away from there in that short time doesn't matter, I wasn't being abused, I wasn't being raped, I wasn't being beaten up. For a runaway like me and many boys, that time was bliss to us [21a]

Another speaks of how he learnt to urinate in his clothing to avoid the toilets where he was being abused: "It got to the stage I would urinate in my pyjamas so I didn't have to go to the toilet"

[23a]. While another details how he played on his injuries to have extended stays in hospital where he felt safe:

I went to hospital when I was in Owairaka. My file reflects this was on 1 August 1972. My hip was sore. It got better but I played on it a bit because I felt safe in hospital. A lot of boys tried to get to hospital. No one was hitting me, no one was sexually abusing me. You had nurses who cared about you as a kid [10a]

Young women would also pretend to be menstruating or collect soiled sanitary items to avoid forced internal examinations:

We would say we had our periods so we didn't have to undergo those examinations. They would make us show evidence of our period. So, when we did have our periods, we would hide the evidence, so when it came to the test day we had something to show [4a]

Another showed creativity in escaping his abuser. He intentionally damaged property to be transferred to another residence:

About five or six months after GRO-B-15 arrived at the Family Home I stole my best friend's bike from school and went to his house, then proceeded to smash it up when I knew the family was all out. I did this because I knew they would take me away from the Family Home for my behaviour. Mrs Pratt begged Social Welfare to let me stay with her. It was really difficult for me because I wanted to stay with her but also wanted to get away from GRO-B-15 [12a]

Māori or Pasifika learnt to hide their ethnic identity to avoid racially targeted abuse. While this behaviour was adaptive and used to avoid abuse it also exemplifies the cultural abuse and oppression experienced by these young people during their time in care in addition to the other abuse they suffered:

I hid that fact because I learnt in the boys' homes to keep my mouth shut about what race you were. They pounded that into me, that we were no good, we were dog shit. You lose your identity. I would think 'no I'm not Samoan because this is what happens, Islanders are no good'. As a child that's how you think, and that it must be right. Bad things happen to Islanders. Bad things happen to Māori [10a]

Protecting Others. Survivors also describe how they developed defensive behaviours to protect others. One survivor talks about how she sacrifices herself by purposely leaving the residence to travel home so her father would rape her instead of her sisters:

He would also tell me that I had to go to him or he would abuse my younger sisters who were still at home. I would go to the softball park down the road from Bollard where I knew he had left money for a taxi to go home in the ticket booth. I would get changed and go home to be abused by him. Sometimes I didn't go to protect myself but I would always be thinking of my sisters. Because of the guilt and constant fear for my sisters, I went most of the time [6a]

Another survivor speaks of how, after being raped by two older girls in the facility, she made a conscious effort to prevent this from happening to others in the future: “And I swore from that time on that nobody will go through what I went through, and when new ones come in I'd just kind of make sure that those girls kept away from them, yeah” [15a]. Through her efforts, others thanked her for protecting them from being sexually abused in care:

I was quite domineering, violent and disruptive. I never beat anyone else up, but I would stand over other girls. A lot of it was about having the reputation... A lot of those girls from Strathmore, even today, come and say thank you to me for looking after them there. I stopped them from being abused by other girls like I had been. As soon as those two girls left Strathmore it stopped. As far as I was aware, no more sexual abuse amongst the girls happened while I was there [4a]

Maladaptive Survival. While serving an important purpose when the young person is in care, these behaviours become engrained and extend into adult life where, at times, they become maladaptive. For example, survivors report avoiding internal examinations in adulthood which screen for cancer (1a, 4a): “I have struggled to go for smear tests because of the medical examinations I experienced in care. I've had cancer scares. I was so traumatised by those experiences” [4a].

As was seen in the discourse of child sexual abuse in residential care as harmful, whereby survivors exhibit retribution behaviours, a survivor feels a strong responsibility to seek out social justice through a self-driven investigation of Alan Moncrief-Wright during restorative justice conferences after inadequate convictions from the White trial:

So I went there trying to get information, but not to the extent of pressing him to the point where he would stop talking. So it was a delicate situation and we kind of at times played a game of chess where he gave away as little as possible, and I tried to get as much as possible, without pressing him to the point where he'd stop talking, and so I could also foster him for the future, if you like, in terms of further engagement [16a].

I wanted to give -- I wanted to get out of him more information about other people offending. And so I could have possibly pushed him harder in the initial conference I had with him about that, but decided I didn't want to push him too hard unless -- in case I pushed him to the point where he clammed up completely. So those four questions were designed to get more information [16a].

Chapter 5: Discussion, Conclusion, Limitations and Future Inquiry

This thesis aimed to uncover the discursive formations of child sexual abuse in residential care. It did this by answering two research questions: What are the ways in which child sexual abuse in residential care is understood? What are the conditions which legitimise or silence these understandings? Using a Foucauldian Discourse Analysis six discourses were discovered that provide useful insight into child sexual abuse in residential care: control and punishment, fabrication, harmful, power and oppression, shameful, and State and institutional failure. This chapter sets out a summary of each discourse in relation to what was found for both research questions and an overarching conclusion of the research findings. Next, a brief overview of the weaknesses and limitations of the research is presented. The chapter concludes with recommendations for future inquiry.

Summary of Research Findings

Discourse 1. Child Sexual Abuse as a Means of Control and Punishment

Statements and utterances identified within the discourse *of child sexual abuse in residential care as control and punishment* were reminiscent of prison culture with individuals describing how an ideology existed within the residences which focused on the control and punishment of young people who were placed into a harsh prison-like settings akin to adult prisons. This discourse was legitimised by three conditions: a political agenda (or system of thought) which focused on control and punishment, the assignment of dehumanizing subject positions which rationalised the mistreatment of young people, and the materialisation of sexual abuse as a tool that served to control and punish. In the first of these three conditions, a strong political agenda emerged from the 1950s through to the late 1970s from what was described as a great moral panic within society in regard to youth delinquency and female promiscuity as well as a series of reports and legislative changes that aimed to control and punish the delinquent or promiscuous including the *Mazengarb* (1954) report, the Child Welfare Act 1954, and the Children and Young Persons Act 1974. In addition, the *Hunn* (1961) report attributed increased youth offending by young Māori as a failure to assimilate to Western ways of being rather than the damaging effects of colonisation and increased urbanisation. As such, young Māori were deemed in need of “civilisation” and “saving” from their culture and their “bad parents.” Young Pasifika faced similar sentiments as their families grappled with the challenges of migration, limited State support, the dawn raids, and unfair classification as overstayers which resulted in exposure to poverty, drug and alcohol use, family harm and sexual violence.

This strong political agenda transcended into the police force and institutions which focused on a risk-adverse and punitive approach to the child or adolescent instead of an approach which would provide the care and wellbeing they needed given their histories of poverty, colonisation, racism, abuse, and trauma. This ideology was so pervasive that young people in care were assigned dehumanising subject positions by which they were viewed as “worthless”, “dirty”, and “n***er” boys. In combination, the ideology of control and punishment and the assignment of these subject positions justified and normalised the mistreatment of these young people in care, including the materialisation of sexual abuse as a means to control and punish (i.e., internal examinations, strip searches, surveillance while showering and toileting). This discourse provides novel insights into child sexual abuse with this understanding not identified or discussed within the existing literature. Not only do we gain an understanding of child sexual abuse as a material form of control and punishment, but we also discover how in some cases political agendas can significantly shape institutional and public servant behaviour as well as the development of cultures and subject positions which rationalise and normalise the mistreatment and sexual abuse of young people in care.

Discourse 2. Doubting Survivor Truth Claims: Child Sexual Abuse as Fabrication

The statements and utterances from the discourse of *child sexual abuse in residential care as fabrication* demonstrate how survivors of abuse are often not believed, heard, or listened to, and how their allegations of abuse are often wrongfully dismissed as fabrication. This discourse is legitimised by the assignment of sceptical subject positions by which survivors are labelled as “liars”, “scammers”, and “crooks” which emerges from their State Ward status as a “troublemaker” and/or “promiscuous” girl. Based on these labels they are subjected to extreme scrutiny and their truth claims are dismissed by institutional employees who are in positions of power and who decide what is truth and what is fabrication. The survivor’s subject position as a “liar”, “scammer”, and “crook” results in the denial of truth claims due to common misunderstandings of child sexual abuse; institutional employees prioritising reputational maintenance over the wellbeing of the survivor who is viewed as an inferior State Ward; police failing to investigate in a timely manner due to erroneous prioritisation or police perceiving the survivor as an “unreliable witness” who is unable to secure conviction in the courtroom due to their State Ward status; and MSD and Crown Law taking on a win-at-all costs mentality. In addition, institutional employees obstruct access to valuable discursive resources which would validate survivor allegations by censoring complaints and denying medical care for abuse related injury. This discourse supports existing research which demonstrates perceptions of survivor trustworthiness acts as a barrier for action and social justice and that survivor credibility is often tainted by common misunderstandings of sexual violence.

Discourse 3. Child Sexual Abuse as a Harmful Form of Violence

The discourse of *child sexual abuse in residential care as harmful* emphasises the negative impacts of victimisation with statements and utterances describing the trauma, sadness, loss, and hurt suffered as well as the profound impact and damage caused. This discourse is reinforced through the materialisation of psychopathology, criminality, and intergenerational care placement in survivors. Survivors describe suffering from PTSD, avoidance, alcohol and substance use disorders, emotional dysregulation, interpersonal difficulties, employment difficulties, suicide and self-harm, underachievement from mental distress, and a loss of identity or cultural genocide. Criminality is another harmful outcome that materialises from victimisation with data illustrating young people in care and protection are significantly more likely to enter prison than young people in the general population. The relationship between care and protection involvement and criminality is attributed to abuse and trauma in childhood with references made to several mediating factors including brain structure abnormalities; conditioned responses to violence and self-protective behaviours; gang membership as a form of belonging and protection; and mental health or addiction issues from unresolved or untreated trauma that leads to criminality. Finally, intergenerational care placement was presented as a possible outcome for abuse survivors with abuse in care described as having a long-term and corrosive intergenerational impact and with survivors at increased risk of exposure to a series of placement indicators including a range of social outcomes. Overall, within this discourse, three key survivor outcomes – cultural genocide, intergenerational care placement, and self-retribution as a motivator of criminality – offer additional insights into survivor sequelae which has previously noted psychopathology (PTSD, depression, substance use disorders, suicide, low self-esteem, borderline personality disorder), underachievement (unemployment, under education), and criminality (via unresolved mental distress and brain structure abnormalities).

Discourse 4. The Nexus of Power and Oppression in Child Sexual Abuse

The discourse of *child sexual abuse in residential care as power and oppression* demonstrates the power imbalances and abuse of power which exists within residences. Statements and utterances describe an inherent violence that emerges from large institutional arrangements where young people are placed into large groups with adults who do not have adequate training or who exploit their positions of authority. It acknowledges physical and developmental power imbalances as key feature of the phenomenon with children who are smaller, younger, or developmentally weaker targeted by perpetrators who are bigger, in positions of authority, and who are developmentally superior. The materialisation of sexually abusive acts which are representative of power and oppression provide further support for these statements. The acts were violent to force compliance with survivors grabbed, pushed, forced, beaten, threatened with guns, and tied up.

In addition, perpetrators exploited the developmental weaknesses of young people by taking advantage of their positions of authority and through grooming practices. Last, and as is consistent with feminist literature on sexual violence, survivors highlight how they were “there for the taking” (selected) to service the needs of masculine shock troops.

Interestingly, within this discourse survivors describe how sexual abuse serves as a tool for young people to gain social capital and to avoid their own sexual victimisation. This somewhat echoes the ideas of feminist theorists who argue sexual terrorism is used to control women and children, Gold & Hefner (1998) who argue childhood sexualised behaviour is a tool for regaining control lost through victimisation, and social learning theory researchers who have found young people with harmful sexualised behaviour and who have been victims of abuse will often replicate their own abusive experiences when they victimize others (Veneziano et al., 2000, as cited in Hackett, 2014). However, this discourse adds further nuance by conceptualising motivations for the behaviour of the young person as a means of gaining the social capital required to avoid their own victimisation. This conceptualisation is similar to why young women ‘voluntarily’ partake in female genital mutilation – despite the trauma experienced – because the social capital they gain from undergoing the procedure acts as an inoculation against the psychological torment they experience from being an ‘uncut’ woman (Omigbodun et al., 2020). As with the practice of female genital mutilation, this discourse proposes young people in care may become involved in a complex habitus which promotes the continuation of abuse as young people acquire social capital and avoid victimisation through the domination and exertion of power over others. In addition to these insights, the discourse also uncovered how young people who sexually abuse others may sometimes do this at the direction of those who are in positions of authority, engaging in this behaviour as victims, through forced participation and the power imbalances which exist and not as willing perpetrators of abuse.

Discourse 5. Shame as a Mechanism of Silence

The discourse of *child sexual abuse in residential care as shameful* was the least prominent of the six discourses. It was found to silence three alternate discourses – control and punishment, State and institutional failure, and power and oppression. Survivors report either feeling shame and embarrassment or fearing humiliation for their family or others as reasons for non-disclosure. These findings are consistent with previous research on this topic which has consistently demonstrated fear of tainting the family name and fear of bringing shame onto oneself or others as a barrier to disclosure.

Discourse 6. Child Sexual Abuse as a Symptom of State and Institutional Failure

The discourse of *child sexual abuse in residential care as State and institutional failure* iterates the obligations of the State and its institutions in protecting young people in care from harm, including sexual abuse. It exemplifies how the State and its institutions failed in this obligation to protect by presenting a large number of sexual abuse cases across the scope of the inquiry. The discourse is further legitimised through the materialisation of adaptive safety behaviours in residents who found it necessary to protect themselves and others from harm in the face of the State's failure to protect them. This discovery adds new insight into the research of child sexual abuse victimisation, demonstrating how young people protect themselves from further abuse. In addition to the development of these safety behaviours, the speakers also attribute the failure of the State and its institutions to a series of systemic failures including an underinvestment in professional capabilities, vetting blind spots, inadequate complaints and grievance processes, a culture of tolerance, poor internal monitoring and oversight, inadequate external monitoring structures, and questionable accreditation and monitoring of 396 providers. These systemic failures add significantly to the current literature. Not only does this knowledge provide new insights which have not yet been discussed, but it also shifts us toward having a deeper, ecological understanding child sexual abuse in a specific setting/context and provides the knowledge required for stronger primary prevention efforts which aim to stop abuse before it occurs.

Overarching Conclusion: State Ward Subject Position Promotes Cultures of Tolerance and Sexual Violence in Residences

In analysing the six discourses, it became clear the young persons' subject position as a State Ward profoundly influenced the development of both a culture of sexual violence and a culture of tolerance toward abuse within residences. The culture of tolerance is exemplified by the inaction of trusted adults despite legislative and child protection protocols which mandate action when abuse is disclosed. Perceptions of State Wards as "delinquent", "deceitful", and "promiscuous" undermine their credibility when disclosing abuse and encourages inaction. Consequently, young people resort to self-protection strategies in the face of the State's failure to protect them, leading to both effective self-protection and a problematic culture of sexual violence among peers. This culture is further fuelled by the normalisation and rationalisation of sexual abuse by staff as a means of control and punishment, perpetrated by a political ideology of controlling and punishing "delinquent" youths, "promiscuous" young women, and "n***er* boys. In addition, the 'no narking' culture and power of shame silences survivors. From these realisations it becomes clear that cultural shifts are integral in the fight against child sexual abuse, with a call-out-culture – a culture of intolerance, accountability, and speaking out – the ultimate defence in flushing out abuse as it

happens and preventing abuse before it occurs. Through this call-out-culture survivors can speak out without fear of shame and with the confidence they will be believed while an increased fear of exposure, scrutiny and surveillance may discourage perpetration from those who sexually abuse.

Limitations and Weaknesses: Threats to Reliability, Internal Validity, and Generalisability

While this thesis provides new insights into child sexual abuse in residential care, it is not without its limitations and includes a series of threats to the reliability and validity of the research. In respect to reliability, the researcher has made efforts to facilitate reproducibility with a clear articulation of the methodology and method presented throughout. However, due to the subjective and interpretative nature of the research some divergence in the findings is to be expected (Gillies & Alldred, 2012). In respect to internal validity the accounts provided within the evidence from both hearings may not be accurate and objective and may have been influenced by political agendas, cultural norms, the availability of evidence, cultural dominance (Bhat et al., 2023) and social desirability (Tofthangen, 2012). However, the impact of these effects on the research may have been counteracted by the inclusion of a large and diverse sample size which allowed for data triangulation and the use of FDA which challenges dominant perspectives and empowers marginalised voices (Bhat et al., 2023). In addition, while perceived trajectories to psychopathology, criminality, and intergenerational care placements were discussed, other factors may have contributed to these perceived outcomes (i.e., history, maturation, and single-group threat) and therefore a cause-and-effect inferences cannot be made (Tofthangen, 2012). Last, the external validity of this study is questionable with limited generalisability due to its focus on residential care settings and the population within this setting. Given the threats to both internal and external validity, the findings within this thesis cannot be used to make generalised or cause-and-effect inferences but instead provides preliminary data that can help to guide the development of confirmatory studies in future inquiry.

Implications for Future Research: Working Toward Cultural Shifts, Identifying Positive Sequelae, and Uncovering Mechanisms of Disclosure

The overarching theme of the State Ward subject position encouraging cultures of sexual violence and tolerance toward abuse is concerning. This prompts the need for further inquiry into perceptions of young people in care and whether these young people still experience the assignment of dehumanising subject positions in the current day and outside the scope of inquiry, which may encourage sexual victimisation or scepticism from trusted adults when disclosing abuse allegations. Such research would be invaluable in identifying spaces that require a cultural shift toward acknowledging the young person as credible and deserving of care and protection. This research is particularly important given the young person's State Ward status appears to supersede

systems and processes which have been introduced to prevent abuse (i.e. Vulnerable Childrens Act 2014, complaints systems). In addition, research addressing whether ideologies of control and punishment still exist within contemporary residences and political agenda would offer similar advantages of identifying spaces which require cultural shifts. Again, this is important given the way this ideology, coupled with the young persons' State Ward status, has rationalised and normalised sexual abuse in care as well as the materialisation of other human rights violations including dehumanisation and racism.

There is also the potential for further inquiry into survivor sequelae and disclosure. The research provided three new insights of survivor outcomes (cultural genocide as an outcome of racially targeted abuse; self-retribution and self-protective behaviours in survivors spurring criminality; and intergenerational care placement as an outcome of abuse in care). However, these insights are merely suggestive and discursive in nature. Further confirmatory inquiry of these outcomes would be beneficial in validating these results. In addition, as with other research on survivor sequelae, the discourse of child sexual abuse in residential care as harmful perpetuates the 'harm story' whereby long term and pervasive negative outcomes are seen as the only pathway for survivors. This leaves open a space for further research into alternate outcomes for abuse in care survivors including the potential for post traumatic growth and increased resilience in the face of adversity. Uncovering stories or evidence of positive outcomes would allow us to identify mediating and protective factors that encourage these outcomes and to deliver more effective therapeutic interventions for survivors. Last, as with other research, shame was found to be a barrier to disclosure. This prompts the need for inquiry into the mechanisms which facilitate disclosure. Understanding these functions can aid in producing an effective survivor and child-centred complaints systems, given the current ineffectiveness of these systems in drawing out incidences of abuse.

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Appendix A – Source Documents and Internal Reference Code

Table A1

Analysed Documents from the Children’s State-run Residential Care Hearing

Code	Document Type	Speakers
1a	Opening Statement	Royal Commission Counsel
2a	Survivor Statement	WITN0245001
3a	Survivor Statement	WITN0220001
4a	Survivor Statement	WITN0159001
5a	Survivor Statement	WITN0080030
6a	Survivor Statement	WITN0267001
7a	Survivor Statement	WITN0412001
8a	Survivor Statement	WITN0302001
9a	Survivor Statement	WITN0291001
10a	Survivor Statement	WITN0157001
11a	Survivor Statement	WITN00427001
12a	Survivor Statement	WITN0145001
13a	Survivor Statement	WITN0293001
14a	Survivor Testimony	WITN0245001
15a	Survivor Testimony	WITN0159001
16a	Survivor Testimony	WITN0080030
17a	Survivor Testimony	WITN0267001
18a	Survivor Testimony	WITN0412001
19a	Survivor Testimony	WITN0302001
20a	Survivor Testimony	WITN0291001
21a	Survivor Testimony	WITN0157001
22a	Survivor Testimony	WITN00427001
23a	Survivor Testimony	WITN0145001

Table A2*Analysed Documents from the State Institutional Response Hearing Used in the Study*

Code	Document Type	Speakers
1b	Institution Testimony	MSD Chief Executive, Te Kahui Kahu General Manager, ICM Executive Director
2b	Opening Statement	Survivor Advisory Group Experts (SAGE)
3b	Opening Statement	The Crown Lawyers
4b	Opening Statement	Royal Commission Counsel
5b	Institution Testimony	New Zealand Police Commissioner and Deputy Commissioner for Leadership and Capability
6b	Institution Testimony (Day 1)	Oranga Tamariki Chief Executive, Director of Transformation Te Oranga o te Whānau, Tumu Tauwhiro Chief Social Worker, Chief Advisor Pacific, Deputy Chief Executive Quality Practice and Experiences, General Manager of International Case Work and Adoption Services
7b	Institution Testimony (Day 2)	Oranga Tamariki Chief Executive, Director of Transformation Te Oranga o te Whānau, Chief Advisor Pacific, Deputy Chief Executive Quality Practice and Experiences, Chief Advisor of Disability
8b	Institution Testimony (Day 3)	Oranga Tamariki Chief Executive, Director of Transformation Te Oranga o te Whānau, Tumu Tauwhiro Chief Social Worker, Deputy Chief Executive Quality Practice and Experiences, General Manager of International Case Work and Adoption Services
9b	Institution Testimony	Ara Poutama Department of Corrections Chief Executive, General Manager of Psychology and Programmes, Chief Custodial Officer and General Manager Custody, General Manager for Reintegration and Housing Support Services
10b	Institution Testimony	Children's Commissioner, Office of the Children's Commissioner Executive Director, and Assistant Māori Commissioner for Children
11b	Closing Statement	Survivor Advisory Group Experts (SAGE)
12b	Closing Statement	The Crown Lawyers

13b	Institution Testimony	Public Service Commissioner
14b	Brief of Evidence	Commissioner of the New Zealand Police
15b	Brief of Evidence	ICM Executive Director
16b	Brief of Evidence	Te Kāhui Kāhu General Manager
17b	Brief of Evidence	MSD Chief Executive
18b	Brief of Evidence	Ministry of Education Chief Executive and Secretary of Education
19b	Response to Notice to Produce No. 418	Oranga Tamariki
20b	Brief of Evidence	Oranga Tamariki Chief Executive and Secretary for Children
21b	Institutional Statement	Office of the Children’s Commission Executive Director
22b	Institutional Statement	Children’s Commissioner
23b	Brief of Evidence	Education Review Office Chief Executive Officer and Chief Reviewer
