Child Sexual Abuse: An Epidemiological Study At The Child and Family Unit - Lentegeur Psychiatric Hospital

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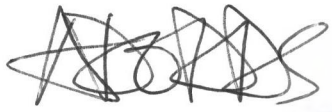
ABSTRACT

Across international and local epidemiological studies of child sexual abuse, two aspects of the literature have remained empirically consistent. Many more girls are sexually abused than boys and most perpetrators are male. Of all theoretical models of child sexual abuse, feminist theories offer the most comprehensive explanations for the gender bias found in child sexual abuse literature. In this regard, feminist explanations for child sexual abuse have been explored and used to interpret the results of this research. The current study aimed to describe the epidemiology of child sexual abuse at the Child and Family Unit (CFU) of Lentegeur Hospital using a retrospective descriptive study design. 241 case records were reviewed to determine the prevalence of child sexual abuse. Data was collected concerning: demographics; presenting symptoms; nature and duration of abuse; risk factors; perpetrator characteristics; legal action and service utilisation of CFU. Results were analysed using the Fisher's Exact Test and the Wilcoxon 2 - Sample Test. $P< 0.05$ was used to indicate statistical significance while cross tabulations were used for descriptive associations. Results revealed a 23.7% prevalence rate of child sexual abuse, which was lower than other clinically based studies. This finding was not understood to reflect an actual low prevalence of child sexual abuse, but rather a lower service utilisation of the Unit by sexually abused children. Girls were seven times more likely to present at the Unit with child sexual abuse than boys. Children presented with an array of symptoms, difficulties at school occurring the most frequently. Most perpetrators were male, usually a person known to the victim (neighbour or a peer) or an extended family member (usually an uncle). Rape and sexual molestation were the most common types of abuse experienced. Most subjects presented at the Unit a year after the sexual abuse had ended. Overall, services offered at CFU were poorly utilised by sexually abused children, most subjects attended only one session at the Unit and did not return for further intervention. Findings suggest that a protocol for the management of child sexual as well as an evaluation of services offered at CFU is currently necessary.

DECLARATION

The author hereby declares that this whole thesis, unless specifically indicated to the contrary in the text, is her own original work.



AMANDA DODDS

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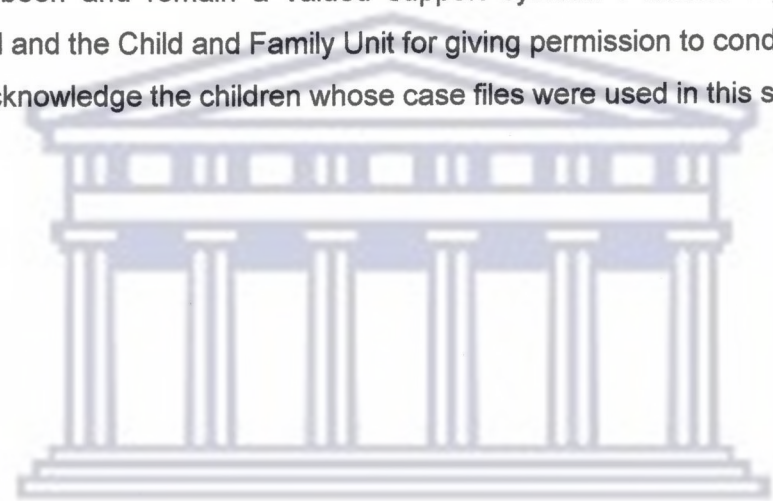

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CHAPTER 1

1. INTRODUCTION

Awareness of child sexual abuse largely grew from the Women's Liberation movement which began in the 1970's. This movement created a forum in which women could speak openly for the first time of the violence and oppression which had so pervasively characterised their sexual and domestic lives. It was within this context that women where able to break the silence which had surrounded their experiences of child sexual abuse (Herman, 1994). Since this time, child sexual abuse has been given considerable attention in the literature. Epidemiological studies have been instrumental in providing information concerning the extent and nature of child sexual abuse in many countries around the world (Finkelhor, 1993; Leventhal, 1998). Particularly where no prior research has been conducted, these studies have offered valuable baseline data which have been instrumental in motivating for the establishment of services for sexually abused children.

Across epidemiological studies of child sexual abuse, two aspects of the literature have remained empirically consistent. Many more girls are sexually abused than boys and most perpetrators are male. The gender bias which characterises child sexual abuse literature was the motivating force behind utilising a feminist theory with which to understand child sexual abuse. Chapter one, therefore details feminist understandings of child sexual abuse and focuses on the issues of power, control and sexual stereotypes. In contrast to the feminist perspectives, a description of the more traditional models of child sexual abuse is given and includes some of the feminist critiques aimed against them.

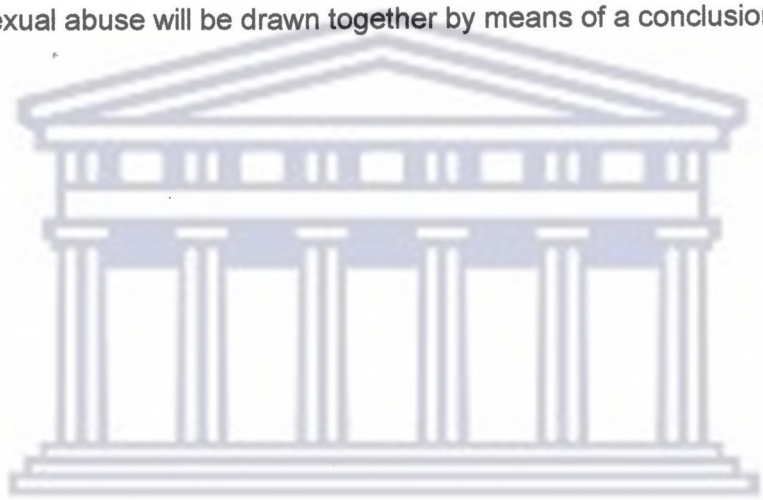
Chapter two consists of a literature review of both international and locally based epidemiological studies of child sexual abuse. It broadly covers four major areas of child sexual abuse literature, namely: prevalence; demographic characteristics of sexually abused children;

the nature of sexual abuse and the initial effects of child sexual abuse. Prevalence and incidence studies are then introduced followed by some of the methodological factors which explain the broad range of prevalence rates found in child sexual abuse literature. Studies concerning the prevalence of child sexual abuse in internationally and locally based studies are reviewed and include clinical and non-clinical populations. Data from these and additional studies of child sexual abuse are reviewed to ascertain the demographic features of sexually abused children, the type of sexual abuse and characteristics of the perpetrator. This is followed by a review of the literature concerning risk factors for child sexual abuse. The latter part of the literature review concerns studies which have focused on the effects of child sexual abuse. This section of the literature begins with a look at some of the major methodological limitations in effects literature as well as feminist critiques against the psychiatric construction of child sexual abuse.

Chapter three focuses on the current study which aims to describe the epidemiology of child sexual abuse at the Child and Family Unit (CFU) of Lentegeur Hospital. It is anticipated that the preliminary data from this research will be used to evaluate current services for sexually abused children at CFU and to inform future research in this field. Current research on child sexual abuse within Western Cape Hospitals is then discussed and is followed by a description of the research method and procedures of the current study, including data analysis and ethical considerations.

In the fourth chapter the results of the study are documented. Like most epidemiological studies, the results are grouped into a number of categories consisting of: prevalence, demographic details of the sample, risk factors, nature of presenting problem, clinical symptoms, diagnosis, the nature of sexual abuse, characteristics of the perpetrator and in addition, service utilisation of CFU.

In chapter five the results of the study are detailed. In chapter six the results of the study will be discussed in relation to both the international and local literature. Observed differences between findings of the current study and the literature will be highlighted. Hypotheses concerning the reasons for such findings will be inferred from both the research data itself and current literature. In the discussion chapter, causal relationships will not be inferred concerning the findings because of the descriptive nature of this study. The findings of the current study will then be discussed in relation to implications for future research, as well as highlight the limitations of such a study. Finally, the major themes characterising the current study and the reviewed literature on child sexual abuse will be drawn together by means of a conclusion.



CHAPTER 2

2. THEORETICAL FRAMEWORK

This chapter introduces the concept of epidemiology and the nature of it's relationship to the theoretical frameworks of child sexual abuse. Since a feminist understanding forms the theoretical basis of this study, a feminist critique of the more traditional theories of child sexual abuse has also been included in this chapter.

2.1. EPIDEMIOLOGY

The discipline of epidemiology constitutes a scientific method of enquiry, whereby methodological tools and empirical principles are used to understand the nature and extent of particular problems in society (Katzenellenbogen, Joubert & Abdool Karim, 1997). As it is a science within itself, the discipline of epidemiology does not adhere to any particular theory of child sexual abuse, but rather draws from various theoretical perspectives to postulate appropriate research hypotheses and to inform research design. It is therefore common across epidemiological studies to find the influences of various theoretical perspectives of child sexual abuse.

The objectives of epidemiology, in relation to child sexual abuse, stretch much further than simply documenting the extent and demographics of sexually abused children. Rigorous scientific methods have been utilised in an attempt to provide empirical data to assist in the identification of child sexual abuse, to determine the prognosis for those who have been abused, and to assess the impact of current intervention strategies for child sexual abuse survivors (Runyan, 1998). Where intervention services have been lacking or absent, epidemiological data have been instrumental in motivating for the establishment of such services. Other contributions include the study of risk factors associated with child sexual abuse, which has helped guide appropriate prevention strategies (Runyan, 1998).

Of particular importance to this study however is the contribution of epidemiology in exposing the continued sexual violations experienced by children in their social and domestic environments.

Given that research shows many more girls are sexually abused than boys and the vast majority of perpetrators are male. It follows to assume that any theory of child sexual abuse which omits to address the gender bias observed in empirical literature, would fail to explain the most pervasive aspect of this phenomenon. For this reason feminist perspectives of child sexual abuse will form the major theoretical foundation of this study.

2.2. A FEMINIST UNDERSTANDING OF CHILD SEXUAL ABUSE

Feminist approaches to child sexual abuse form part of broader feminist theories of widespread violence against women and children (Driver & Droisen, 1989). In such theories women and children are victims of various types of trauma, like rape, domestic violence, sexual harassment, prostitution and pornography. Awareness of abuse towards women and children can be traced to the Women's Liberation Movement which began in the 1970's. Women, for the first time, were given a forum to speak of the violence which had so pervasively characterised their sexual and domestic lives. It was the focus on the sexual victimisation of women at this time, that led to the re-discovery of child sexual abuse (Herman, 1994). The term re-discovery of child sexual abuse is used in the text to prevent the misconception that the increase of child sexual abuse in the seventies 70's marked it's origin. Search (1988) argues that child sexual abuse has been endemic to society, rather than an epidemic in society.

Broadly, feminists working and researching within this field (Driver & Droisen, 1989; Herman, 1994; Levett, 1989a; Mackinnon, 1987; Russell, 1984a) understand the sexual victimisation of women and particularly female children, as a form of female oppression by men. The process in which women are oppressed by men is commonly known as patriarchy and operates within most structural or social systems of society. The resultant power imbalances found in a gender - stratified society invariably serve the needs of men rather than women. Feminists therefore argue that sexual abuse is a form of female oppression, reflecting the broader oppression of women and children in patriarchal society.

2. 3. FACTORS CONTRIBUTING TO CHILD SEXUAL ABUSE

2. 3.1. The issue of power

The issue of power is central to a feminist understanding of child sexual abuse. Waldby, Clancy, Emetchi and Summerfield (1989) argue that, 'where there is power over others there exists the potential to misuse or abuse that power' (p. 102). The legitimate sanctioning of male power over women, evidenced historically in the exclusion of women from the clergy, judiciary and politics has perpetuated the enduring notion of male entitlement. Such an attitude asserts the assumption that women are the property of men, and therefore accords them the right to have sexual access to women, including their daughters. Driver and Droisen (1989) argue that the incest taboo which inhibits sexual activities amongst first degree blood relatives is no more than an agreement amongst men about sexual access to women. The need for such an agreement in the first place, assumes that women are the sexual property of men. Driver and Droisen also find it noteworthy that incest taboos are more frequently violated by men than women, because it was men who accorded themselves the authority to make such decisions in the first place.

Power imbalances in society particularly affect children. Firstly, children totally depend on adults for their survival. Secondly, children particularly depend on their mothers in patriarchal

communities for child rearing. Within this context, children are reliant on mothers who occupy less powerful positions in society than men. Such a position compromises a mother's ability to protect her children from perpetrating males. The following quotation aptly portrays the vulnerable place children occupy in society:

> Child abuse often highlights the powerlessness of children, not only as a class of people who are younger, smaller and in the physical and legal control of adults, but also as people who are almost universally treated as the possessions and servants of adults, especially within the family (Driver & Droisen, 1989, p. 20-21).

In summary, the assumption of male ownership of women, particularly the assumed right to sexual access, leaves female children who are in the legal care of men, particularly vulnerable to sexual exploitation.

2.3.2. Control through sexual aggression

The widespread rape and sexual abuse of females by men, also serves another function. '[Rape] is nothing more or less than a conscious process of intimidation by which *all* men keep *all* women in a state of fear' (Herman, 1994, p. 30). Sexual abuse therefore perpetuates a psychology of victim consciousness in the female psyche. This primes women to take on a subservient role to men in patriarchal societies, a role in which the status quo is not challenged for fear of reprisal (Driver & Droisen, 1989). Furthermore, Jacobs (1994) and Levett (1989a) argue that even without the direct experience of sexual victimisation the female personality cannot escape being shaped by the forces of male domination, where women experience a sense of helplessness in the face of predatory male sexual aggression.

2.3.4. Sexual stereotypes

The differences in the socialisation of men and women also contribute to the sexual abuse of children. Men are socialised to be attracted to partners who are smaller, younger and less powerful than them, or in other words, more childlike (Russell, 1984a). Men are also not as well socialised to distinguish between sexual and non-sexual forms of affection. This is particularly enforced by the absence of men in the rearing of children (Jacobs, 1994). Men who are not involved in the child rearing process remain less emotionally attached to children, enabling them to sexually objectify female children more readily. This is re-enforced by society where men are also socialised to become more easily aroused by sex which takes place outside intimate relationships, for example pornography.

In summary, feminists argue that child sexual abuse is not an independently occurring phenomenon, but rather part of the rubric of patriarchy. According greater power and privilege to men over women and children in society is understood by feminists as socially sanctioning child sexual abuse. In this regard the gender bias found in child sexual abuse is understood in feminist theory to reflect the power imbalances between men and women in society.

2.4. FEMINIST CRITIQUE OF OTHER MODELS OF CHILD SEXUAL ABUSE

Despite feminist theory offering an understanding of the inherent gender bias in child sexual abuse, feminist models have not been the dominant models drawn upon in many epidemiological studies. For this reason, it seems important to introduce some of the more traditional models which have dominated child sexual abuse theory and highlight some of the feminist critiques aimed towards them.

Gomes-Schwartz, Horowitz and Cardarelli (1990) argue that there have been three dominant theoretical models which have been utilised to understand the aetiology of childhood sexual abuse.

First is the psychiatric model, which focuses on the individual child, particularly the child's early development to make sense of current responses to trauma. Second is the social-psychological model, which investigates the characteristics of the offenders which predispose them to sexually abuse children. Third is the sociological/family model, which focuses on family characteristics which potentially increase the risk of a child being abused. For clarity, these models will be referred to as; the psychiatric model, the perpetrator model and family model.

2. 4.1. The psychiatric model

Psychiatric understandings of child sexual abuse have been predominantly characterised by psychoanalytic theory (Driver & Droisen, 1989). Freud's notion of infantile sexuality whereby unconscious sexual desires are attributed to children (Khun, 1997) and particularly his account of the female child's fantasy of being seduced by the father in the oedipal phase of development, has led to the widespread assumption that female children are seductive. Freud's original seduction theory was that adult hysteria originated from the actual sexual assault of girls, usually by their fathers. In the development of his theory of infantile sexuality, however, he retracted his original theory and claimed instead that patient's accounts were 'merely due to early childhood autoerotic fantasies' (Olafson, Corwin & Summit, 1993, p.11). In this theoretical development, the notion of the seductive child became entrenched in analytic thought. Waldby et al. (1989) argue that the notion of the seductive child is problematic in that accounts of child sexual abuse, rather than taken as fact are conceptualised as fantasy. Secondly, the notion attributes blame to the child for provoking the assault, and thirdly it serves to protect the perpetrator. Herman (1994) argues this point in the following statement.

> The tendency to blame the victim has strongly influenced the direction of psychological enquiry. It has led researchers and clinicians to seek an explanation for the perpetrator's crimes in the character of the victim (p.116).

Despite the growing recognition of child sexual abuse among medical and clinical staff and greater efforts to detect child sexual abuse, Waldby et al. (1989) argue that revision of analytical assumptions about sexual abuse aetiology still need attention.

2.4.2. The perpetrator model

A common assumption of the perpetrator model is that sex offenders are considered to have some form of psychopathology. Waldby et al. (1989) argue that the analyses of perpetrators in terms of psychopathology remain one-dimensional. They argue that perpetrators do not exist in a social vacuum, but exist in a society which sanctions male dominance over women and children. A further criticism of the perpetrator model is aimed at the model's notion that child sexual abuse is on a continuum with normal male sexuality. In the perpetrator model, the distinction between the pathological perpetrator and the average man is the degree to which sexual impulses towards young girls are repressed or acted upon. The author argues that the implied assumption of this model, namely, that male sexuality is naturally directed to little girls, including daughters, potentially normalises abusive behaviour towards children.

2.4.3. The family model

There are numerous family therapy models have been be applied to the understanding of child sexual abuse. Barker (1986), identifies eight categories of family therapy models, namely; psychoanalytic, group, experiential, behavioural, extended family systems, communications, strategic and finally structural models. Whilst he maintains that some models, like the first four mentioned, utilise theoretical models designed to help understand individuals, he argues that systems theories have become far more popular in family therapy models. Barker (1986) goes on to state 'Nowadays most family therapists look upon the family system as the entity they are treating, rather than any of the individuals in it' (p. 75).

The application of systems theory in the treatment of child sexual abuse, runs the risk of conceptualising child sexual abuse as a problem within the family system, rather than a problem of an individual within the family. Waldby et al. (1989) further argue that pathological family relationships become the central therapeutic issue in systemic models, while the actual occurrence of incest is seen as a secondary manifestation, or a symptom of deeper family pathology. Therefore within the systems model, potential exists for diminished perpetrator accountability whilst the victim is assigned shared blame for sexual offences. The potential of the systemic model to be misconstrued in this manner leads to damaging misconceptions about the aetiology of sexual abuse.

Taking the notion of diminished perpetrator accountability further, Waldby et al. (1989) highlight that the family dysfunction literature has placed much emphasis on the collusive mother in the dysfunctional family. There is a tendency to blame the mother for not playing a protective enough role within the family. The implied assumption here is that it is a mother's responsibility to anticipate that her husband will sexually violate her children.

In addition to the diminished perpetrator accountability, dysfunctional family models have neglected the structural power relations which exist in the patriarchal family. Jacobs (1994) argues that power within patriarchal families is divided into set gender roles. Mother, as the primary caregiver, controls the affective/emotional domain. Where mother is ascribed the affective domain, she is experienced by the child as omnipotent in her ability to attune to the emotional needs of her children. This 'contributes to the idealisation of mothers [by daughters] and the rage that accompanies the discovery of her [mother's] powerlessness in the face of the father's sexual violence' (Jacobs, 1994, p. 18). In summary, critiques of the application of family systems theory to child sexual abuse have largely focused upon its potential for diminished perpetrator responsibility and mother blame.

To conclude, the relationship between epidemiology as a discipline and theories of child sexual abuse is an interactive one. Epidemiological studies have brought to attention the demographics, the extent and the nature of child sexual abuse, as well as associated risk factors. Feminist theories have enriched our understanding of why child sexual abuse is so pervasively characterised by male perpetrators and a preponderance of female victims. Feminist theories have also given valuable criticism to the more traditional theories of child sexual abuse, particularly how traditional models have failed to contextualise child sexual abuse within the broader context of patriarchal society, and how the threat of sexual violence towards women and children acts as a means of continuous female oppression by men.

CHAPTER 3

3. LITERATURE REVIEW

INTRODUCTION

This chapter explores the prevalence and incidence of child sexual abuse. Literature is reviewed from international and wherever possible, South African research as well as studies conducted in both clinical and non-clinical settings. As research design impacts on the accuracy of prevalence and incidence, it also seems useful to give an overview of the main methodological factors effecting prevalence studies in this chapter.

3.1. INTRODUCTION TO PREVALENCE AND INCIDENCE

Studies to determine the extent of child sexual abuse have relied primarily upon two sources of data. One involves interviewing adults about their sexual experiences in childhood; the other uses data obtained from sexually abused children and adolescents. Incident studies pertain to the number of new cases of child sexual abuse recorded during a specific time period. In contrast, prevalence studies involve the number of sexually abused individuals new and old at a particular point in time (Katzenellenbogen et al., 1997).

Incidence studies have yielded important information concerning the characteristics of child sexual abuse. A major limitation of these studies however, is that they tend to underestimate the true incidence of child sexual abuse. By definition, incidence studies rely on reported cases of child sexual abuse. Yet it is well documented that most cases of child sexual abuse are not reported to the authorities (Lewis, 1994; Randall, Josephson, Chowance & Thyer, 1994; Robertson, 1993; Search 1988). Factors contributing to the under-reporting of child sexual abuse are numerous. For example, children are often threatened emotionally and physically by the perpetrator to not disclose their abuse. Given that perpetrators are often male adults, who are in a position of greater power over a child, it is easy to understand the maintenance of secrecy around children's victimisation.

Another contributing factor in under-reporting is high-lighted by Levett (1989a) who argues that the assumption of traumatic effects in child sexual abuse assumes victims are damaged in some way. Therefore, a decision to not report sexual abuse may be in order to protect victims of child sexual abuse from further stigmatisation. Socio-political factors also play a role in the under reporting of sexual abuse. In the United States of America (USA) and in Britain for example, child protection budgets have not kept pace with the increase in abuse reports (Olafson et al., 1993), hindering the efficacy of child protection services for those who choose to use them. Schurink (1996) argues that in South Africa, child protection services are struggling to deliver effective services due to limited resources. In addition, one must also consider that the former South African Police force (S.A.P.) was used by the previous regime to enforce apartheid. It is logical to assume that the legacy of the S.A.P. would inhibit many people reporting abuse to the child protection services.

Prevalence studies are an important adjunct to incidence studies in that they are able to estimate a far greater proportion of the population who may have been sexually abused. Limitations of prevalence studies include sample representation and recall bias. The accuracy of prevalence studies depends on how representative the study sample is in relation to the general population. Prevalence studies conducted in community samples may not be representative of the general population (Finkelhor, 1984). The role of recall bias in adult's retrospective accounts of childhood sexual abuse can also effect the reliability of prevalence studies carried out in adult populations. There has been much research on the process of storing and retrieving memory (Briere, 1990; Louw & Edwards, 1993). In cases where child sexual abuse has been experienced as traumatic, victims may be amnesiac, contributing to the under- reporting of sexual abuse.

3.2. METHODOLOGICAL LIMITATIONS IN THE STUDY OF PREVALENCE

It is well documented in the literature that prevalence rates for child sexual abuse vary across studies (Finkelhor, 1993). Variance in prevalence rates have been attributed to a number of methodological issues; for example, the definition of child sexual abuse, the sample, and the method of data collection .

3.2.1. Definition

Briere (1992) and O'Donohue (1992) argue that the major methodological difficulties in the epidemiology of sexual abuse is the high variability in the definition of child sexual abuse. The definitions of child sexual abuse are characterised by a number of dimensions namely: statutory law, the type of abuse, the perpetrator's relationship to the victim and the issue of consent.

Definitions based on the legal system tend to be restrictive, as they have a high degree of specificity in regard to the type of sexual act and the age of the victim (Knuston,1995). This excludes a broad range of offensive sexual acts and thereby underestimates the true extent of sexual victimisation (Russell, 1995). Traditionally, definitions of child sexual abuse only included contact forms of sexual abuse. Feminist writers like Russell (1986), recognised that abuse covered a broad spectrum of sexual acts, including non-contact forms of abuse. Non - contact forms of sexual abuse include exhibitionistic and voyeuristic activities with children in which the perpetrator derives sexual pleasure. It also includes inappropriate sexualisation of women and children, which is argued by feminists like Jacobs (1994) and Levett (1989a) can be subtle, yet pervasive in patriarchal societies. The impact of broad definitions of child sexual abuse is highlighted by Goldman and Padayachi (1997), who found that prevalence rates for sexual abuse dropped by 5% in both males and females when they omitted the non-contact definition of sexual abuse and applied the more restrictive definition of contact form of sexual abuse.

The victim's relationship to the perpetrator is another factor given consideration in the definition of child sexual abuse. A differentiation in incest versus non-incestuous forms of abuse, or intra-familial versus extra-familial abuse remains an important distinction in the literature. In some studies, like Russell's (1986) study of female San Fransisco residents, incestuous abuse was defined as any kind of exploitive sexual contact or attempted sexual contact that occurred between relatives, no matter how distant the blood relationship. Other studies, like Robin, Chester, Rasmussen, Jaranson and Goldman (1997) described incest as sexual acts between a child and a parent figure; be they biological, adoptive, foster or step parents and excluded other family relatives.

Driver and Droisen (1989) argue that consent is an important concept in the definition of child sexual abuse. Sexual relations with a child is a violation, precisely because the child lacks the ability to consent to such relations. 'The lack of consent stems from the child's relative ignorance of the implications of adult sexuality and from the absence of any real choice in a relationship where a child is forced to rely on adults for her well-being' (Driver & Droisen, 1989, p. 4). Driver and Droisen therefore view adult-child sex as wrong because the fundamental conditions of consent cannot prevail in the power imbalances between adult and child. The definition of child sexual abuse used in this study is presented in chapter four.

3.2.2. Sample

Studies using easily captured samples like university students are common. International studies using student populations include the work of Goldman and Padayachi (1997) and Singh, Yiing and Nurani (1996). Local studies using student populations include Levett, 1989a, 1989b and Collings, 1991, 1997. Although helpful in estimating the extent of child sexual abuse, the selection bias employed in the admission procedures to universities limit the

generalisability of these studies (Haugaard & Emery, 1989). Attempts to overcome this are made by conducting representative surveys, to give national incidence and prevalence data. South Africa however, has no available figures for the national prevalence rate of child sexual abuse.

3.2.3. Data collection

Data collection methods also have an impact on the prevalence rates obtained in studies. Higher prevalence rates have been obtained in studies where female respondents received face to face interviews about their sexual abuse histories instead of self administered interviews (Peters, Wyatt & Finkelhor, 1986; Pilkington & Kremer, 1995). More specifically, Peters et al. (1986) found that higher prevalence rates were found in studies where more than four questions about the occurrence of sexual abuse were asked. Multiple opportunities given to respondents to talk about abuse resulted in higher rates of disclosure and therefore higher prevalence rates in women. In contrast, more anonymous methods of data collection like self administered interviews, provided better opportunities for disclosure in men and yielded higher prevalence rates (Collings, 1991). This highlights the importance of matching the study sample to an appropriately researched study design.

3.3. PREVALENCE IN NON-CLINICAL SAMPLES

3.3.1. International studies

In a review of 24 non-clinical epidemiological studies conducted in over 21 countries around the world, Finkelhor (1993) reported that on an international scale prevalence rates in non-clinical studies ranged from 7 - 36% in females and 3 - 29% in males. Levett (1989a) estimates that across reliable community surveys of women in North America, one in three North American women will have experienced sexual abuse of a contact type in childhood.

In a later review, Finkelhor (1994) estimated that globally one in four girls and one in ten boys will suffer some type of sexual victimisation. Finkelhor (1993) primarily attributes the broad range of prevalence rates found across epidemiological studies to methodological factors. More recent community based studies not included in Finkelhor's (1993) review include prevalence rates for child sexual abuse in Finland, Malaysia and Australia. In Finland, Sariola and Uutela (1994) found that 6 - 8% of high school girls and 1 - 3% of high school boys reported experiences which could qualify as sexual abuse. In Malaysia, Singh et al. (1996) found the prevalence rate for contact forms of sexual abuse in a sample of trainee para-medical staff was 69% and for non-contact 21%. Goldman and Padayachi (1997) found the prevalence of child sexual abuse in a sample of university students in Queensland to be 45% in females and 19% for males. These rates included both contact and non-contact forms of sexual abuse.

3.3.2. African studies

Overall, the study of child abuse in Africa, including South Africa, has been limited. Accounting for this, Lachman (1997) argues that developing countries lack a formal research culture because political and economic problems overshadow child protection issues. In an attempt to highlight child abuse, the International Society for the Prevention of Child Abuse and Neglect, known as ISPCAN was established. The society acts as a co-ordinating body for research and data concerning the ongoing protection and prevention of child abuse internationally. South Africa and Africa have established their own subsidiaries of this society, namely, the South African Society for the Prevention of Child Abuse and Neglect (SASPCAN) and the African Network for the Prevention and Protection Against Child Abuse and Neglect (ANPPCAN). In 1993, the Second African Conference on Child Abuse and Neglect under the auspices of ISPCAN, was held in Cape Town. A third conference took place in Kenya 1998, but no published papers were readily available at the time of this research. Therefore, papers from the 2nd conference have been reviewed in this chapter.

Supporting feminist understandings of child sexual abuse which address the social contexts within which child sexual abuse occurs, many of the academic papers presented at the conference addressed the socio-political factors perpetuating child sexual abuse in Africa. Khama (1993), addressing the problems of sexual abuse in Botswana at the conference, argues that the preponderance of patriarchy in economic and family institutions in Botswana results in the subservience of women and children to the male head of the family. She further states 'in cases of sexual abuse, particularly incest, some children believe [child sexual abuse] is a parental prerogative not to be questioned or divulged to anyone' (p. 57). Similarly in Kenya, Anyanzwa (1993) argues that African societies have always been male dominated and chauvinistic. 'In these societies women's rights have been trampled on and their voices never heard' (p. 60). These arguments are echoed by Rubagiza (1993) concerning the Ugandan situation in which incest, child labour, female circumcision and child marriage all contribute to the victimisation of young girls. Omari (1993) of Tanzania argues on a sociological level that urbanisation, current family structure and traditional customs all perpetuate the occurrence of child sexual abuse. In summary, arguments amongst academics concerning the widespread sexual abuse of children in Africa attribute the role of social factors, particularly the preponderance of patriarchy in social institutions in perpetuating child sexual abuse.

3.3.3. South African studies

Levett & Lachman (1991) highlight that in South Africa, most research on child sexual abuse remains unpublished. Lachman (1997) further argues that 'there have been few, if any, epidemiological studies in the field of child abuse in South Africa' (p220). Prevalence figures for child sexual abuse in South Africa predominantly come from community samples, and many of these have utilised student populations which are not generalisable to the general population (Collings, 1991, 1997; Lachman, 1997; Levett, 1989a; Russell, 1995). The only national study of child sexual abuse in South Africa was a national incidence study of crimes

against children conducted by the Human Science Research Council in 1996. Results showed that reported crimes against children in South Africa are estimated to increase by 29% each year. This is significant when statistics for crimes against adults show an increase of 2.7% annually. They also found that 62% of crimes against children are sexual in nature (Schurink, 1996).

The following studies conducted in local community and student populations offer a review of prevalence rates found in South Africa. Levett's (1989b) study using a student sample, revealed a prevalence rate of 43.6% for both contact and non-contact forms of child sexual abuse and 30.9% for contact types of abuse in a sample of female students at the University of Cape Town. Collings (1991) found 28.9% of male students at the University of Natal had experienced unwanted contact sexual experiences. In a follow up study, Collings (1997) used the same study design for female students at the University of Natal, and found the prevalence rate for contact forms of child sexual abuse in females was 34.8%, a figure consistent with Levett's study.

The prevalence rates of child sexual abuse in South African student populations are higher than those of other countries. For example, Bergner, Delgardo and Graybill (1994) report that prevalence rates for child sexual abuse in female American college students ranged from 7 - 24%. After having ruled out the possibility of methodological factors causing higher prevalence rates in South African studies, Collings (1997) argues that the higher prevalence rates in South African student populations reflect a true higher prevalence of child sexual abuse.

Congruent with Colling's argument that child sexual abuse in South Africa is higher than in North America, Russell (1993) estimates that the rate of incestuous abuse in South Africa may

be at least 50 % higher than that of North America. Such an estimation suggests that a quarter of all sexually abused females in South Africa have experienced incestuous abuse. Russell (1993) attributes the high prevalence rate in South Africa to the following three factors. Firstly the rape rate in S.A. is almost double that of North America. Secondly, the number of broken families is exceptionally high in South Africa, resulting in more families with step-fathers, adoptive and foster-fathers. This increases the risk for sexual abuse since girls are over seven times more likely to be abused by their step-father than a biological father (Russell, 1986). Thirdly, high rates of substance abuse, which characterise many poor and disfranchised communities of South Africa, are associated with increased risk of incestuous abuse. These factors, intrinsically linked to the destructive impact of apartheid on South African society, have increased the potential for abuse.

A community based study by Lachman (1997) gives further support to high prevalence rates for child sexual abuse in South Africa. To determine the extent of child abuse in Cape Town, Lachman set up a co-ordinated reporting centre for reported cases of child abuse in the Cape Town area. Results showed that the most common type of abuse experienced by children was sexual abuse, occurring in 61% of reported cases. Lachman reports that the results of his study are probably an underestimation of the extent of child sexual abuse in Cape Town, as figures pertain to reported cases of child sexual abuse only. In an earlier community based survey, Collings (1993b) reported that 40% of cases presenting at Durban Child and Welfare in a one year period were for sexual abuse. He repeated the study one year later at the same institution and found that 70% of child abuse cases were for sexual abuse.

In summary, international prevalence rates in non-clinical studies range from 7-36% in females and 3 -29 % in males (Finkelhor, 1993). South African prevalence rates in university students samples for contact forms of abuse in females range from 30.9 % (Levett, 1989a) to 34.8 %

(Collings, 1997) in females and 28.9% in males (Collings, 1991). Bergner et al. (1994) report that American prevalence rates for female college students are far lower than South African rates, ranging between 7 - 24% . It is argued that the higher rates of sexual abuse found in non-clinical South African studies reflects an actual higher prevalence of child sexual abuse (Collings, 1997; Russell, 1993).

3.4. PREVALENCE IN CLINICAL SAMPLES

3.4.1. International studies

Clinical studies on the prevalence of child sexual abuse have focused either on children and adolescents or on adults presenting in clinical settings. For the purpose of this study, only those concerning children and adolescents will be reviewed.

Robin et al. (1997) investigated the prevalence of child sexual abuse amongst children and adolescents of an American Indian tribe, attending a community clinic. Data was collected regarding sexual abuse histories using a semi-structured psychiatric interview. Child sexual abuse was defined as direct physical contact between a child of 16 years and under with a perpetrator at least five years older than the victim at the time of abuse. Results revealed that 49% of females and 14% of males had experienced at least one episode of childhood sexual abuse before 16 years of age involving direct physical contact.

Randall et al. (1994) conducted a study at a public psychiatric hospital in Georgia in North America, to determine the prevalence of physical and sexual abuse amongst children and adolescents attending the hospital. Over a one year period a 13% prevalence rate of child sexual abuse in children and adolescents was reported. However, whether prevalence rates pertained to contact or non-contact forms of abuse was not commented upon. The results of both these studies support Painter's (1986) finding that prevalence rates amongst clinical settings are substantially higher than national prevalence rates.

Gale, Thompson, Moran and Sack (1988), conducted a study at a community mental health care clinic in Portland, Oregon U.S.A., over a two year period. The aim of the study was to compare the presentation of child sexual and physical abuse to children without histories of abuse. All of the children in the study were less than seven years old. A contact definition of sexual abuse encompassing molestation and penetration was used. Results of the study show that one in three or 33% of children under the age of seven years in clinical settings, have experienced child sexual abuse.

3.4.2. South African studies

Westcott (1984) reported 18 cases of contact forms of child sexual abuse at Red Cross Children's War Memorial Hospital in Cape Town over a six month period, in 1982. Six years later, Jaffe & Roux (1988) reported 88 cases of contact forms of child sexual abuse at the same hospital over a one year period. McKerrow (1989), reported a 42.9% prevalence rate for child sexual abuse at Red Cross Children's Hospital which included both contact and non-contact forms of sexual abuse. Argent, Lachman, Hanslo & Bass (1995) conducted a study on children presenting at the same hospital with evidence of sexually transmitted diseases (STDs). Over an 18 month period 107 children referred to the hospital for medical care had evidence of STDs. On further follow up it was found that the majority of these children had corroborative evidence of child sexual abuse.

In Natal, Jacobs and Loening (1991b) reported that 83% of abused children presenting at King Edward VIII Hospital in 1989, were victims of contact forms of sexual abuse. In an unpublished study a year earlier in 1988, Jacobs and Loening (1991a) reported that 73% of abused children seen at the hospital had been sexually abused. Results of these studies indicate that prevalence rates in South African clinical studies range from 42 - 83 % (Jacobs & Loening, 1991a, 1991b; McKerrow, 1989; Westcott, 1984).

South African prevalence rates for child sexual abuse in clinical settings are considerably higher than North American and European rates. This is understood by Russell (1993) and Collings (1997) to reflect the actual higher prevalence of child sexual abuse in South Africa rather than be due to methodological distortions. The higher prevalence rates of child sexual abuse in both South African clinical and non-clinical settings have been attributed to not only methodological differences in study designs, but to numerous political and socio-economic problems experienced in South Africa.

3.5. DEMOGRAPHIC FEATURES OF CHILD SEXUAL ABUSE

3.5.1. Gender

It is well documented across clinical and non-clinical studies of child sexual abuse that females are abused in far higher numbers than males (Driver & Droisen, 1989; Levett, 1989b; Risin & Koss, 1987; Russell, 1984a). Finkelhor (1993) reports that internationally 2.5 girls are sexually abused for every boy. This ratio is consistent with Gomes-Schwartz et al. (1990) who found childhood sexual victimisation was twice as common in females than in males. South African clinical studies reflect higher female to male ratios for child sexual abuse. Jaffe and Roux (1988) found gender ratios in their sample of sexually abused children consisted of 90% girls and 10% boys, similarly, Westcott (1984) reported gender ratios of 80% girls and 20% boys.

Although the prevalence rates for child sexual abuse are lower in males, Finkelhor (1993) argues that there has been an increase in the prevalence rate of sexual abuse in males. This he ascribes to a greater number of studies concentrating on child sexual abuse in males. In Finkelhor's (1993) review, the highest prevalence rate for sexual abuse in males came from a South African study by Collings (1991), who reported a 29% prevalence rate of child sexual abuse in male university students in Natal.

3.5.2. Age

Finkelhor (1979) found in his analyses of 13 epidemiological studies of child sexual abuse that the average age at which children were sexually abused was between 9.3 and 10.6 years. In a later review of six studies in North America, Finkelhor (1993) reported that the risk for child sexual abuse increased dramatically for children under the age of ten years. Results of a study by Gomes-Schwartz et al. (1990) showed that the average age at which a child was first sexually abused was 9.1 years old. Robin et al. (1997) found that for both boys and girls onset of child sexual abuse was between six and nine years. International literature therefore suggests that pre-adolescent children are at greater risk for sexual abuse.

Onset of child sexual abuse appears younger in South African clinical studies. McKerrow (1989) found that children between the ages of 3 - 8 years were most at risk for sexual abuse, with the highest risk peaking at four years of age. McKerrow's results are supported by other hospital based studies in South Africa like Jacobs & Loening (1991a, 1991b) and Jaffe & Roux (1988), who both show the most common age for children to be sexually abused is between 4 - 6 years. Argent et al. (1995) also found that the majority of children presenting at Red Cross Children's Hospital with evidence of sexually transmitted diseases and concurrent histories of child sexual abuse were less than five years of age.

Clinical studies in South Africa support the results of international studies in which children under the age of ten years are at higher risk of sexual abuse. However, it appears that the onset of child sexual abuse tends to be younger in South African clinical settings, between four to six years, as opposed to North American studies which suggest onset at nine years.

Interestingly, onset of child sexual abuse in non-clinical settings was older than in local clinical studies. In a retrospective study of female university students, Collings (1997) found that the

majority of females were first abused between the ages 12 - 14 years, which is far older than local clinical studies suggest. Lachman (1997) who conducted a study using a community sample found that the risk for sexual abuse in girls increased with age. His results showed that girls sexually abused between the ages 10 - 15 years of age constituted 70.3% of his sample, followed by 65.4% between the ages 5 -10 years and 46% between 1- 5 years. Local literature therefore suggests that early onset child sexual abuse is more likely to present in clinical studies, whereas later onset of child sexual abuse is more likely to be detected in community based studies. This finding is discussed in some detail in relation to the current study in chapter five. Finally, it is important to note that results across the literature highlight that no particular age category excludes the risk of child sexual abuse.

3.6. NATURE OF ABUSE AND PERPETRATOR CHARACTERISTICS

Studies detailing the type of sexual abuse inflicted upon children give varying results. Types of child sexual abuse tend to fall into two broad categories. The first is contact forms of sexual abuse which include penetrative sexual acts, as well as the inappropriate touching of body parts, broadly known as molestation. The second category consists of non-contact forms of sexual abuse which involve exposure to exhibitionism and voyeuristic activities which give sexual pleasure to the perpetrator (Russell, 1986).

3.6.1. International studies

Gomes-Schwartz et al. (1990) studied a sample of children and adolescents who presented at a community mental health clinic in North America, and found that 29% of the total sample were subjected to vaginal or anal intercourse and 23% to molestation. Most experiences were one off abusive incidents, and 40% of the offenders were functioning in the role of parent. Nearly half the offenders lived in the same home as the victim. Similar results were obtained in a study by Gale et al. (1988). In this study the most common type of sexual abuse in children under the

age of seven years was what they broadly termed sexual molestation, which occurred in 68% of the sample. The second most common type of abuse was penetrative sex occurring in 32% of the sample. They also noted that 54% of the cases involved repeated sexual abuse. The most common repeated type of sexual offence was molestation, usually perpetrated by a relative. These findings are consistent with a study carried out in Hong Kong by Ho and Lieh Mak (1992), who found that intra-familial cases of sexual abuse where characterised by significantly more molestation.

Robin et al. (1997) conducted a community based study on a South Western American Indian tribe. In this study, 375 children under 17 years were assessed for child sexual abuse. Results concerning the type of abuse experienced, showed that 55% of the total sample were subjected to penetrative sex, defined as object or penile insertion into the vagina or anus. The second largest category of abuse was molestation, occurring in 30% of the total sample. In 50% of the total sample, the perpetrator was an extended family member. For females the second largest category of perpetrator was an immediate family member 18%. For males, the second largest category of perpetrator was a friend of the family 23%. These results differ from Russell's (1986) study, which showed a higher precentage of children had been abused by a non-family member.

Ho and Lieh Mak (1992) conducted a retrospective survey using the case reports of sexually abused Chinese children. Their results support Robin et al. (1997) in that they found the most common type of sexual abuse was penetrative sex, followed by molestation. They also discovered that in cases of intra-familial abuse, molestation was the most common type of sexual abuse. In extra-familial abuse, vaginal intercourse was more common, occurring in 78% of all cases. Regarding the perpetrators in this study, they found that 64.2% of perpetrators were a male friend of the child or of the family. Strangers accounted for the second most common type of perpetrator occurring in 37.3% of cases. Abuse by a step-father was lower

than that of biological fathers who accounted for 11.9% of the cases. These results are contrary to Russell's (1986) estimation that the risk of being sexually abused by a step-father is seven times more likely than by a biological father.

In summary, the type of sexual abuse experienced by children tends to differ across studies. Whilst Gomes -Schwartz et al. (1990) and Gale et al. (1988) found sexual molestation was the most common type of sexual abuse, Robin et al. (1997) and Ho and Lieh Mak (1992) found sexual intercourse (vaginal and anal) the most common type of abuse inflicted upon children. Most studies supported the notion of Gomes-Schwartz et al. (1990) who argue that children are usually sexually abused by someone they know and often trust. The review of international literature suggests that most sexual abuse occurs as a one off incident. It also shows that females are at higher risk of repeated sexual abuse than males. It also seems that children abused by a close family member are at higher risk of repeated sexual abuse.

3.6.2. South African studies

In South African studies, variations are also present in the type of abuse experienced by children. For example, McKerrow (1989) found that rape was the most common type of abuse, occurring in 49% of the study sample. This remained consistent across both genders as over half of the males in the sample were sodomised and over half of the females had been raped. The second largest type of abuse was molestation occurring in 19% of the sample. Most of the children were abused as a one off incident. Females were more often repeatedly abused than male children, which is consistent with the international literature. In this study, female victims were more likely to be abused by someone they knew outside of their immediate family, whilst males were predominantly abused by a stranger. This differs from the findings of Robin et al. (1997) who reported that the majority of abuse to boys was perpetrated by an extended family member.

Collings (1991) found the two most common types of child sexual abuse in a sample of male university students fell into the non-contact category of sexual abuse. These consisted of 26.4% of males subjected to exhibitionistic types of abuse and 15.4% subjected to performing sexual acts for the voyeuristic pleasure of the perpetrator. In the contact category of abuse, 15.4 % of males were subjected to anal intercourse. The perpetrators were usually strangers occurring in 43% of the sample and mostly male. The second most common perpetrator in the study was a family member at 17%. In 72% of cases the sexual abuse occurred as a one off incident (Collings, 1991).

A similar profile emerged in Collings' (1997) study of female university students, where 93% of the perpetrators were male and 56.1% of the sexual abuse occurred as a once off incident. Molestation was the most common type of sexual abuse followed by penetrative sexual acts. The major difference between the male 1991 and female 1997 studies was that females were more often sexually abused by a family member (31%), while males were more often abused by a stranger (43%).

In summary, there were no consistent patterns across clinical and non-clinical studies, either internationally or locally, with regard to the nature of sexual abuse in children. Clinical studies did however suggest that a higher proportion of children had experienced penetrative sexual acts while non-clinical studies showed molestation to be more common in females and non-contact forms of sexual abuse to be more common in males. From a feminist perspective, the non-contact forms of sexual abuse which characterised males' experiences in the Collings (1991) study, suggests that male perpetrators more readily inflict more severe forms of sexual abuse like molestation and rape onto girls than they do boys. The fact that girls are subjected to greater sexual violence than boys is congruent with the wisespread occurrence of women abuse in patriarchal societies.

3.7. RISK FACTORS ASSOCIATED WITH CHILD SEXUAL ABUSE

Studies concerning the risk factors for child sexual abuse help identify children who are potentially at risk for sexual abuse, which assists in the early identification of child sexual abuse. Secondly, Fleming, Muller and Bammer (1997) argue that risk factors inform prevention strategies and intervention programs. Knuston (1995) argues that most risk factors associated with child sexual abuse are environmental in nature, rather than due to the qualities of the child. Such environmental factors include, for example, the absence of a biological parent, a mentally ill mother, or physical violence in the home. This has important implications for prevention programs which have traditionally focussed on children, rather than the child's environment. Knuston's argument parallels feminist perspectives which contend that the environment, particularly the role of social institutions in society, perpetuate the sexual abuse of children.

One of the most comprehensive literature reviews of risk factors associated with child sexual abuse was conducted by Finkelhor (1994). In this paper, Finkelhor reviewed epidemiological literature from North America and Europe concerning risk factors for child sexual abuse. A summary of his findings are listed in point form below:

- Girls are at higher risk of being abused.
- Risk of sexual abuse rises in pre adolescence from around the age of ten years.
- Research does not support the notion that sexual abuse is more common amongst lower social classes.
- Race and ethnicity, like social class has not been found in epidemiological research to be a risk factor for sexual abuse.
- The most documented family related risk factor for child sexual abuse is the presence of a step-father in the household. Girls are over seven times more likely to be abused by their stepfather than a biological father (Russell, 1986).

- Children living without one or both their birth parents are at greater risk of abuse.
- Impairment in the quality of parenting, and a lack of adequate supervision of the child's activities and contacts puts children at greater risk.
- In some studies, paternal violence has been shown to be a risk factor in incestuous abuse.
- On the whole, emotionally, physically and psychologically abused children are more vulnerable to falling prey to the seemingly 'benign attention' offered by a perpetrator.

Bergner et al. (1994) and Fleming et al. (1997) found however that many of the risk factors identified by Finkelhor (1994) did not remain consistent after multi-variate analysis. Bergner et al. (1994) argue that variables which remained statistically significant predictors of risk for sexual abuse were: the experience of being physical abused as a child; having a mother who was mentally ill; not having someone to confide in and being socially isolated. Social isolation and experiencing the death of a mother were significant predictors for sexual abuse before 12 years. Whereas predictors after 12 years of age for sexual abuse were physical abuse and a mentally ill mother.

Risk factors for intra-familial abuse were: physical abuse; having no one to confide in; having no caring female adult and an alcoholic father. Risk factors for extra-familial abuse were: physical abuse; social isolation; death of a mother; and an alcoholic mother. The presence of a step-father, seen in other studies (Herman & Hirschman, 1981; Mullen, Martin, Anderson, Romans & Herbison, 1996; Russell, 1984b) as an important risk factor, did not remain significant after multivariate analysis. Two critiques are aimed at the study by Fleming et al. (1997) on risk factors associated with child sexual abuse. The first is their use of statistics to invalidate findings of other empirically sound studies like Russell (1986, 1984b) who has shown the presence of a step-father to increase the risk of child sexual abuse.

Secondly, they fail to give any explanation as to why these particular factors place a child at risk for sexual abuse.

In summary, debate continues concerning which factors put children most at risk for child sexual abuse. However, literature strongly suggests that environmental factors, rather than attributes of the child, increase the risk of child sexual abuse. This is congruent with feminist perspectives which associate the greater risk of child sexual abuse with the social environment, particularly between women and men in society.

3.8. EFFECTS OF CHILD SEXUAL ABUSE

In a review of the literature concerning child sexual abuse effects, Friedrich (1998) identifies three themes which have characterised the development of research in this field. The first theme concerns the effort made by researchers to show that child sexual abuse existed in large enough numbers to be of concern, achieved primarily through the use of prevalence and incidence studies.

The second theme, demonstrated that sexual abuse had adverse or traumatic consequences for the child. This was accomplished with the association of child sexual abuse with Post Traumatic Stress Disorder. Such studies found that anxiety responses in adults were similar to anxiety symptoms in children with histories of trauma, like sexual abuse (Briggs & Joyce, 1997; Rowan, Foy, Rodriguez & Ryan, 1994; Walker, 1993; Wolfe, Sas & Wekerle, 1994). The third theme is characterised by a developmental perspective of child sexual abuse. Such a perspective is one in which the effects of child sexual abuse are examined not only in relation to the abuse itself, but also in relation to pre and post abuse factors. Freidrich (1998) argues that limitations of earlier research necessitates a new challenge in which the impact of pre and post

abuse factors on research outcomes become central to research on child sexual abuse effects. Friedrich's argument is supported by Gomes-Schwartz et al. (1990) who state 'the way in which the child is most likely to express emotional distress is influenced by the child's prior history and current developmental level, as well as the nature of the sexual abuse' (p.78). Whilst, an understanding of pre and post abuse factors is crucial to an understanding of the impact of child sexual abuse, feminist theory would caution against placing child sexual abuse on a continum with other stressful events in the developmental life span, as this potentially normalises the occurrence of child sexual abuse.

3.8.1. Methodological limitations

One of the major methodological difficulties in the effects of child sexual abuse is to find empirical measures to determine whether the observation of psychopathology in sexually abused children is a direct consequence of the abuse, or because of other possible variables. In the past, studies on the effects of child sexual abuse tried to empirically demonstrate a linear cause and effect relationship between the abusive incident and the development of symptoms. However, Mannarino, Cohen and Berman, (1994) argue that there are numerous moderating variables that may affect the psychological adjustment of sexually abused children within the contexts of pre abuse and post abuse factors, including the experience of child sexual abuse itself. This notion is supported by Friedrich (1998) who argues that 'if one looks at the larger picture, sexual abuse is probably as much about parent child relationships in combination with adverse life circumstances as it is about specific aspects of trauma' (p. 523).

The literature cites various factors which may impact upon the effects of child sexual abuse. Broadly, these consist of: age of child at the onset of child sexual abuse, the victims relationship to the perpetrator, the duration of the abuse, the reactions of others to the disclosure of child sexual abuse and the degree of force used in the sexual assault (Browne & Finkelhor, 1986; Gomes-Schwartz et al., 1990).

Concerning age and effects of child sexual abuse, authors debate whether sexual abuse at a young age is less traumatic than in teenage years. It is hypothesised that younger children do not understand sexual taboos, where as the teenager is more aware of the stigma surrounding sexual abuse. However, a teenager is seen to have better developed internal resources than a young child to cope with the trauma of child sexual abuse (Adams-Tucker,1982; Bagley & Ramsey, 1986). Studies by Gomes-Schwartz et al. (1990) and Randall et al. (1994) demonstrate how age often determines the symptomatic responses in children to child sexual abuse, which in turn affects diagnoses.

Groth 1978 (cited in Gomes-Schwartz, 1990, p. 80) argues the closer the relationship the child has with the offender, the more severe the trauma. He also argues that the longer the duration of the abuse the greater the trauma. Browne and Finkelhor (1986) however, have not found the empirical evidence to support this. Other factors impacting on effects is the type of sexual abuse and the reactions of others in the initial disclosure of child sexual abuse. Whilst inconsistencies exist in the literature concerning the factors which most accurately determine child sexual abuse effects, Browne and Finkelhor (1986) suggest that sexual acts in which force was used tend to result in a greater fear response as well as aggressive behaviour in the child. They also suggest some evidence of increased symptomology in children who experienced negative parental reactions when they disclosed sexual abuse. It therefore shows that there are a number of variables which impact upon the effects of child sexual abuse. The literature however, displays inconsistent results concerning the impact of moderating variables on child sexual abuse.

3.8.2. Feminist critiques of traumatic effects

Most research on the effects of child sexual abuse support the notion that it often results in adverse affects for victims including increased risk for the development of psychiatric illness. (Browne & Finkelhor, 1986; Collings, 1993a; Summit, 1983). While the association of traumatic

effects with child sexual abuse has highlighted its seriousness, and has acknowledged the depth of trauma often experienced by child sexual abuse survivors, a number of feminist critiques have been aimed at the notion of traumatic effects. The first critique is at the tradition of psychiatry for failing to incorporate a notion of woman abuse, including child sexual abuse into a construction of mental illness (Wilson, 1998). Effects have largely been constructed around a medical model in which psychiatric symptoms and diagnoses replace the issue of trauma in relation to abuse. Feminists like Levett (1989a) argue that the construction of child sexual abuse effects as mental illness runs the risk of further stigmatising women and children with abuse histories.

Effects literature demonstrates that child sexual abuse presents with an array of pathological symptomology (Carey, Kempton & Gemmill, 1996; La Barbera, Martin & Dozier, 1980; Rech, 1991; Robin et al., 1997). More specifically, it is argued that 'psychological distress in sexually abused children ranges from a complete absence of any conventional symptoms of childhood psychopathology to extreme and pervasive emotional problems' (Gomes-Schwartz et al., 1990, p.100 - 101).

In regard to the above, Levett (1989a) argues that the widespread assumption that child sexual abuse has traumatic consequences, is problematic for a number of reasons. Firstly, the literature offers inconsistent evidence for pathogenic effects of child sexual abuse. Secondly, the assumption of traumatic effects does not accommodate cases in which there is an absence of traumatic symptoms. Thirdly, the notion of traumatic effects assumes psychological damage, which further stigmatises individuals with abuse histories as mentally ill. Levett (1992) calls for a more thorough deconstruction of the concept of trauma, especially in its relation to the misuse of power.

In summary, there has been much debate, particularly amongst feminist theorists about the value of associating traumatic effects with child sexual abuse. Furthermore there are numerous methodological difficulties in this field of study, which result in inconsistent empirical evidence for traumatic responses to child sexual abuse. Finally, traumatic effects have predominantly been constructed within a medical or psychiatric framework which fails to incorporate an understanding of the role woman abuse and child sexual abuse plays in the development of mental illness.

3.9. STUDIES ON THE EFFECTS OF CHILD SEXUAL ABUSE

The literature concerns itself with two major areas of traumatic effects; namely initial effects, usually occurring within two years after the sexual abuse has terminated, and long term effects, normally persisting into adulthood (Browne & Finkelhor, 1986).

As this particular study focuses on children and adolescents' experiences of sexual abuse and not adult accounts of childhood sexual abuse, studies concerning the initial effects of sexual abuse will be focused on in this chapter. One is reminded however, that the connection between initial and long term effects remains a conceptual one. In a review of empirically based studies, identifying the effects of child sexual abuse, Browne and Finkelhor (1986) categorised observed symptomology in children into 4 broad areas: emotional reactions and self perceptions; physical consequences and somatic complaints; effects on social functioning and effects on sexuality.

3.9.1. Emotional reactions

The most common emotional reaction noted by Browne and Finkelhor (1986) to child sexual abuse, was fear. In support of Browne and Finkelhor's study, Gale et al. (1988) found that 68% of children in their study exhibited anxiety symptoms. Meiselman (1978) reports that fear commonly manifests as nightmares, hypervigilance, enuresis, sleep disturbances and impaired

impulse control. Anger and hostility were the second most common emotional feature identified by Browne and Finkelhor. Gale et al. (1988) found the second most common symptom in a sample of sexually abused children under the age of 7 years was non-compliance. Non-compliance or defiant behaviour may be understood as a form of passive aggression in some children.

Sgroi (1982) argues that whilst anger in children is often repressed, it can manifest in aggressive behaviour, depression or withdrawal. Guilt and shame was also noted to be a common emotional response by Browne and Finkelhor (1986), especially in relation to the disclosure of sexual abuse. Conte and Schumerman (1987) argue that despite guilt being a common response in most cases of sexual abuse, it becomes more pervasive in survivors of incestuous abuse particularly as they mature and cognitively grasp incest taboos. Browne and Finkelhor (1986) note that self blame and guilt often intensifies feelings of low self esteem in the survivor. Oates, Forrest and Peacock (1985) found that children with sexual abuse histories obtained low scores on the Piers-Harris Children's Self Concept Scale. Browne and Finkelhor (1986) contradict these findings by arguing that empirical studies have not established lowered self esteem as an effect of child sexual abuse.

3.9.2. Physical and somatic complaints

The most common physical and somatic complaint in child sexual abuse was sleep disturbance. Anderson, Bach and Griffith (1981) reported that 17% of sexual abuse victims had experienced sleep disturbance. Other physical and somatic complaints were eating disturbances and adolescent pregnancy. A hospital based study conducted by Argent et al. (1995) identified 107 children under the age of five years with evidence of sexually transmitted diseases (STDs), 67% of these children had a history of child sexual abuse. The most common STD was neisseria gonorrhoeae.

In another hospital based study of sexually abused children, Jaffe and Roux (1988) found genital discharge occurred in 28% of children in their study, laceration of the vagina in 11%, Syphilis 9% and bruised genital area in 8% of the sample. It is important to note that physical effects of child sexual abuse are more likely to be found in general hospitals or trauma settings, where medical examinations are mandatory. They are also more likely to be present where greater force and violence has been used in the sexual assault. One may also hypothesise that where there is physical evidence of sexual trauma, adults are more likely to believe a child on disclosure which results in the sexual abuse being reported. Similarly, it would be misleading to assume that a lack of physical symptoms excludes the possibility of child sexual abuse.

3.9.3. Effects on social functioning

Difficulties at school, truancy, and running away from home are commonly experienced by sexually abused children and teenagers (Briere & Runtz, 1988; Browne & Finkelhor, 1986). Early marriages have also been seen as an effect of child sexual abuse. The high prevalence of teenage marriages has been attributed to the need of victimised children to escape their abusive home environments (Meiselman, 1978). Other effects on social functioning are evidenced in withdrawal from social relationships including peers and sometimes fear of adult contact (Rech, 1991). It was found by Gomes-Shwartz et al. (1990), that school problems were particularly common in both pre and adolescent children with histories of sexual abuse. This is supported by Rech (1991) who also acknowledges a high association of learning difficulties with child sexual abuse.

3.9.4. Sexual effects

Browne and Finkelhor (1986) noted that sexuality related problems were more common in younger girls than older boys. They noted that inappropriate sexual behaviours consisted of open masturbation, excessive sexual curiosity and frequent exposure of the genitals. With regard to effects on sexuality, an interesting study was undertaken by Gale et al. (1988). They

conducted a study of physically and sexually abused children as well as a group of non-abused children under the age of seven years to compare their clinical presentations. Results showed that the presentation of all three groups overlapped in terms of symptomology, except for one statistically significant variation. In the group of sexually abused children, they found subjects had a significant higher frequency of inappropriate sexual behaviour than the two other groups. These results are consistent with studies reported by Friedrich (1993) and Browne and Finkelhor (1986). Sexually inappropriate behaviours reported by Gale et al. (1988) often involved marked sexual aggressiveness, including coercive fellatio, insertion of objects into the rectum and attempted forcible intercourse with other children.

Whilst inappropriate sexual behaviour is strongly associated with sexual abuse in this age group, the authors emphasise that determining whether sexual abuse has occurred will depend heavily on corroborative findings. Thompson, Authier and Ruma (1994), conducted a study on behavioural problems in sexually abused children in foster care. They found that sexually inappropriate behaviour was not the most common behavioural problem in any age category. However, they found that of all the behavioural problems evidenced in the sample, sexually inappropriate behaviour was the most difficult and uncomfortable behavioural problem to manage by foster parents. Unfortunately, no data concerning emotional and behavioural problems of sexually abused children could be found in the published South African studies of child sexual abuse in clinical settings (Argent et al., 1995; Jaffe & Roux, 1988; McKerrow, 1989; Westcott, 1984). This may be because these studies were conducted in general medical settings where children are seen for too brief a period of time to obtain such information.

In conclusion, empirical data on the effects of child sexual abuse does not support the notion that there are consistent psychological responses to sexual abuse (Briere & Runtz, 1988; Browne & Finkelhor, 1986; Mannarino, Cohen & Gregor, 1989). Child sexual abuse can present

with an array of emotional and behavioural problems, which makes it difficult to distinguish the sexually abused child from other psychiatric conditions.

CHAPTER 4

4. METHODOLOGY

INTRODUCTION

This chapter begins with an overview of local mental health services available to children and adolescents in the Western Cape context. Next the motivation, aims and objectives for this study are outlined, followed by a detailed description of the study design. The chapter ends with both ethical considerations.

4.1. MENTAL HEALTH SERVICES FOR CHILDREN & ADOLESCENTS IN THE WESTERN CAPE

The provincial administration of the Western Cape offers psychological services for children and adolescents at four institutions; Red Cross Children's War Memorial hospital, Lentegeur hospital, William Slater Adolescent Clinic and Tygerberg hospitals. Published studies on child sexual abuse could only be found at Red Cross Childrens Hospital. This reflects that three quarters of the service area covered by the provincial administration of the Western Cape lacks basic epidemiological data on child sexual abuse.

4.1.1. Lentegeur Hospital

The current rationalisation of state psychiatric services (Strategic Management Team, 1995 cited in Stacey, 1997. p. 39) has resulted in the closure of numerous in-patient wards at Lentegeur Hospital, including their in-patient adolescent Unit in 1995. In 1998, under the auspices of the Department of Health, the Child and Adolescent Mental Health Service Committee was established to lobby for continued provision of mental health services. Minutes of committee meetings available at CFU, document the intention of the committee to fight against the possible closure of CFU. Lentegeur Hospital provides psychiatric services to Mitchell's Plain and Khayelitsha on the Cape Flats. Historically these areas were subject to an unequal distribution of health care resources under the apartheid system (Swartz & Levett,

1990). Today, post-apartheid, these communities remain under-resourced due to numerous socio-political and economic problems experienced in South Africa. The communities serviced by Lentegeur Hospital experience high levels of gang related crime and violence; many of the families are of low socio-economic status, and in some areas, basic amenities like water, electricity and housing, are still absent.

The climate of rationalisation in South Africa's mental health care system necessitates sound empirical research in which the extent of particular social problems like child sexual abuse can be determined. Such data is essential for the appropriate planning of intervention and prevention strategies (Finkelhor, 1994; Lachman, 1997).

4.2. MOTIVATION FOR THE CURRENT STUDY

As a member of the staff team at CFU at Lentegeur Hospital during 1997, it was noted by the researcher that a history of child sexual abuse was a common feature of cases at the Unit. However, the Unit had no data concerning current management strategies for child sexual abuse, nor any outcome measures for existing interventions. As a consequence, management strategies were inferred from ward rounds, supervision and international studies (which are not necessarily applicable to local populations). It was therefore felt that a preliminary study of child sexual abuse would be of value to the Unit, as it would provide empirically based data on the extent and nature of child sexual abuse at the Unit.

4.3. HYPOTHESES

Based on the reviewed international and local literature, the following hypotheses were made in relation to child sexual abuse at the Unit.

- The prevalence of child sexual abuse will be high.
- More girls will be sexually abused than boys.

- Perpetrators will predominantly be male and known to the child.
- The presenting symptoms of children with a history of child sexual abuse will be varied.

4.4. AIMS OF THE STUDY

The aim of this study is twofold: first is to describe the epidemiology of sexually abused children treated at the Child and Family Unit of Lentegeur Hospital; secondly, it aims to generate the impetus for a data base on child sexual abuse within the Unit, providing both a resource for the assessment of current services and a basis for future research.

4.4.1. Objectives

1. To determine the prevalence of child sexual abuse at the Unit, during January - December 1997.
2. To describe the demographics and clinical presentation of sexually abused children seen at the Unit during this time period.
3. To describe the types of sexual abuse experienced by children and demographic characteristics of the perpetrators.
4. To describe the pattern of service utilisation at the Unit by sexually abused children in order to assist with the management of this problem.
5. To produce a research document which can be used to assist the Child and Adolescent Mental Health Service Committee to motivate for continued psychological services to children and adolescents, particularly services to survivors of child sexual abuse in the Mitchell's Plain and Khayelitsha areas.

4.5. STUDY DESIGN

The grossly unequal distribution of health care during the apartheid era (Swartz & Levett, 1990), and the current rationalisation of health services in South Africa demands accurate preliminary studies of problems like child sexual abuse. Descriptive study designs have mainly been used to give service providers and planners information that will help them design services and allocate resources efficiently and have been used successfully in numerous clinical settings (Gale et al., 1990; Ho & Lieh Mak, 1992; Jaffe & Roux, 1988; McKerrow, 1990; Randall et al., 1994). The use of a retrospective descriptive study design provides an economical method of conducting preliminary research on the extent of child sexual abuse at Lentegeur Hospital. It also provides an impetus for future research in this field.

4.5.1. Sample

Heiman (1989), refers to a sample 'as a relatively small subset of a population that is intended to represent or stand for the population' (p. 23). However, clinical samples have limited generalisation in that they are only comparable to other clinically based samples. The sample for this study consisted of 241 children who had presented at CFU from January-December 1997 for psychological intervention. Of the 241 case records reviewed, 57 cases had child sexual abuse documented as a presenting problem. It was these 57 case records of child sexual abuse that formed the sample for this study.

4.5.2. Definition of child sexual abuse

The retrospective nature of the study design demanded that definitions of child sexual abuse would be based upon the definitions used in the case records. Due to the preliminary nature of this study, and the use of feminist theories to explain child sexual abuse, a broad definition including contact and non-contact forms of sexual abuse was used in this study.

Contact forms of sexual abuse included anal and vaginal intercourse, oral sex, and the touching or kissing of any body parts, more commonly known as molestation. Non-contact types of abuse include exhibitionistic and voyeuristic activities which give sexual pleasure to the perpetrator.

Children in this study pertained to any persons eighteen years old or younger as this is the stipulated age category of CFU. There was no limit placed on the age of the perpetrator in this study in support of Russell (1995) who argues that sexual abuse of children by peers whose age differential is less than five years, should not be excluded from data bases.

Intra-familial or incestuous sexual abuse referred to a perpetrator who was either a biological, step, adopted or foster parent. Extra-familial abuse referred to anyone outside the immediate family. For example; extended family members like grandparents, uncles, cousins, a friend of the family, acquaintance, or a stranger. As this study concerns itself with children who have been sexually abused, cases of children who had presented at the Unit for allegedly sexually abusing other children were not included in this study.

Cases in this study included both alleged and confirmed cases of sexual abuse. Alleged cases consisted of the child or the primary care giver spontaneously stating sexual abuse as the presenting concern at the time of intake. It is acknowledged that in cases where there has been no legal prosecution, recorded accounts of sexual abuse remain alleged. Confirmed cases consisted of those subjects who had received a case conviction after taking legal action against the perpetrator.

4.6. MEASURES

Data was gathered from the case reports of patients. Information contained in the case reports was collected using the standard intake procedure of CFU which consists of the clinical

interview and an assessment of the child's family. The clinical interview consists of three components; (a) factual data related to the development of symptom formation in the patient (b) the psychiatric history in which the examiner is required to record, in the parent's words, the child's psycho-social development from birth to her/his current age and (c) the mental status examination which gathers data concerning the examiner's observations and impressions of the patient at the time of the interview (Kaplan, Sadock & Grebb, 1994).

Assessment of the family is carried out with a standard intake form. Four major areas of family functioning is assessed, namely: the problem solving capacity of the family; roles in the family; types of discipline and communication styles. Information contained in case reports from psychometric and projective tests was not utilised .

The data was analysed using the Statistical Package for Social Sciences (SPSS) for the basic frequencies, and the Statistical Analysis Software package(SAS) for all other analyses. The skewness of the data necessitated a non-parametric analysis of the data. Given the relatively small number of males in the sample (7 boys) in relation to the females (50 girls), a gender stratified analysis was not appropriate. The Fisher's Exact Test was used to test for associations between categorical variables, because in most cases the cell frequencies were < 5. For the stratified analysis where more than three groups were compared, the Wilcoxon 2 - Sample Test or Kruskal - Wallis Test was used to detect differences in the continuous variables. $P < 0.05$ was used to indicate statistical significance. As this is a descriptive study rather than a comparative study design, causal relationships between variables were not able to be inferred. Non-causal associations in the data remain at the descriptive level.

4.7. PROCEDURE

The researcher personally reviewed every case record of CFU for the year of 1997, and extrapolated all files with child sexual abuse documented as a presenting problem. A data capture form was designed by the researcher to encode data from these files under potential coded categories. The system of codes was adjusted accordingly when unanticipated categories were found in the course of data capturing. Data were captured on 38 different variables (see appendix) describing the demographic features of the child, presenting symptoms, the nature and duration of the abuse, family characteristics, the demographic features of the perpetrator, action taken by the social service and the judicial system in the case, and the type of intervention received at the hospital. The variables were not assessed for content validity, due to the descriptive nature of the study.

4.8. ETHICAL CONSIDERATIONS

Permission was first obtained from both the University of the Western Cape's Higher Degrees Senate Committee and the medical superintendent of Lentegeur Hospital to gain access to the case files of the Child and Family Unit. All information was obtained from hospital records, and no patients were interviewed or contacted in person. The anonymity of the study sample was maintained by not gathering any of the children's identifying data. No persons other than the researcher herself, were given access to the case files. Research findings from this study will be made available to the staff members of the Unit.

CHAPTER 5

RESULTS

The results of the analysis are presented as follows: the prevalence of child sexual abuse in the unit; the demographics of sexually abused children; risk factors; nature of the presenting problem; clinical symptomology; diagnosis the nature of sexual abuse; characteristics of the perpetrator and in addition, service utilisation of the Child and Family Unit.

5.1. PREVALENCE OF CHILD SEXUAL ABUSE

All case files opened at the Child and Family Unit from January-December 1997 were reviewed by the researcher. During this time period, 241 cases of children requiring psychiatric intervention had been opened. Of these 57 (23.7 %) had child sexual abuse documented as a presenting problem. It is these 57 cases that constituted the sample for this study. The prevalence of child sexual abuse at the Unit over a one year period in 1997 was 23.7 % which translates into almost one in four children presenting at the unit due to child sexual abuse. As discussed in the previous chapter, not all of the cases used in the study sample had been reported or prosecuted, therefore the obtained prevalence rate of 23.7% include cases of alleged child sexual abuse.

5.2. DEMOGRAPHIC VARIABLES OF THE SAMPLE

The age of the total sample ranged from 2 years to 18 years of age, and averaged 12.8 years (SD = 3.63). Males had a mean age of 10 years 8 months (SD = 4.45), whilst the mean age for females was older at 13 years (SD = 3.46).

The gender breakdown of the total sample consisted of 50 females (87.7%), and 7 males (12.3%). This translated into a female to male ratio 7:1 in the total sample. For one female subject, age details were not available, hence n= 49 rather than 50 (see Table 1).

Table 1 Total sample by age and gender.

Age		Female		Male	
		n = 46	%	n =7	%
7 - 12 yrs	primary school	13	26.53	5	71.43
13- 18 yrs	high school	33	67.35	2	28.57

When comparing only primary and high school age groups to gender, it was found that significantly more girls were sexually abused between the ages 13 - 18 yrs than boys in this age category. Whilst more boys were sexually abused in the 7 -12 yr age category than girls. Fisher's Exact test (2 - tail), (p = 0.037).

Concerning educational level, most of the subjects (17.5%), were standard five pupils, followed by standard six pupils (15.8) % and standard two pupils (12.3%). It was noted that 80.5 % of the total sample were in standards below recommended schooling requirements, 17.02% of the sample were in the appropriate standard for their age and only one subject in the sample was in an educational standard higher than recommended requirements.

5.3. RISK FACTORS ASSOCIATED WITH THE FAMILY

Certain risk factors associated with family and domestic circumstances were analysed. Results in this study showed that the absence of a biological father in the home was the most commonly recorded risk factor, occurring in 32 subjects (56.1%) of the total sample. The presence of a step-father in the home, associated in the literature with higher risk, was the second most common risk factor occurring in 17 subjects (29.8 %). This was followed thirdly

*The term 'standard' has now been replaced by the term 'grade' in government schools. At the time of this study however, educational 'standard' was still in use.

by 12 subjects (21.1%), who experienced the presence of a substance abusing family member in the home. Fourthly, the presence of a physically or mentally ill biological mother and the absence of a biological mother occurred concurrently in 8 subjects (14%) of the total sample.

5.4. NATURE OF THE PRESENTING PROBLEM

5.4.1. Singular versus multiple presenting problems

It was noted that 54.4% of the total sample had multiple presenting problems which included child sexual abuse. Those with a singular presenting problem, solely of child sexual abuse, occurred in 43.9% of the total sample. Therefore in over half of the study sample, child sexual abuse concurred with other presenting complaints.

5.4.2. Prior history of child sexual abuse

Of all subjects in the sample 71.9%, had no prior history of child sexual abuse while 15.8 % had been sexually abused before. In this regard, most cases presenting at CFU were for first time presentations of child sexual abuse.

5.5. CLINICAL SYMPTOMOLOGY

5.5.1 Common clinical symptomology

The first four symptoms recorded in the presenting problem of case files were collected from each subject. Of the first four symptoms extrapolated from the case files, difficulties at school was the most commonly occurring symptom, followed secondly by sadness or feeling low. The third most common symptoms were tearfulness, sleep disturbance, fear and aggressive behaviour which occurred with equal frequency. The fourth most common symptoms were nightmares and suicidal ideation also occurring in equal frequency (see Table 2).

Table 2 Most commonly occurring symptoms documented in case files

Symptoms	N = 57	%
Difficulties at school	17	29.8
Sadness / feeling low	16	28.1
Tearfulness	14	24.6
Sleep disturbance	14	24.6
Fear	14	24.6
Aggressive behaviour	14	24.6
Nightmares	12	21.1
Suicidal ideation	12	21.1

5.5.2. Symptoms in relation to age

Clinical symptoms and age categories were tabulated to explore associations. Children under the age of seven years, were omitted from the table due to the small number of subjects. The four most commonly occurring symptoms in children aged between 7 - 12 years and 13 - 18 years are tabulated below (see Table 3).

Table 3 The 4 most commonly occurring symptoms in relation to age

Symptoms for **7 - 12 years**	7-12 yrs n = 18	%	Symptoms for **13 - 18 years**	13-18 yr n = 35	%
School difficulties	9	50.0	Sleep disturbance	10	28.6
Nightmares	5	27.8	Sadness/feeling low	10	28.6
Fearful	5	27.8	Suicidal ideation	10	28.6
Withdrawn	5	27.8	Aggressive behaviour	9	25.7

Tabulations did not suggest any clear associations between the age of the child and clinical symptoms.

5.5.3. Symptoms in relation to gender

Clinical symptoms and gender were tabulated for associations (see Table 4).

Table 4 Symptoms and gender

Symptoms	**Female**		**Symptoms**	**Male**	
	n =50	%		n =7	%
Sadness / feeling low	16	32.0	Defiant behaviour	5	71.4
Tearful	14	28.0	Aggressive behaviour	4	57.1
Fear	14	28.0	Difficulties at school	4	57.1
Sleep disturbance	14	28.0	Inappropriate sexual behaviour	2	28.6
Difficulties at school	13	26.0	Theft / stealing	2	28.6

Tabulations suggest that girls tended to present more commonly with emotional or internalising symptoms, whilst boys tended to present with more behavioural or externalising symptoms.

5.5.4. Symptoms in relation to multiple versus singular presenting problems

It was noted that clinical symptoms in relation to multiple presenting complaints including child sexual abuse, versus a singular presenting complaint of child sexual abuse alone, showed descriptive differences in symptoms. Symptoms associated with multiple presenting complaints were more commonly characterised by behavioural problems, for example: school difficulties;

in 10 subjects (32.3%); defiant behaviour in 9 subjects (29.0%); and aggressive behaviour in 8 subjects (25.8%). Subjects with a singular presenting problem of child sexual abuse showed more emotional symptoms. For example: sleep disturbance in 10 subjects (9.0%); nightmares in 8 subjects (8.0%) and fear, tearfulness and difficulties at school in 7 subjects (7.0%). It was further noted that cross tabulations of symptoms in relation to the type of abuse experienced and symptoms in relation to the identity of the perpetrator, suggested no associations.

5.6. DIAGNOSES

In 34 subjects (59.6%) of the total sample, a provisional diagnosis for the case had not been documented in the case file, despite this being a requirement of the clinical interview. Of the 23 subjects who had received a diagnosis, the most common were: Adjustment Disorder (6 subjects); Major Depression (5 subjects); Diagnosis deferred (5 subjects) and Post Traumatic Stress Disorder (3 subjects).

5.7. NATURE OF THE ABUSE

The terms used to describe the nature of abuse were taken directly from the case records. For one subject, no details of the type of abuse was available hence, N=56 rather than 57 (see Table 5).

Table 5 Types of abuse

Nature of abuse	N=56	%
molestation	22	39.29
rape	21	37.50
sexual abuse with no other details	10	17.86
non-contact sexual abuse	3	5.36

The most common type of abuse documented in case files was molestation, followed closely by rape. 'Sexual abuse with no other documented details' was the third most common type of sexual abuse, whilst non-contact sexual abuse occurred far less commonly. In summary, 43 subjects or (77%) of the total sample experienced contact types of child sexual abuse described in case files as rape or sexual molestation. The figure for contact types of abuse may even be higher as the figure of 77% excludes the catergory of 'sexual abuse with no other details', due to a lack of specific information concerning the nature of abuse experienced by these subjects.

5.7.1. Type of abuse in relation to the gender of the child

There was no significant difference between the type of abuse experienced by boys and the type of sexual abuse experienced by girls. Both girls and boys in this study sample were at equal risk for rape and sexual molestation. Fisher's Exact Test (2 - Tail), ($p = 1.000$).

5.7.2. Type of sexual abuse in relation to the age of a child

When comparing younger children (7-12 yrs) with older children (13-18 yrs) for associations between age and type of sexual abuse, results showed that these age categories did not have a significant impact on the type of sexual abuse experienced. Children younger than seven yrs were excluded from the analysis due to the small sample size (3 subjects only). Fisher's Exact Test (2- Tail), ($p = 0.089$) (see Table 6).

Table 6 Sexual abuse and age

Type of sexual abuse	**7 - 12 years** n = 18	%	**13 - 18 years** n = 35	%
Rape - no other details	3	16.7	16	45.7
Molestation - no other details	9	50.0	12	34.9
Sexual abuse - no other details	5	27.7	5	14.2
Non-contact sexual abuse	1	5.56	2	5.71

5.7.3. Duration of the abuse

In 18 subjects, the duration of the abuse was not documented. Of the remaining 39 subjects in which this information was available, sexual abuse occurred as a one off incidence in 51.2%, whilst in 12.8% the abuse continued over a period of two years. This suggests most cases of sexual abuse seen at the Unit involve one off incidents of sexual abuse.

5.7.4. Place of the abuse

In 21 subjects, no information was documented concerning where the sexual abuse took place. Of the 36 cases in which it was documented, 16 (44.4%) were abused in their own homes, whilst 11 subjects (30.5%) were abused in the perpetrator's home.

5.7.5. Disclosure of the abuse

No documentation concerning to whom the child first made a disclosure of sexual abuse was available in 22 subjects. In the remaining 35 subjects in which such information was documented, 18 subjects (51.4%) had disclosed to their biological mother, 3 subjects (9.0%) had disclosed to a friend and 3 subjects (9.0%) disclosed to a sibling. The nature of disclosure was documented in 35 subjects. Of these subjects, spontaneous disclosure from the child occurred in 69%, followed by 29% disclosing after being prompted by another person.

5.8. CHARACTERISTICS OF THE PERPETRATOR

5.8.1. General information

In the total sample, 89.5% of perpetrators were male. There was no record of any female perpetrators. Of the 52 cases in which some information was documented concerning the age of the perpetrator, 70.2% of perpetrators were described as "as a man" or "an adult". Notably, 10.5% the perpetrators were teenagers, aged between 13 -19 years old. Information concerning whether the perpetrator had a history of sexually abusing other children, was not available in the

available in the majority of cases. Only two subjects (out of the total sample) knew the perpetrator had sexually abused other children.

5.8.2. Perpetrators relationship to the victim

The most common perpetrator category was a person known to the child. A neighbour followed closely by a peer were the most common perpetrators within this catergory. An extended family member (other than a parent figure) constituted the second most common perpetrator category. Of extended family members, an uncle was the most common perpetrator. The third most common perpetrator category was that of step-father. The fourth most common perpetrator category was a person unknown to the child and the least common perpetrator category was biological father. In 10.53% of the cases there was no documentation concerning the perpetrator's relationship to the victim (see Table 7 below).

Table 7 Identity of perpetrator

Perpetrator	N =57	%
Person known to child	16	28.07
Extended family member	14	24.56
Step-father	11	19.30
Person unknown to child	6	10.53
Not documented	6	10.53
Biological father	4	7.02

5.8.3. Perpetrator's relationship to victim by gender

Both girls and boys were most commonly sexually abused by a person known to them, followed secondly by an extended family member. Although tabulations suggests that gender was not associated with the perpetrator, it is interesting to note that boys were less likely to be sexually abused by a biological or a step-father (see Table 8).

Table 8 Perpetrator by victim's gender

Type of abuse	**Female**		**Male**	
	n = 50	%	n = 7	%
biological father	4	8.00	0	0.00
step father	11	22.00	0	0.00
extended family member	12	24.00	2	28.57
person known to child	12	24.00	4	57.14
person unknown to child	6	12.00	0	0.00
not documented	5	10.00	1	14.29

5.8.4. Perpetrator's relationship to the victim by age

Descriptive associations were noted between the perpetrator and the child's age (see Table 9).

Table 9 Perpetrator and age of victim

Perpetrator	0 - 4 yrs		5 - 6 yrs		7 - 12 yrs		13 - 18 yrs	
	n = 2	%	n = 2	%	n = 18	%	n =35	%
Biological father	0	0.00	1	50.0	1	5.56	2	5.71
Step father	0	0.00	1	50.0	2	11.1	8	22.8
Extended family member	2	100.	0	0.00	6	33.3	6	17.1
Person known to child	0	0.00	0	0.00	5	28.7	11	31.4
Person unknown to child	0	0.00	0	0.00	2	11.1	4	11.4
Not documented in file	0	0.00	0	0.00	2	11.1	4	11.4

Children aged 0 - 6 years were more commonly sexually abused by a family member, whereas children aged between 7 - 12 and 13 - 18 years showed varied associations between age and the identity of the perpetrator.

5.8.5. Reporting of abuse and legal action taken

The reporting of sexual abuse to the authorities was documented in 35 case files, (61.4%) of the total sample. Information concerning legal action taken in response to child sexual abuse however was documented in 37 cases. Of the 37 cases, 35.1% were still under current investigation at the time of this study. 29.7% had not taken any legal action in response to the sexual abuse, 8.1% withdrew the case after reporting, 5.4% were dismissed by the court, and in another 5.4%, the accused were acquitted. Overall, only 16.2% had received a conviction as a result of taking legal action against an alleged perpetrator.

5.9. SERVICE UTILISATION OF THE UNIT

5.9.1. Referral route to the Unit

In the majority of cases, the referral person and institution at which the subjects were first seen, was not available in the case records. Where the information was recorded, social workers and doctors were equally responsible for referral to CFU. Hospitals were the most commonly recorded places of referral, followed by social service agencies (see Table 10).

Table 10 The 3 most common referral persons and places to CFU

Referral person	N=57	%	**Referral place**	N=57	%
Not documented	15	26.3	Not documented	15	26.3
Social worker	14	24.6	Day hospital	12	21.1
Doctor	14	24.6	Social service agency	10	17.5

5.9.2. Delay in presentation to the Unit

The time delay from the most recent incidence of sexual abuse to the time of presentation at CFU was available in 49 cases. Of these, 61.2% presented within one year of the last abusive incident terminating, followed by 22.4% within 2 - 4 years, and 16.3% more than 4 years later (see Table 11).

Table 11 Time delay

Time delay (most recent incident to presentation at CFU)	N =57	%
< 1 month	7	12.28
1 - < 12 months	13	22.81
1 year later	10	17.54
2 - 4 years	11	19.30
> 4 years	8	14.04
not documented in case file	8	14.04

It was noted when comparing younger children of 7-12 years to older children of 13-18 years, younger children had significantly less data recorded in the case files concerning when the sexual abuse terminated than older children. Fisher's Exact Test (2 tail) ($p = 0.037$).

There was also a significant difference in the time delay in presentation to the Unit in relation to the identity of the perpetrator. The three most common perpetrator categories namely; step-father, extended family member and person known to the child showed significantly different time delays in presentation to the unit, using the Kruskal - Wallis Test. ($p = 0.0095$). It was found that children sexually abused by their step-fathers present for intervention at the Unit far later (M = 34.8 months; SD = 19.96) than children abused by an extended family member (M = 14.20 months; SD = 18.21) or by someone known to the child (M = 11.87 months; SD = 15.60). Interestingly, children sexually abused by their biological fathers presented at the Unit earlier (M = 21.25 months; SD = 25.91) than those abused by their step-fathers. It was also noted, that there was no significant association between gender and time delay in presentation to the Unit. Fisher's Exact Test (2 - tailed), ($p = 0.952$).

5.9.3. Case manager

Table 12 Breakdown of cases in relation to case manager

Case manager	N=57	%
Psychiatric nurse	17	29.8
Registrar	14	24.6
Intern psychologist	12	21.1
Social worker	6	10.5
Psychologist	5	8.8
Not documented in file	2	3.5
Consultant	1	1.8
Occupational therapist	0	00

Most of the subjects in the total sample were managed by a psychiatric nurse at the Unit, followed by a registrar and then by an intern psychologist. Professionals in training therefore, constituted 45% of the case managers dealing with child sexual abuse at the Unit during 1997 (see Table 12).

5.9.4. Attendance at the Unit

Overall, service utilisation at the Unit by sexually abused children was poor. Most subjects attended only one session at the Unit and only 14% of the total sample attended more than 4 sessions (see Table 13).

Table 13 Number of sessions attended

Number of sessions	N=57	%
1 session only	25	43.9
Adolescent program	8	14.0
2 sessions	6	10.5
3 sessions	5	8.8
4 sessions	5	8.8
> 4 sessions	8	14.0

5.9.5. Termination

Of the total sample, 50.9% terminated prematurely. Planned termination occurred 24.6% of the sample (see Table 14).

Table 14 Nature of termination

Nature of termination	N=57	%
Premature	29	50.9
Planned	14	24.6
Not documented in case file	14	24.6

5.9.6. Reason for termination

In the 34 cases in which it was documented, the most common reason for premature termination was that patients did not return for their appointments occurring in 67.6% of the total sample. Concerning follow up arrangements, of the 49 subjects in which this information was documented, 53.0% of subjects received no follow up arrangements after therapy terminated while 30.6% of subjects were offered follow up at the subjects' request.

CHAPTER 6

6. DISCUSSION

INTRODUCTION

The results of this study are discussed under nine categories: prevalence; demographic characteristics; risk factors; presenting problem; nature of abuse; disclosure; characteristics of the perpetrator; legal action and service utilisation of the Unit. In most sections the results of the study are explored in relation to both local and international literature.

6.1. PREVALENCE OF CHILD SEXUAL ABUSE AT THE UNIT

The prevalence rate for child sexual abuse in this study was 23.7%. Prevalence for contact forms of sexual abuse was 17.8% and for non-contact forms of sexual abuse 1.24%. Almost one in four children treated at Lentegeur Hospital's CFU had a history of child sexual abuse. Whilst this is congruent with Finkelhor (1994) who estimated on an international scale that 1 in 4 children will have suffered some sexual victimisation, the prevalence rate in this study is low when compared to other clinically based studies. Despite possible methodological differences across the clinical studies reviewed (Briere, 1992 & Finkelhor, 1993) it seems important to speculate on other reasons for the low prevalence rate obtained in this clinical sample.

Prevalence in clinically based international studies range from 30 - 49% (Robin et al., 1997 & Gale et al., 1990) and in clinical South African studies 38 - 83% (Argent et al., 1995; Jacobs & Loening, 1991a, 1991b; Jaffe & Roux 1988; McKerrow, 1989; Westcott, 1984). These Prevalence ranges are far higher than the 23.7% prevalence rate obtained in this study. Only one study reviewed had a lower prevalence rate than that of the current study. Randall et al. (1994) reported a 13% prevalence rate for child sexual abuse at a community mental health centre in North America.

The lower prevalence rate obtained in the current study may be due to a number of factors. Firstly, as stated in earlier chapters, CFU is a specialised chilld and adolescent Unit operating at the tertiary level of mental health care provision. The current rationalisation of primary health care necessitates that acute child sexual abuse cases are first managed by the Day Hospitals. Only those cases deemed un-managable by staff at the Day Hospitals are referred on to CFU which substantially reduces the number of sexually abused children treated at CFU. Another consideration in the low prevalence rate for child sexual abuse at the Unit is the high 'drop out' rate that occurs in secondary referral. Individuals seen by staff at the Day Hospitals may be reluctant to seek out further therapeutic contact at another institution like CFU. In addition, the often sensitive nature of sexual issues, particularly the sexual abuse of children makes contact with numerous health care workers uncomfortable for many children and their families, contributing to 'drop out' rates.

The existence of other organisations equipped to deal with child sexual abuse in the Cape Flats area, may also contribute to the lower rates of child sexual abuse seen at CFU. Examples of such organisations are: Safeline; Childline; Child Welfare Society; Islamic Social Workers Association and the Mitchell's Plain co-ordination group for the management of child abuse and neglect. In addition, social service agencies or Day Hospitals may be the preferable institutions from which to seek help because of the stigma of madness often associated with mental hospitals like Lentegeur. In addition, communities serviced by Lentegeur Hospital have traditionally been denied a therapeutic culture of mental health due to the legacy of apartheid, which may contribute to seeking help from the Day Hospitals or social services rather than psychiatric institutions.

In summary it is hypothesised that the low prevalence rate for child sexual abuse at the Unit reflects a lower service utilisation of CFU as a facility, rather than a low prevalence of child sexual abuse in communities serviced by Lentegeur Hospital.

6.2. DEMOGRAPHIC CHARACTERISTICS OF THE VICTIMS

6.2.1. Age

The average age of victims in the current study was 14 years. The age at which subjects were first sexually abused was not available from the case records. Considering that over 50% of subjects presented at CFU one to four years after the last incident of sexual abuse, one may speculate that over half of the subjects in this study were being sexually abused between the ages of 10-13 years, and for some the sexual abuse may have started much younger. Internationally, children are most commonly abused between the ages of 9-10 years (Finkelhor, 1979,1993; Gomes - Schwartz et al, 1990) which is consistent with the results of this study. South African clinical studies show however, that the onset of child sexual abuse is considerably younger (usually between four to six years) than was found in the current study (Argent et al., 1995; Jacobs & Loening, 1991a, 1991b; Jaffe & Roux 1988; McKerrow, 1989). It is noteworthy, that in local community based study, Lachman (1997) found that the age of onset for child sexual abuse was older than international literature suggests and older than local clinical studies suggest, including the current one. The risk of child sexual abuse peaked in Lachman's study at 10-15 years.

The greater number of younger children, between four to six years, presenting in South African clinical settings as opposed to community settings may be because in many more younger children the sexual abuse would have been more recent, and therefore more acute. Evidence of physical trauma in younger sexually abused children is also common, which might result in medical or clinical help being sought for child sexual abuse (Argent et al., 1995; Jaffe & Roux, 1988; Westcott, 1984). In addition, the inability of young children to verbalise their abuse may result in more younger children getting referred to a child specialist who is better equipped to communicate with pre-verbal children about abuse issues. In addition, the lower number of teenage children found in clinical settings may reflect a perception that teenage sexual abuse

is not as 'serious' as the sexual abuse of younger children, and therefore does not warrant clinical care.

6.2.2. Gender

There was a far higher percentage of sexually abused girls than boys in the study sample. This is consistent with both international and local literature, and supports the need of a feminist framework in which to understand the widespread sexual victimisation of females. Results of this study show that sexually abused females are seven times more likely to present at CFU for treatment than boys. While the feminist theories in chapter two help to explain the higher prevalence of sexual abuse in girls, it seems important to hypothesise why the prevalence of child sexual abuse in boys was far lower than girls in this particular study.

The low prevalence of sexually abused boys in this study may be due to a number of factors. Collings (1991) argues that most studies of child sexual abuse have focused on girls, resulting in less awareness of child sexual abuse in boys. Another contributing factor, discussed by Hepburn (1994) is the tendency for sexually victimised males to act out their conflict and anxiety in sexually inappropriate, aggressive or anti-social ways. In analysing case records for the current study, it was noted that a number of male children presented at the Unit for allegedly sexually abusing other children. Boys were excluded from this study sample, despite suspicion of child sexual abuse because of their alleged 'offender' status. The tendency for sexually abused males to act out their conflict results in a number of sexually abused males presenting via the juvenile justice system, rather than in clinical settings.

The lower prevalence of sexually abused boys in this sample is probably further influenced by the traditionally patriarchal nature of South African society. This is particularly evident in communities where masculinity is defined by power, especially power gained by aggression and violence. For boys in such communities disclosure of sexual abuse, particularly sodomisation

by a male perpetrator, leaves boys vulnerable to further victimisation by other men. In traditional patriarchal environments, masculine identity is strongly associated with power, dominance and being the aggressor, rather than vulnerability, or helplessness. In this regard, the choice of boys to remain silent about their sexual abuse becomes a means of protecting their 'masculine' identity.

6.2.3. Education

It was noted that 80.5% of subjects were in school standards below State educational recommendations. Difficulties at school as a result of child sexual abuse are well documented in the literature (Briere & Runtz, 1988; Browne & Finkelhor, 1986; Rech, 1991). The high number of children in the sample experiencing difficulties at school is congruent with the finding that difficulties at school was the most commonly occurring symptom in subjects. While it may seem that child sexual abuse shows an association with school difficulties, socio-economic factors may also play a role in lowered scholastic performance. In working class communities for example, it is quite common for some children to have not attended crèche because of financial constraints. Some children may be in academic standards below their age category, not because of sexual abuse but because they started school a year late, or they may have failed a year due to specific scholastic difficulties. Therefore, despite results showing an association between child sexual abuse and school difficulties, no causal assumptions can be made without more rigorous research. Finally, one also needs to consider that school difficulties may serve as a protective factor in sexually abused children of this sample. Difficulties at school are more likely to be investigated by teachers and parents, increasing the chances of discovering child sexual abuse.

6.3. RISK FACTORS

The absence of a biological father from the home of subjects was the most common risk factor ocumented in the current study. Increased risk of child sexual abuse in homes where a

biological parent is absent is well documented in the literature (Finkelhor, 1994). Causal relationships between the absence of a biological father and increased risk for child sexual abuse can not be inferred in this study, due to the descriptive nature of the study design. However, speculation as to why the absence of a biological father may increase the risk of child sexual abuse in this study is warranted. One may hypothesise that in patriarchal communities, the absence of a male figure head in the family creates easier sexual access to the women of that family by other men, as male competition has been removed. This leaves a matriarchal family vulnerable to the sexually predatory behaviour of men. This coupled with the loss of the incest taboo when a step-father takes on a fatherly role, leaves women and children particularly vulnerable to sexual exploitation. In addition, the socially conditioned need of women to depend on a male figure head in the family, and the often economic necessity of a second bread winner in the home, single women parents may feel pressured to find male partners, without considering the potential for abuse.

6.4 . PRESENTING PROBLEM

Literature on the effects of child sexual abuse has highlighted the difficulty of distinguishing whether symptomology in sexually abused children is the direct consequence of sexual abuse, or of pre- or post-abuse factors (Friedrich, 1998; Mannarino et al., 1994). In the current study, the majority of subjects presented with multiple problems in conjunction with child sexual abuse. Many of these were characterised by social and family problems, for example domestic violence, divorce and marital conflict. These results support a stream of recent research which advocates further investigation in to the psycho-social correlates of child sexual abuse rather than focusing solely on observed symptomology (Friedrich, 1998). In addition, feminist perspectives emphasise the role of social and cultural factors like women abuse in perpetuating the occurrence of child sexual abuse.

Difficulties at school was the most commonly recorded symptom in the current study. This was followed in order of occurrence by: sadness; tearfulness; sleep disturbance; fear; aggressive behaviour; nightmares; and suicidal ideation. The results of this study support the notion that child sexual abuse presents with an array of symtomology, ranging from no symptoms at all to severe traumatic responses (Carey et al., 1996; Gomes - Schwartz et al., 1990; Levett, 1989a; Rech, 1991; Robin et al., 1997). It was noted that no locally published studies had documented the effects of child sexual abuse, or clinical symptoms. Most had focused on prevalence, demographics, the nature of abuse and characteristics of the perpetrator (Jaffe & Roux, 1988; Jacobs & Loening, 1991a; McKerrow,1989; Westcott, 1984)

While the symptoms recorded in this study were observed in sexually abused children, the variety of symptoms recorded could just as easily represent symptoms observed in other psychiatric disorders. These results support Gale et al. (1988) who found that presenting symptomology of children with varying abuse and non-abuse histories in psychiatric settings overlapped a great deal. These findings highlight the need for adequate controls in study designs for effects research.

6.5. NATURE OF ABUSE

76.8% of the subjects had experienced contact forms of sexual abuse, a figure that is consistent with both international literature (Gale et al., 1988; Gomes - Schwartz et al., 1990; Ho & Lieh Mak, 1992; Robin et al., 1997; Russell, 1986) and local literature (Jaffe & Roux, 1988; McKerrow, 1989; Collings, 1997). Over half of the subjects were sexually abused as a one off incident, something that is consistent with both local and international literature (Collings, 1991; Finkelhor, 1993; McKerrow, 1989). Results also showed that subjects were commonly abused in their own homes, which characterises the vulnerability of sexually abused children. One may hypothesise that the magnitide of being sexually abused in ones own home, universally accepted as a place of safety, functions to oppress victims from a place of fear.

After all, if one is not safe from male sexual aggression in ones' own home, one is not safe anywhere in society. Such a notion ensures subservience to male domination.

6.6. DISCLOSURE

It seemed important to mention the way in which subjects disclosed sexual abuse in this study, despite the fact that disclosure did not form part of the literature review. Results showed that most children in this study disclosed to their biological mother, and most disclosed in a spontaneous manner without prompting by another person. Similarly, Gomes-Schwartz et al. (1990), found that the majority of children in their study disclosed their experience of sexual abuse spontaneously, and most commonly, to a mother figure. Such findings have important implications for prevention programmes. In this regard, it would seem that programmes aimed at empowering children to disclose experiences of abuse to trusted adults, would be beneficial. It also suggests that educating mothers about child sexual abuse would help them cope better with sexual abuse disclosure. Findings of the current study also challenge the notion of the colluding mother found in more traditional models of child sexual abuse. As intervention was sought for all the children in the current study, and most children in this study had disclosed to their biological mothers, one can argue that many mothers in this study did not collude with their children's abuse and took appropriate steps to protect their children.

6.7. CHARACTERISTICS OF THE PERPETRATOR

The results of this study revealed that most perpetrators were male adults and most were known to the child. This is consistent with both international and local studies (Collings, 1997;Gale et al., 1988; Goldman & Padayachi, 1997; Gomes - Schwartz et al., 1990; Levett, 1989a, Russell, 1995; McKerrow, 1989). The gender bias found in this study, further supports the need for feminist perspectives and the insight they shed on sexual victimisation as a form of male control (Herman, 1994).

6.8. LEGAL ACTION

While most of the subjects had reported their sexual abuse to the authorities, only 6 subjects received a case conviction after taking legal action against the perpetrator, while others chose not to take legal action at all. According to Piennar (1996), the choice to not take action may be due to a number of factors, such as, the emotional difficulty of reporting a close family member; ignorance concerning the rights of children or a lack of awareness about child sexual abuse; fear concerning the outcome of a court case; (eg. removal of a child from home), or the imprisonment of a bread winner. Another factor hindering legal proceedings is the disintegration of child protection services in the face of overburdened government sectors in South Africa (Schurink, 1996).

Feminists like Driver and Droisen (1989), Herman (1994) and Levett (1992) would argue that the judicial system and statutory laws concerning the sexual abuse of children were made by men and perpetuate the ideology of patriarchy. In such a system the needs of men, rather than the needs of sexually victimised women and children are served. In this regard, the entire structure of the judicial system colludes with patriarchal ideology in a process of secondary victimisation. Secondary victimisation takes place when victims of child sexual abuse are further abused by the social system created to protect them. For example, social workers have the legal power to remove a child who has been allegedly sexually abused to a place of safety, but do not have the power to remove the alleged perpetrator. Ironically, the removal of the child re-enforces the notion that the child is to blame for the abuse rather than the offender. Other examples of secondary victimisation include; the mandatory gynaecological examination of a sexually abused child by a district surgeon who is usually male and not unlike the perpetrator from the child's perspective. The use of cautionary laws in cases where there is only one adult witness to the child's sexual abuse or in the case of the witness being a child fosters the notion that children should not be believed. Similarly, the open court in which children without an intermediary are still required to testify in front of the perpetrator, favours the offender rather

than the child. One may argue that the inadequacy of these legal procedures simply perpetuates a system of patriarchal control.

6.9. SERVICE UTILISATION OF THE UNIT

7.9.1. Delay in presentation to the Unit

The time taken from the last abusive incident until presentation at the Unit varied across the sample from four weeks to over four years. Only seven subjects out of 57 presented at the Unit within one month of the sexual abuse ending. Most subjects presented at the Unit within 12 months to one year after the sexual abuse had ended which is a considerable time gap. Age and gender appeared to have no particular association with delay in presentation to the Unit, but subjects' relationship to the perpetrator did suggest such an association. Results showed that children sexually abused by their step-fathers presented far later (a mean of two years and nine months) for intervention at the Unit, than those abused in other perpetrator categories.

The later presentation of children abused by thier step-fathers to the Unit may be due to the proximity of the step-father to the child. Results of the current study showed that more step-fathers were present in the home of subjects than biological fathers. The presence of a perpetrating step father in the home, particularly one accorded most of the power in the home, would certainly delay the help-seeking behaviour of a child. One may hypothesise that the closer the proximity of the perpetrator to the child, like a "live in" step-father, the harder it is for a child to seek help.

An important consideration to take into account when looking at the results of this section is the referral route to CFU, described earlier. Although presentation patterns to the Unit are delayed, a series of interventions have already taken place, usually with social workers and doctors before referral to CFU takes place. The true time lapse between the sexual abuse ending and the first seeking of intervention was not available in this study. Case files had scant information

information concerning prior referrals, which potentially hold valuable information for our understanding of help seeking behaviour of sexually abused children.

6.9.2. Management of sexual abuse cases

During 1997 most sexually abused children were managed by trainee staff at the Unit, consisting of intern psychologists and psychiatric registrars. The management of child sexual abuse by trainees is hampered not only by limited experience with child sexual abuse, but also by the lack of a formal protocol in the Unit for the assessment and management of such cases. While ward rounds and peer supervision groups offer a forum to discus the management of individual cases of child sexual abuse, an evaluated management protocol for child sexual abuse at the Unit was lacking. This resulted in a reliance on international literature concerning child sexual abuse which is not always applicable or relevant to South African contexts.

6.9.3. Attendance at the Unit

Utilisation of therapeutic services at CFU by sexually abused children and their families was low. Half of the subjects attended only one session and did not return, whilst the other half attended no more than four sessions on average. Most cases terminated prematurely, and over half of the subjects received no follow up. While service utilisation was not the focus of the literature review, it seems worthy to mention a recent study by Horowitz, Putman, Noll and Trickett (1997) who found that sexually abused children referred for therapy through the social services in North America, attended on average 9-25 sessions. Attendance at CFU was substantially lower, challenging the efficacy of current services in meeting the therapeutic needs of sexually abused children.

In Summary, almost one in four children presenting at CFU during 1997 had a history of child sexual abuse. Girls were seven times more likely to present at the Unit for child sexual abuse than boys.

While sexually abused children in the study presented with an array of symptomology, difficulties at school was the most commonly occurring symptom in the total sample. The majority of the sample experienced sexual abuse of a contact type, namely, rape and sexual molestation. The majority of perpetrators were described as male adults and were more commonly a family member or a person known to the child. While most of the cases in ths study were reported to the police, only two subjects had recieved a case conviction at the time of this study. The services offerred by CFU to sexually abused children were poorly utilised overall, with the majority of subjects in this study attending only one session of intervention.

CHAPTER 7

7. RECOMMENDATIONS AND CONCLUSION

The limitations of this study and the implications of the results for future research are discussed in this chapter. This is followed by an integration of the major themes emerging from this research project in the form of a conclusion.

7.1. LIMITATIONS OF THE CURRENT STUDY

Descriptive retrospective study designs like the one used in this study, have some methodological limitations (Katzenellenbogen et al., 1997). One of the major limitations is the inability to infer causal relationships between variables. In this regard, observed associations between variables in the current study remain speculative. Also, the ability to generalise results obtained from clinical settings is limited in that they can only be compared with results from other clinically based studies as patients in clinical settings tend to have more severe psychiatric difficulties than those found in community settings (Ho & Leih Mak, 1992).

Another limitation is the retrospective nature of the study design which necessitates a reliance on data contained in the case files which is subject to the bias of both the client and the clinician (Dill, Chu, Greb & Eisen, 1991). There are also qualitative differences in the reporting styles of the multi-disciplinary team responsible for case reports. Additionally, reliance on case files for data precludes the use of specific child sexual abuse measures, like the Trauma Symptom Check List for Children and the Sexual Conflict Scale (Briere & Runtz, 1988), which enhance cross comparative research. Furthermore, the reliance on retrospective designs using case records excludes information on the pre-morbid functioning of sexually abused children, which is necessary in assessing more accurately the impact of sexual abuse on a child. Finally, the absence of control groups in descriptive studies, makes it difficult to determine whether symptoms observed in sexually abuse children are reflective of child sexual abuse or other

psychiatric conditions, or children who have been physically or emotionally abused as opposed to sexually abused (Freidrich, 1998).

7.2. IMPLICATIONS FOR FUTURE RESEARCH

This study elicited four major findings which are important to future local research on child sexual abuse. Firstly, it was found that the prevalence of child sexual abuse in this study was far lower than prevalence rates found in other international and local clinically based studies. The lower prevalence rate in this study has mainly been attributed to the referral route to the Unit, whereby only those cases which can not be managed by staff of the Day Hospitals (usually because symptoms are severe, or resistant to initial interventions) are referred on to CFU. One would therefore expect the prevalence of child sexual abuse at the Day Hospitals to be high. This highlights the need for a community based study to ascertain accurate prevalence rates of child sexual abuse as well as service utilisation of Day Hospitals located in Lentegeur Hospital's catchment area. Such information would assist in the identification of service gaps between CFU and primary health care settings like the Day Hospitals, stimulating greater collaboration and support between both institutions.

The second key issue to emerge from the research was the poor service utilisation of the services offered at CFU. Only the most severely symptomatic of sexually abused children are referred to CFU from the Day Hospitals and of these, more than half attend only one session and do not return. This suggests that services provided at CFU are not meeting the needs or expectations of sexually abused children within the catchment area of Lentegeur Hospital. These findings necessitate that CFU evaluate current service provision to sexually abused children at the Unit. This should include an investigation into the perceived needs of sexually abused children and their families who have previously attended CFU for intervention.

Thirdly, the Unit needs to develop a clear protocol for the management of child sexual abuse within the Unit. This ought to also include stipulations for standardised and comprehensive case reporting, as case files showed major inconsistencies in quality and detail in recorded case histories. The development of a management protocol for child sexual abuse not only ensures the needs of sexually abused children are met with consistency and well conceptualised management strategies, but also serves as a valuable resource for trainee staff members serving their rotation at the Unit.

Finally, one of the most fundamental issues derived from this study concerns the current structure of State mental health services.The current system necessitates that sexually abused children have to be severely or chronically symptomatic before receiving therapeutic intervention at the tertiary level. The fact that child sexual abuse does not warrant direct access to therapeutic services at the tertiary level demands some re-evaluation. This is particularly important from a feminist perspective, as minimising the therapeutic needs of sexually abused children is a form of structural abuse in which the mental health care system participates in the secondary victimisation of sexually abused children.

7.3. CONCLUSION

As a member of the staff team at CFU during 1997, it was noted that numerous children presenting at the Child and family Unit of Lentegeur Hospital had a history of child sexual abuse. This coupled with the lack of a formal protocol for the management of child sexual abuse, or any local data on child sexual abuse in this community, served as the motivation for the current study. The aim of the study was to describe the epidemiology of child sexual abuse at the Unit. I anticipated that the data generated from such research would serve as a valuable resource to staff at the Unit which could be used to evaluate and improove current services for sexually abused children. It was also anticipated that research findings would provide an

impetus for further research, given the academic association of the Unit with the University of the Western Cape.

The retrospective descriptive design was chosen because of the preliminary nature of the study as well as time constraints and resources available for this project. Results of this study showed that almost one in four children presenting at CFU for intervention have histories of child sexual abuse. While this is prevalent enough to be of concern to the Unit, the prevalence of child sexual abuse at CFU was far lower than other international and local clinical studies. One of the major hypotheses for this finding was the referral procedure to CFU, which reduces the number of sexually abused children treated at the Unit.

In this study, the demographic features of the sample, the nature of the sexual abuse and characteristics of the perpetrator were consistent with international and local literature. Child sexual abuse was more prevalent in girls than boys and children of all ages were sexually abused. The majority of child sexual abuse involved rape and sexual molestation occurring most frequently as a one off incident and usually in the victims' own home. Most children were sexually abused by a person known to them (a neighbour or peer), followed closely by an extended family member (usually an uncle). The majority of perpetrators were male.

The author's understanding of child sexual abuse was guided by a feminist framework. This theoretical stance was chosen because no other theories addressed the gender bias found in child sexual abuse as effectively. Furthermore, feminist perspectives offer a broader understanding of the factors which perpetuate child sexual abuse in society. An understanding of the multiple social and cultural systems which perpetuate the abuse of children in society is deemed essential by the author for any sustained prevention of child sexual abuse. Finally,

the findings from this study highlight the need within the Child and Family Unit of Lentegeur Hospital for a clear protocol outlining the management of child sexual abuse and secondly, the need to re-evaluate why sexually abused children do not have direct access to tertiary psychological services within our current mental health care system. Within a feminist framework these issues take on a particular significance, in that failure to adequately meet the needs of sexually abused children highlights the patriarchal bias of the mental health care system in fostering secondary victimisation of abused children, at a structural level.

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APPENDIX 1

DATA CAPTURING FORM

1. Case number : 0001

2. Age : Date of birth

3. Sex : male - 1
female - 2

4. Home language : Afrikaans - 1
Xhosa - 2
English - 3
N/D - 4

5. Current level of education passed :

creche	- 01	std 6	-09
sub a	- 02	std 7	- 0
sub b	- 03	std 8	-11
std 1	- 04	std 9	-12
std 2	- 05	std10	-13
std 3	- 06	adapt class	-14
std 4	- 07	remed class	-15
std 5	- 08	not documented	-16

6. referral person

social worker	-	01
police	-	02
teacher	-	03
nurse	-	04
medical practitioner	-	05
self	-	06
family member	-	07
work supervisor	-	08
friend	-	09
psychologist	-	10
other	-	11
not documented in file	-	12

7.Referral place

hospital	-	01
police	-	02
private practice	-	03
school	-	04
employer	-	05
social service agency	-	06
N.G.O.	-	07
other	-	08
not documented in file	-	09
S.A.N.C.A.	-	10

8. Prior history of Child Sexual abuse :

yes	-1
no	-2
not docum	-3

9. Co-existence of other major presenting problems with the CSA?

Yes	-1
no	-2
not docum	-3

10. Clinical symptoms (DSM IV)

aggressive behav	01	nightmares	17
hyperactivity	02	tearful	18
innapr sexual behav	03	sleep disturbance	19
difficulties at school	04	fearful	20
avoidant behaviour	05	sadness/feeling low	21
defiant behaviour	06	eating disturbance	22
social withdrawal	07	withdrawn	23
destruction of property	08	somatic complaints	24
theft/stealing	09	physical complaints	25
truancy from school	10	flashbacks	26
school refusal	11	dissociative phenom	27
running away (home)	12	other	28
clingy behaviour	13	not documented	29
enuresis	14	psychotic/bizare behav	30
encopresis	15	attempted O.D.	31
attention difficulties	16	suisidal ideation	32
		pregnancy	33

11. Diagnosis Axis 1:

psychotic illness	- 01		
somatoform	- 02		
generalised anxiety	- 03	pain disorder	- 26
phobia	- 04	adjustment	- 27
obsessive/compulsive	- 05	hypercondrias	- 28
dissociative	- 06	body dysmorphic	- 29
panic	- 07		
PTSD	- 08		
acute stress	- 09		
maj depression	- 10	mental retardation	- 30
dysthymia	- 11	borderline intelligence	- 31
bi-polar 1	- 12		
bi-polar 2	- 13		
cyclothymia	- 14		
ADHD	- 15	motor skills D	- 32
Conduct D	- 16	Communication D	- 33
oppositional/def D	- 17	pervasive Dev D	- 34
Separation anxiety D	- 18	tic disorders	- 35
Enuresis	- 19	feeding / eating D	- 36

encopresis	- 20		
Seletive Mutism	- 21		
Reactive attachment	- 22		
learning D	- 23		
other	- 24	deferred	- 37
not documented	- 25		

12. V codes :

parent child rel prob	-1	sibling rel prob	-5
physical abuse/ child	-2	sexual abuse /child	-6
neglect /child	-3	bereavement	-7
academic problem	-4	not documented	-8

13. To whom disclosure was made

bio mother	-01	cousin	-14
Bio father	-02	family relation	-15
step mother	-03	friend	-16
step father	-04	sibling	-17
guardian	-05	neighbour	-18
foster mother	-06	family relation	-19
foster father	-07	health worker of case	-20
adoptive mother	-08	unknown	-21
adoptive father	-09	other	-22
grand mother	-10	not documented in file	-23
grand father	-11	school psychologist	-24
aunt	-12	teacher	-25
uncle	-13		

14. Nature of disclosure

spontaneous	-1
prompted by another	-2
unintentional	-3
other	-4
not documented in file	-5

15. Nature of abuse :

molestation	-01
rape	-02
sexual abuse no other details	-03
non - contact sexual abuse	-04

16. Time lapse between last abuse incident and presentation at CFU

< 1 month	-01
1 - <12 months	-02
1 year later	-03
2 - 4 years later	-04
not documented	-05

17. duration of abuse :

once off	-01	6 years	-10
1 week	-02	7 years	-11
1 month	-03	8 years	-12
6 months	-04	9 years	-13
1 year	-05	10 years	-14
2 years	-06	>10 years	-15
3 years	-07	unknown by patient	-16
4 years	-08	not documented in file	-17
5 years	-09		

18. Sex of perpetrator :

male	-1	Not documented in file	-3
female	-2	unknown by patient	-4

19. Number of perpetrators :

one	-1	not documented in file	-4
two or more	-2		
unknown to patient	-3		

20. Age of perpetrator

<12 "child"	-1
13 – 19 "teenager"	-2
20 – 25 "young adult"	-3
>25 yrs "adult" or "man"	-4
other	-5
unknown to patient	-6
not documented in file	-7

21. Perpetrator's relationship to victim

bio father	-01
step father	-02
extended family member	-03
person known to child	-04
person unknown to child	-05
not documented	-06

22. Place of abuse :

home of perpetrator	-1
home of victim	-2
home of another family member	-3
school	-4
veld	-5
neighbourhood	-6
other	-7
unknown to patient	-8
not documented in file	-9

23. Absence of bio mother in home at time of abuse

yes	1
no	2
not doc	3

24. Absence of biological father in home at time of abuse

yes	-1
no	-2
not doc	-3

25. Presence of a step father in home at time of abuse

yes	1
no	2
not doc	3

26. Reporting of abuse :

abuse was reported	-1
abuse not reported	-2
unknown by patient	-3
not documented in file	-4

27. Legal action taken in response to abuse :

none	-1	unknown to patient	-6
case conviction	-2	other	-7
aquital	-3	not documented in file	-8
case dismissed	-4	currently investigating	-9
case withdrawn by patient	-5		

28. Action taken by social services :

none	-1	place of safety	-5
child removed	-2	other	-6
child adopted	-3	not documented in file	-7
child in foster care	-4	continued management	-8

29. Other action taken resulting from sexual abuse :

none	-1	divorce	-5
separation	-2	child living with other family membs	-6
change of residence	-3	change of schools	-7
other	-4	not documented in file	-8
		perpertrator left home	-9

30. Case manager at CFU

psychologist	-1	intern psychologist	-6
social worker	-2	psychiatric nurse	-7
occupational therapist	-3	registrar	-8
consultant	-4	other	-9
not documented in file	-5		

31. Number of sessions attended :

1 only	-01	8	-08
2	-02	9 -15	-09
3	-03	16 -19	-10
4	-04	>20	-11
5	-05	not docum	-12
6	-06	in patient prog	-13
7	-07		

32. Type of intervention received :

inpatient	-1	assessment	-6
family therapy	-2	individual therapy	-7
play therapy	-3	psychometric assessment	-8
pharmacotherapy	-4	group	-9
not documented in file	-5		

33. Termination :

premature	-1	planned	-3
not documented in file	-2	case still open	-4

34. Reason for termination :

termination was as contracted	-1	reason not known	-5
work constraints	-2	financial difficulties	-6
transport problems	-3	other	-7
not documented in file	-4	pt didn't return	-8
		pt referred on	-9

35. Follow up arrangements:

Ref to SW/social services	1
CFU	2
Community clinic	3
none	4
not documented	5
pt didn't want follow up	6
available at patient's request	7
pt contacted telephonically	8

36.criminal history of perpetrator :

none	1
yes	2
unknown by patient	3
not documented in file	4

37. Number of people in patient's household at time of abuse :

1	-01	10	-10
2	-02	11	-11
3	-03	12	-12
4	-04	13	-13
5	-05	14	-14
6	-06	15	-15
7	-07	>15	-16
8	-08	not doc	-17
9	-09		

38.History of substance abuse in home environ

yes	1
no	2
not doc	3

39. Bio mother with history of physical or psychiatric illness

yes	1
no	2
not doc	3