Test balloons? Small signs of big events: A qualitative study on circumstances facilitating adults’ awareness of children's first signs of sexual abuse

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A R T I C L E   I N F O

Article history:
Received 1 December 2012
Received in revised form 23 May 2013
Accepted 26 June 2013
Available online 27 July 2013

Keywords:
Child sexual abuse
Sexual abuse disclosure
First signs
Dialogical research

A B S T R A C T

This research examined caregivers’ awareness of children’s first signs of sexual abuse. The aim was to explore circumstances that facilitate adults’ awareness of first signs in everyday natural settings. Data were obtained from a Norwegian university hospital's outpatient specialty mental health clinic. Included were all cases (N = 20) referred during a two-year period for treatment after the disclosure of sexual abuse that was reported to the police and child protective service. Nonabusing caregivers’ awareness of first signs were recollected in hindsight as part of therapy. Qualitative analysis was conducted to capture caregivers’ experiences. As identified by caregivers, all children gave signs. Thereafter, children either stopped, delayed, or immediately disclosed sexual abuse. At first signs, each child had time and attention from trusted adults, connection to the abuser, and exhibited signs of reservation against that person or related activities. Then, if met with closed answers, first signs were rebuffed as once-occurring events. If met with open answers and follow-up questions, children continued to tell. Unambiguous messages were prompted only in settings with intimate bodily activity or sexual abuse related content. In sum, when trusted adults provided door-openings, children used them; when carefully prompted, children talked; when thoughtfully asked, children told. The study suggests that children’s signs of sexual abuse can be understood as “test balloons” to explore understanding and whether anything is to be done. A disclosing continuation hinges on the trusted adult’s dialogical attunement and supplementary door-openings. Divergent from an idea of behavioural markers, or purposeful versus accidental disclosures, this study calls for a broader attention: Moments of first signs are embedded in dialogue. A uniqueness at moments of first signs appears: Both to form such moments and to transform them into moments of meeting for joint exploration and telling, hinge upon how trusted caregivers scaffold opportunities for the child to disclose. Subsequently, support offers need to be addressed not only to strengthen children to tell, but also for caregivers and professionals to take into account the necessity of a dialogically oriented sensitivity towards children, both for telling to occur and for hearing to take place.

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http://dx.doi.org/10.1016/j.chiabu.2013.06.007
Introduction

As clinical psychologists working with children and adolescents, we have been increasingly surprised and concerned about how difficult it is to see and hear when child sexual abuse happens and to recognize the first signs that a child gives. The present work examines nonabusing caregivers’ experiences of how they became aware of the first signs and explores how they responded to meet the needs of the child.

The sexual abuse of children is a global problem; it occurs in every country and cuts across all socioeconomic, educational, and ethnic groups (Shackel, 2012). Studies show that serious obstacles hinder children from disclosing (Goodman-Brown, Edelstein, Goodman, Jones, & Gordon, 2003; London, Bruck, Ceci, & Shuman, 2005; Ungar, Tutty, Mcconell, Barter, & Fairholm, 2009). As a rule, it is difficult for a child to reveal secrets (Kelley & McKillop, 1996), and this type of secret sets formidable barriers towards disclosure (Crisma, Bascelli, Paci, & Romito, 2004; Paine & Hansen, 2002). One main barrier is the fact that the abuse often happens inside the child’s family or by trusted persons in the child’s life, combined with threats to prevent disclosure (Berliner & Conte, 1995). Second, across all types of sexual abuse, children usually feel responsible (Ney, Moore, McPhee, & Throught, 1986). Third, children fear hurting others, making trouble, and not being believed (Hershkowitz, Lanes, & Lamb, 2007; Jensen, Gulbrandsen, Mossige, Reichelt, & Tjersland, 2005). Across settings, studies of the circumstances in which a child discloses sexual abuse, show that children face significant obstacles (Leventhal, Murphy, & Asnes, 2010; Priebe & Svedin, 2008; Ullman, 2003).

As for the circumstances that facilitate children to tell, most studies build upon retrospective data from adults who have experienced sexual abuse as children, or from peripheral data from other aspects of child sexual abuse (Alaggia, 2004; Arata, 1998). Depending on the child’s age and who the perpetrator is, a distinction has been drawn between accidental versus purposeful disclosures and whether the child talks to trusted adults or peers (Shackel, 2009). Recently, however, studies exploring children and youngster’s own decisions to tell or wait, expand the idea of making a distinction between purposeful and accidental disclosures. These studies demonstrate the importance for the child to perceive a purpose, an occasion, and a connection in the situation at hand to what they want to tell (Jensen et al., 2005), the many ways of telling (Alaggia, 2004), as well as their considerations of the possible consequences that inform their ongoing strategies of telling (Crisma et al., 2004; Petronio, Reeder, Hecht, & Ros-Mendoza, 1996; Staller & Nelson-Gardell, 2005). Likewise, when asked directly through forensic interviews, children tell (Gamst & Langballe, 2004; Myklebust, 2012; Philips, Oxburgh, Garvin, & Myklebust, 2012), and inform about their pros and cons whether to tell or to wait (Schaeffer, Leventhal, & Asnes, 2011). Additionally, they respond if asked considerately and directly when there is a good relationship and working alliance in therapy (Jensen et al., 2010). As emphasized by Staller and Nelson-Gardell (2005), children do not tell, delay, recant, or reaffirm accounts of their sexual victimization in a vacuum. They accommodate to the adult world. In order to better understand the process of disclosure, not only do the actions and words of children need to receive focus but also the reactions and responses from the adults (London et al., 2005). Lack of opportunities to tell may be a concrete obstacle that children face (Norwegian State’s Barneombud, 2012; Schaeffer et al., 2011). Likewise, poor sensitivity towards children’s first signs may be a concrete obstacle for adults to face.

Several studies point to the difficulties caregivers have in perceiving children’s signs of abuse (Arata, 1998; Plummer, 2006). Obstacles are related to cultural codes and a lack of cultural rituals for initiating conversations with children on issues of sexual abuse (Jensen, 2005; Kogan, 2004), as well as to the puzzles connected to interpreting children’s signs (Jensen, 2005). Other hindrances include adult’s misconceptions of how children commonly disclose sexual abuse (Shackel, 2009), in addition to substantially insufficient professional assistance (Bruck & Ceci, 2004; Ormhaug, Jensen, Hukkelberg, Holt, & Egeland, 2012; Read, Hammersley, & Rudegeair, 2007; Reigstad, 2012; Reigstad, Jørgensen, & Wichstrøm, 2006). As Crisma et al. (2004) highlight in their study of Italian adolescents who had been sexually abused as children, the main problem is not primarily the children’s reluctance to tell, but the poor willingness of adults to listen, believe, and to offer support.

Some studies have examined caregivers’ responses at disclosure. These studies, however, set up choices among fixed, presumably typical scenarios (Walker-Descartes, Sealy, Laraque, & Rojas, 2011), or provide choices among close-ended responses (Plummer, 2006). Studies are needed to illuminate what caretakers themselves have experienced as being useful openings in natural settings for children to tell and their afterthoughts on circumstances that reinforced their child to tell or to wait. Studies on involved caregivers’ own experiences on when and how to be receptive towards early signs so that children can feel safe and encouraged to tell, may add important knowledge to this field. The present study aims at examining children’s first signs of sexual abuse as perceived by their involved, nonabusing caregivers.

Key-moments of change in an intersubjective field

How an intersubjective field can be dramatically reorganized during a short, fast changing moment is outlined by Stern (2004, 2007). Stern’s notion of key-moments highlights how an interchange between persons can change into completely new directions during a short moment that lasts only a few seconds. His notion supplies a tool to the study of moments of first signs of sexual abuse. To analyze key-moments, Stern suggests a distinction between now-moments and moments of meeting. In both cases something is at stake between persons. A now-moment, however, where something is at stake, differs from a moment of meeting, where what is at stake, is resolved. According to Stern, a moment of meeting is characterized by mutual other-centred participation in which both partners create and undergo a joint experience. Here, the resonant
experience enlarges the intersubjective field between persons, and opens up new possibilities for exploration. Then, quality leaps are accomplished, where change occurs.

In accordance with Stern’s notion, the research question of the present study is as follows: At children’s first signs of sexual abuse, what facilitates the now-moment, where something is at stake, to become a moment of meeting, for exploration and quality leaps towards disclosure to evolve? Or, on the contrary, what promotes closure, where the now-moment does not evolve into a moment of meeting, but remains unexplored and unresolved? Thus, exploring cases with a similar ending point in which sexual abuse has been disclosed, the study looks retrospectively across cases and asks if and how different coordinations during moments of first signs constituted divergent contingencies for the process to continue. The study explores the interplay between a child’s expressions and signs, and the involved, nonabusing caregivers’ answers as they happened during the short, fast-changing, interpretable moments of first signs.

The study inquires into caregivers’ recollections of children’s first signs, and their considerations in hindsight of what made their child tell or wait. The aim is to develop knowledge about the circumstances that facilitate disclosure in everyday settings on the basis of involved, nonabusing caregivers’ intuitive actions, experiences, and reflections.

The focus is on nonabusing caregivers’ report told as part of therapeutic settings, where they were invited to share and explore their experience with the aim of finding new ways to go on. In this study, however, it is not the therapeutic work that is studied. The subject is caregivers’ knowledge told as part of the therapeutic sessions regarding what made their child tell or wait. Data from clinical settings has typically been lacking in child abuse and protection research. Collecting experiences from clinical practice can give the researcher a valuable position from which to do research on largely private, concealed, and serious issues (Jensen et al., 2005; Kvale, 2003). A qualitative approach to data collection and analysis was employed, suitable for the study of processes like this.

**Method**

**Participants**

Data were clinical cases from an outpatient specialty mental health service for children and adolescents at a Norwegian university hospital. Included were all cases \((N=20)\) during a period of two years referred for treatment after disclosure of sexual abuse that was reported to the police and child protective service. The referrals came from the support area of the clinic through hospitals, child protective services, community doctors, and primary public health services. The clinic covered a geographical area of approximately one sixth of Norway, with a similar ethnicity, and the same relative proportion of children under 18 years of age as the rest of the country.

Types of sexual abuse reported by the children ranged from fondling to intercourse, including intercourse \((n=4)\), masturbation with ejaculation \((n=8)\), and fondling genitals \((n=8)\). The children’s ages ranged from 1 to 17. There were five preschool children, seven in middle childhood, and eight teenagers. All eight teenagers were girls. All of the children, both boys \((n=3)\) and girls \((n=17)\), experienced sexual abuse by a male (in one case from an older boy, the others were adults). All of the children were well acquainted with the abuser: In seven cases, he was a father or a step father who was either living with the child or who the child visited regularly. In six cases, he was a close relative, an uncle, a grandfather, or an older cousin. In the rest of the cases \((n=7)\), the abuser was a close neighbour or a teacher. The children revealed their experiences of being sexually abused either to their mothers \((n=11)\); to their mother and father together \((n=2)\); or to other persons who were tending to the child \((n=7)\), most often to a nurse or a teacher. One child disclosed the abuse to her peers. In the aftermath of the disclosure, all of the mothers—or the mothers and the fathers together—were able to identify earlier episodes during which the child had uttered something that could—in light of what was later revealed—be interpreted as a first sign of abuse.

**Procedure**

The material included comprehensive reports from nonabusing caregivers who provided a hindsight perspective on the circumstances around the first signs given by the child, as well as these caregivers’ afterthoughts about what facilitated or hindered disclosure on that particular occasion or later. The reports contained information about when anything happened that evoked, or might have evoked, some kind of wondering or suspicion that something was wrong with the child. The reports included what the child said, did, who took part, and what happened in the situation, as well as the continuing process towards disclosure. Questions were asked open-ended as part of ongoing clinical conversations and work, and based on a review of the literature and input from professionals working with child sexual abuse. The two authors, both experienced clinical psychologists in the field of specialty mental health service for children and adolescents, were among the clinicians and carried out the work. The material contained substantial verbatim notes of the caretakers’ reports, the clinicians’ reports in medical journals, as well as the clinicians’ reflected notes. All of the cases were subsequently included into a systematic analysis, where the data were anonymized, with all of the specific personal identifications excluded, and any personal information changed and disguised.

At first, the aim of the work was carried out for internal use, in order to evaluate and better qualify the services given by the clinic in this area. Through this systematization process, it was noticed that each child had presented something that could be understood as first signs of abuse, and an analysis was conducted of the proceeding dialogues with the caregivers for
Results

A more thorough view of the circumstances around these signs. We then consulted the The Regional Ethical Committee for Medical and Health Research of Northern Norway about using the clinical material in a research publication. They informed that as long as the data were sufficiently anonymized, it was not required to ask for permission in advance. The analysis carried out is therefore part of an internal evaluation of case work at the clinic. The study was approved by the data protection officer.

Analysis

Areas for exploration and systematization across the subsequent cases included five extensive topics:

1. What do involved, nonabusing caregivers consider in hindsight to be the child’s first signs, including what the child said or did?
2. How do these caregivers retrospectively remember the context, including the activities, participants, place, and time of first signs?
3. What were the caregivers’ immediate answers and reactions, including how did they respond and act towards the child?
4. What consequences and subsequent actions took place both directly afterwards and in the long term in relation to disclosure?
5. What do these caregivers consider in hindsight they could have done better to notice the child’s first signs?

The data generated contained extensive descriptions of these specifications in each case. Substantial reports from all of the cases were collected and subjected to qualitative analyses by the two professionals to acquire expanded awareness of tendencies and exceptions, analyzing patterns, and synthesizing themes across cases and within each case. Each professional carried out independent reading using a systematic approach (Bradley, Curry, & Devers, 2007; Haavind, 2002; Kvale, 1997, 2003). The analysing process was structured according to Consensual Qualitative Research for individual and joint discussions to develop consensus (Hill et al., 2005). The themes that emerged and the similarities and differences within and across cases, were subjected to repeated analyses within the reports of all cases to see if, and how, the conclusions were consistent between cases, or if any case diverged from or negated the conclusions. Each professional analyzed the categories case-by-case to evaluate whether the themes and patterns were considered to be consistent with the data. To establish the reliability and trustworthiness of the analyses, each author conducted the case-by-case analysis separately and then reviewed the themes and patterns together. If differences appeared, the reports were reviewed until consensus was achieved. In employing such a rigorous analysis, a more comprehensive understanding of the complex dynamics of circumstances surrounding the first signs was made possible.

Based on analyses of the completed narratives of 20 cases, the material was synthesized and divided into distinct types of moments of first signs of abuse, which focus on the interplay between the nonabusive caregiver and the child according to how different coordinations during that moment constituted divergent opportunities for the process to continue. Three different and recognizable constellations of moments of first signs of abuse were categorized. Each illustrated divergent contingencies for an opening or closing process towards disclosure. The paper first describes the three typical moments of first signs and what constitutes their separate characteristics. Following, the main characteristics across the divergent moments are outlined. Finally, some suggestions are discussed with regard to fostering a process of disclosure in natural settings at children’s first signs of sexual abuse.

Results

The following three typical moments of first signs illustrate the different ways in which children’s signs were noticed and reacted to by the adults. The first closed off the possibility of exploration and disclosure, the second delayed such possibilities, the third opened directly to exploration and disclosure. Examples are given under each type.

1. Moments of children questioning rules and obligations—with closed, not abuse-related adult answers.
2. Moments of children questioning rules and obligations—with open adult answers, establishing opportunities for later questions and actions.
3. Moments of direct information—with direct abuse-related adult questions and actions.

In all of these moments, the only information provided is according to the adults’ recollection. Where an answer from a child is referred to in the text, it is not as a report from the child, but as it was remembered and told by the adult. Thus, when the term children’s first signs is used, it points to the first signs as perceived by the adults. The term caregiver refers to nonabusing caregivers.

Moments of children questioning rules and obligations—with closed, not abuse-related adult answers

This moment characterized seven out of twenty cases, illustrated by the following examples:
The caregiver receives a question and answers by minimizing the child’s report:

The father, mother, and preschool daughter are visiting their family. The parents are going out, and tell the daughter that her uncle is going to look after her along with her cousins, as he usually does. As they are about to leave, the girl calls out: “Do I HAVE to go to uncle?” The adults interpret this reaction as being a temporary reluctance for them to leave, which requires a comfort: “Yes, your uncle is looking after you. He is so kind.” They leave.

The caregiver receives questions and normalizes the child’s report:

The time has come for the primary school girl to do the dishes at the neighbours’. She asks her father, who is standing close by: “Do I HAVE to wash the dishes even though I get paid?” The father thinks her question is a sign of laziness, which requires a reminder of her responsibility. He says: “You have to keep your promises. If make a promise, you keep it.” The girl leaves.

The caregiver receives questions and normalizes the child:

The little sister has just returned from visiting her uncle, and has gone to bed. The teenage sister approaches her parents relaxing in the dining room: “You should NOT allow sister go visit our uncle to get all those sweets!” Her parents think this is jealousy, which requires correction: “You have to learn to tolerate your little sister getting sweets even though you don’t.” The girl leaves.

In each of these cases, the children never repeated any utterances of sexual abuse to that particular caregiver. Not until after a long delay did new information come forth by children telling through persons from outside, who then informed. The police and child care system was contacted, and comprehensive sexual abuse was disclosed.

In hindsight, these caregivers felt a deep sorrow in not having noticed the children’s questions as being out of the ordinary, and they seriously blamed themselves for being insensitive.

From the perspective of the caregivers, the characteristics of this moment can be summarized in the following way: (a) The child expresses reservation. (b) The reservation is either about a specific person or activities related to that person. (c) The child uses questions as signs of reservation. This is done in the form of questions about rules. The child asks either about the existence of a rule (e.g., “Do I HAVE to wash the dishes even though I get paid?”), or about the relevance of an existing rule (e.g., “You should NOT allow sister go visit our uncle to get all those sweets.”). (d) The child uses selected time. Selected time includes both attention from the trusted person, and a connection to the person the reservation is related to. (e) The caregivers give closed, not abuse-related answers, which finalizes any further interpretations. This is done either through minimizing, normalizing or correcting the child’s report and questions. (f) No questions are asked by the adults.

In sum, as seen from the perspective of the caregivers, this moment is slightly different from ordinary settings, containing only slight divergences compared to issues of daily up-bringing. Yet, it is still divergent: The child introduces reservation, articulated in an upset, questioning form about the existence or application of rules connected to the abusing person or to activities related to that person. The adult closes the interpretation, without realizing the deep importance during the brief interaction of that very moment of first signs. Thus, this now-moment, where something is at stake, does not expand or transform into a joint experience of a moment of meeting, where what is at stake, could be explored and quality leaps towards disclosure could be accomplished. It became a single, once-occurring event between these persons.

Moments of children questioning rules and obligations—with open adult answers, establishing opportunities for later questions and action

This moment characterized ten out of twenty cases, illustrated by the following examples:

The child acts; the adult keeps the interpretations open and establishes opportunities for questions:

The mother and teenage daughter are at home. The mother says good night, and tells her daughter to shut off the TV and go to bed. The daughter continues watching TV with all the lights on. When her mother asks why, she tells she HAS to have that arrangement to fall asleep. The mother repeats her good night. Upon returning later, she finds her daughter sleeping with the TV and all the lights on, and thinks: “How strange she can’t sleep without - a grown-up girl. This is unusual; something serious must have happened to her.” A following evening she asks directly: “Tell me, has anything serious happened? Has anyone done anything abusive to you?” The girl answers yes, and at her mother’s request relates that the mother’s ex-partner had abused her. The mother calls the police and professional helping system. Sexual abuse was disclosed.

The child acts; the adult keeps the interpretations open and uses recurring opportunities for direct actions:

The mother is about to leave for her night job. She goes to her teenage daughter’s room to say good night, and opens the door silently. The daughter jumps up from the bed into a sitting position, and asks in a terrified voice: “Is it YOU, mommy? Do you HAVE to leave for work?” The mother thinks: “Such a strange voice. How scared she sounded? She was not like that before.” Several nights later the mother wakes up to find her husband’s side of the bed empty. She knows, without knowing how to explain it afterwards, that she has to go directly into her daughter’s room. She finds her husband in her daughter’s bed. Without the husband noticing, the mother calls the police at once. They arrive immediately. Comprehensive sexual abuse was disclosed.
In hindsight, these adults regretted not having reacted earlier. However, they found the delay inevitable considering the unexpectedness of the situation.

From the perspective of the caregivers, the characteristics of this moment can be summarized in the following way: (a) Similar to moments with closed answers, the adult encounters a child who exposes signs of reservation, which are articulated in a stressed form as questions or reservations about some rules and obligations connected to the abuser or activities related to that person. (b) The caregiver gives answer where interpretations are kept open. (c) The adult utilizes new opportunities for exploring understanding through questions or actions.

Compared to moments with closed answers, it is the open answers and reactions that constitute the difference. No arresting interpretations are introduced. No finalizing answers are presented. Similar to moments with closed answers, the child’s first signs are not strong enough to create an immediate alarm. However, the adult keeps his/her interpretations and answers open.

Furthermore, it is the adults’ own initiative through proceeding questions and actions that enables the child to tell, and leads the child’s first signs into a process of disclosure. This openness of interpretation provides room for the child’s behaviour and signs to be re-expressed, so that the adult can re-act, re-hear, and hear, the child’s issues as unusual. The signs can be recognized as deviant compared to the child’s former capability or age.

Thus, through this adult’s open dialogical attunement and answer, the transformative potential of the now-moment, where something was at stake, was expanded into a moment of meeting. Here, what was at stake, was resolved, new possibilities were explored, and quality leaps could be accomplished—divergent from moments of closed answers.

Apart from this difference, these two types of moments were similar. None of them included any direct verbal utterances from the child about sexual abuse. None revealed any broad or self-disclosing gateway from which the adult could interpret big events like sexual abuse. They both invited caregivers to puzzles. As will be shown below, this is different for the third type—moments of direct information.

**Moments of direct information— with direct abuse-related adult questions and actions**

This moment characterized three out of twenty cases, which is illustrated by the following examples:

The child tells about unusual bodily experiences. The adult investigates:

*The preschool daughter has recently gotten her fourth diagnosis of urinary tract infection. The mother and child are in the bathroom, washing before the daughter goes to bed. The mother says: “And you have once more gotten a urinary tract infection.” The daughter answers: “Maybe the fingers were dirty?” The mother asks whose fingers, and what those fingers did. The daughter tells about abuse from the neighbour. The mother calls the professional helping system.*

The child asks about words related to sexual abuse. The adult picks it up and acts on it:

*The mother and her primary school son watch a TV-program about paedophilia. Chairs are around for the siblings, who are playing in a nearby room. In the middle of the program the son asks his mother: “What is the name of what he is doing, Mom?” “The name is sexual abuse,” the mother answers. The son continues: “Then, that is the name of what the neighbour is doing to me.” The mother called the professional helping system and the police the next day. Comprehensive sexual abuse was disclosed.*

In hindsight of the cases of direct information, the adults considered their responses to be have been suitable.

From the perspective of the caregivers, the characteristics of this moment can be summarized in the following way: (a) The context has thematic similarity to sexual abuse. It includes activities having to do with intimate bodily contact or sexual abuse. (b) The child gives a direct, verbal message about unusual bodily experiences or sexual abuse. (c) The adult gives immediate answers that focus on abuse, picks up on the child’s signs, asks to investigate, and seeks out help. As for the other moments, the child has the presence of and attention from a trusted person.

Compared to the two other types of moments of first signs of abuse, here it is the context of thematic similarity in moments of direct information that makes the difference. This moment is the only occasion in which thematic similarity regarding issues pertaining to intimate bodily contact or sexual abuse is present. This elicits a direct opportunity and an available context for a now-moment, where something is at stake, to immediately expand into a moment of meeting, where an adult can hear, explore, and immediately act when a child asks or tells. What was at stake, could be resolved.

**Transformative potential across divergent moments of first signs**

In sum, as recollected by caregivers, all children had given signs of abuse. Yet from this point, three different situations followed: Seven children stopped disclosing, ten delayed disclosing, only three disclosed at first signs. Seven were stopped in receiving closed answers from a continuing process of telling to that particular caregiver; more information emerged after a long delay by the help of outsiders. Ten children waited and delayed the process of telling, after receiving open responses from the adults. Three provided direct information, followed by immediate adult exploration and disclosure. Thus, depending on the adult’s open or closed answers, the transformative potential of a now-moment of first signs, where something was at stake between persons, was transformed and expanded into a joint experience of a moment of meeting, where exploration
and quality leaps towards disclosure could evolve. In sum, as identified by the caregivers in hindsight, moments of children’s first signs can be summarized in the following way:

(a) All children gave signs to their caregivers.
(b) All children had the presence and attention from a trusted adult—with a joint focus.
(c) The child showed signs of reservations. The reservation was usually articulated as questions and reservations about rules and obligations.
(d) Contexts and reservations were connected to the abusing person, either directly to the person or to activities related to that person.
(e) If met by closed answers, first signs were rebuffed as once-occurring events towards that particular caregiver.
(f) If no limiting or closed answers were introduced, children continued to give signs.
(g) Children told if trusted adults offered door-openings through direct questions.
(h) Direct verbal messages related to sexual abuse were prompted only in contexts with intimate bodily or sexual abuse-related content. At that point, the child told directly about sexual abuse if the caregiver answered or asked questions related to verbal utterances from the child.

Discussion

This study shows how small and indirect children’s first signs of sexual abuse can be, and how sensitive it is to build contexts and opportunities so that caregivers can see, hear, and act. It demonstrates that even though all of the children had given first signs to their trusted caregivers, as many as 7 out of 20 were stopped from further exploration and telling to these adults. For 10 out of 20, the process was delayed. Only 3 gave direct information. The study highlights how a child’s signs of abuse are easily rebuffed if met by closed answers at moments of first signs. In line with recent documentation of abused children’s accurate perceptions of parents’ reactions, as well as their extreme sensitivity towards caregivers’ tolerance of disclosure, which informs their ongoing strategies of telling (Goodman-Brown et al., 2003; Hershkowitz et al., 2007), this study emphasizes the importance of adults acknowledging their child’s need for assistance in his or her expressions and exploring. It illustrates how everyone, both caregivers and children, is situated in a mutual challenge or collaboration. Challenges arise as to what can be said or asked about, by whom, where, when, and how utterances can be understood. In this sense, each contribution can be considered to be a social offering in order to find meaning and ways to go on (Anderson, 1997; Bakhtin, 2003; Shotter, 1994, 2010).

Children’s dialogical and other-directed nature is substantially documented in research and clinical literature. It is shown how children from their earliest moment involve into a mutual regulation of emotional states, attention to objects and signs, and later into understanding and using language (Bråten, 2007; Ferrari & Gallese, 2007; Siegel, 1999; Stern, 1992, 2007; Vygotsky, 1970). Raundalen (2005) summarizes the new direction in developmental psychology by naming this child a researcher child. This can metaphorically be called a child’s innate green light organization, highlighting the notion that children explore in dialogue with their important persons where to go, where to find a green light for moving on. Difficulties arise if children do not have important adults to organize experiences and scaffold interpretations about danger and to point out at a red light. When child sexual abuse happens, maternal response is the strongest predictor of children’s outcome, and parental support is consistently associated with abused children’s recovery (Elliott & Carnes, 2001). Substantial studies, however, show the difficulties children have in finding warning signals in sexually abusive situations that may help them to find ways of getting support. The nebulous passages and slippery steps taken from an abusing person towards the child, and how the same person not seldom also charms and grooms the family of the child for better access and control, are well documented (Elliott, Browne, & Kilcoyne, 1995; Paine & Hansen, 2002). Many studies also show how threats function as red light to warn of serious danger in case of disclosure, which hinders the child from seeing a green light for chances to tell (Berliner & Conte, 1995). The fact that such mechanisms are strongly in operation, fosters extensive loneliness for a child, with the minimum of advice or encouragement in daring or deciding to use test balloons to find door-openings to explore how to understand and to tell.

The hard-gained knowledge of the caregivers in this study calls for an awareness towards that researching child: Children’s signs of abuse can be understood as a call for joint exploration, understanding and solution in a moment where something is at stake. The first signs can be perceived as an invitation to a dialogical enterprise. On the basis of these caregivers’ recollections, a child’s approach can be conceived as being “test balloons” that are directed towards the trusted person to try out, to test, if that person is willing to or capable of participating in an exploration of how to understand what happened, and if anything is to be done. Thus, the child’s turning to the adult can be viewed as an exploring starting point, from which the continuation depends upon the adult’s answers for the child to find door-openings to continue. The exact type of child expressions is linked to contextual conditions. As shown, what these caregivers recollect, are contexts with a shared focus with a trusted adult, questions and stressed reservation expressed by the child in connection with the abusing person or related activities, or direct thematic information in contexts containing thematic similarity. What happens thereafter, how the child is met and how he or she experiences or imagines how the adult evaluates things, depends on the dialogue that the trusted adult creates towards the child. Thus, the adult keeps the score both to the formation and the transformation of moments of first signs.
In sum, on the basis of these caregivers’ experiences, the study suggests a three-sided attention to create door-openings for exploring and telling: On the one side, to arrange settings of joint attention with the child. On the other side, to create joint settings with intimate bodily activities or sexual abuse related issues for possible contextual prompting. And, on the third side, to beware and dare at hints of reluctance and reservation from a child, to arrange for door-openings to address such signs by posing concrete and open questions to the child.

In general, caregivers’ awareness and discovery of abuse has been described as a process (Alaggio, 2004). Supplementary to a process perspective, this qualitative study emphasizes the uniqueness of moments of first signs, and the possibilities they offer both for early detection and prevention and then for the necessary management and treatment. The study illustrates the singularity of moments of first signs, the uniquely new, the importance of the first time, the unrepeatable event that can emerge. It suggests an understanding of events in the present, more than being determined by events in the past, their being formed by anticipations, by their possible exploration and evolving into the future through anticipations and signs given during a present moment (Shotter, 2012). It shows how the transformative potential of moments of first signs, formed by anticipations and by their possible exploration and evolving into the future, hinges on the trusted adult’s dialogical attunement and answers for moments of meeting to evolve.

In accordance with Stern, the study illustrates the fast changing fluency of a present moment. It shows how an intersubjective field can be dramatically reorganized at moments lasting only a few seconds. In line with Leira (1990), one of the pioneer researchers in the field, these caregivers’ experiences show how child sexual abuse can, by its nature, be a taboo, remain a secret, and become an invalid and traumatic experience if not explored through adult invitation and acknowledgement.

Limitations

It can be argued that since the material used here comprised caregivers’ recollections conveyed as part of clinical conversations, the information presented might be misleading. First, the caregivers may be influenced by their relationships to their therapists to give incorrect reports, and the therapists might ask leading questions. However, since the participants came to sessions over a period of time, misleading answers can be more easily noticed than from single interviews. Second, the fact that the caregivers were part of a therapeutic setting, could lead to a reluctance to generalize the results outside of therapeutic settings. In general, it has been stated that using therapeutic sessions as data gives the researcher a unique in-depth position to gain knowledge of lived experiences about issues that are usually private, personal, and serious, such as sexual abuse. Third, even though the number of participants in this study is fairly large for a qualitative study, caution can be emphasized against generalizing across differences such as age, gender, and the severity and duration of abuse. Certainly, the analysis could have been expanded by supplying it with further inter-rater scoring, as a supplement to the actual one (Haavind, 2002; Jensen et al., 2005; Kvale, 1997). Fourth, there is a general validity problem aroused towards a retrospective study based solely on self-report (Hardt & Rutter, 2004). Recall bias regarding both sexual abuse and the disclosure are to be expected, but can be considered to be a lesser problem since the events studied were close in time. Finally, suspected perpetrators in the study were family members or family friends, which can complicate a disclosure process. Taking the high prevalence of child sexual abuse from inside the family network into account, studies of disclosure processes in such cases are highly relevant. Exploring cases from outside the family network would offer valuable comparison. Additionally, analysing who serve as outside helpers, and how they get involved and contribute—in this study as many as seven out of twenty cases—would add valuable knowledge towards strengthening door-openings for children’s early signs. This is, however, not the focus of the present study.

Conclusion

Divergent from an idea of behavioural markers, or purposeful versus accidental disclosures, this study calls for a broader attention: Moments of children’s first signs of sexual abuse are embedded in dialogue. A uniqueness at moments of first signs appears: Both to form such moments and to transform them into moments of meeting for joint exploration and telling, hinge upon how trusted caregivers scaffold opportunities for the child to disclose. In sum, when children’s trusted adults provide openings, the study shows that children use them; when carefully prompted, children talk; and, when thoughtfully asked, quality leaps towards moments of meeting are created, for the child to tell. Subsequently, offers of support need to be addressed not only to strengthen children to tell, but also for caregivers, confidants and professionals to take into account the necessity of a dialogically oriented sensitivity and attunement towards children, both for the telling to occur, and for the hearing to take place.

Acknowledgements

We wish to thank Hanne Haavind at the University of Oslo for valuable discussions throughout the process, Harlene Anderson at the Houston Galveston Institute for important encouragement, and Jaakoo Seikkula at the University of Jyvaskyla and Tine Jensen at the University of Oslo for comments on a first draft of the manuscript.
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