

**CAREGIVERS' PERCEPTIONS OF DESENSITISATION AMONG
SEXUALLY ABUSED CHILDREN**

by

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DECLARATION

I hereby declare that the dissertation, CAREGIVERS' PERCEPTIONS OF DESENSITISATION AMONG SEXUALLY ABUSED CHILDREN is my own work and that all resources that were used or referred to by me during the research study, are indicated by means of a complete reference and acknowledgement.

Signature: _____

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Mr. R.M. GROBBELAAR

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ABSTRACT

Children react differently to the traumatic incidence of sexual abuse. Some children develop symptomatic behaviours associated with Post Traumatic Stress Disorder in reaction to sexual abuse, such as apathy, which is a form of desensitisation. Others appear less affected by the sexual abuse and may also be regarded as desensitised and possessing resilience. Incongruence thus exists, as the one may be taken incorrectly for the other. Many children enter alternative care settings after being sexually abused, and are cared for by caregivers other than their natural parents. These caregivers interact with the children regularly and their perceptions may provide valuable insight into desensitisation among these children.

This study set out to explore caregivers' perceptions on desensitisation among children who had been sexually abused. The study is explorative and descriptive in nature and grounded in a qualitative design. Purposive sampling was used to form three focus groups. The focus group interviews yielded data that was transcribed and subjected to thematic analysis. The findings arrived at were written up, presented and discussed. The findings were recommended to be used to inform social workers and other members of the helping professions on how to approach and interact with caregivers of sexually abused children in the future, and to influence perceptions they might hold. Further recommendations were made to better design and implement future studies.

KEYWORDS Caregivers, Perceptions, Desensitisation, Child Sexual Abuse, Children

LIST OF ACRONYMS

CSA	Child Sexual Abuse
PTSD	Post Traumatic Stress Disorder
CPU	Child Protection Unit
POWA	People Opposing Woman Abuse
SAPS	South African Police Service
NGO	Non-Governmental Organisation
STD	Sexually Transmitted Disease

DEFINITION OF TERMS

Caregivers

A caregiver is defined in the Children's Act (38 of 2005) as:

“... any person other than a parent or guardian, who factually cares for a child and includes— a foster parent; a person who cares for a child with the implied or express consent of a parent or guardian of the child; a person who cares for a child whilst the child is in temporary safe care; the person at the head of a child and youth care centre where a child has been placed; the person at the head of a shelter; a child and youth care worker who cares for a child who is without appropriate family care in the community; and the child at the head of a child-headed household.”

Perceptions

According to Reber and Reber (2001, p. 519) “perception” denotes the process that gives coherence and unity to sensory input. It is said to cover the entire sequence of events from the presentation of a physical stimulus to the phenomenological experiencing of it. For purposes of this, study the main focus will be the perceptions of caregivers as they perceive sexually abused children in relation to desensitisation.

Desensitisation

Reber and Reber (2001, p. 192) define “desensitisation” as “any decrease in reactivity or sensitivity”. Desensitisation is seen on the one hand as a symptom associated with the trauma of sexual abuse, which includes depression, apathy and Post Traumatic Stress Disorder (Van Rensburgh & Barnard, 2005, p. 1). On the other hand, it could point towards psychological resilience associated with personality traits, positive family factors and social support systems that have a positive influence on the child (Van Rensburgh & Barnard, 2005, P. 5).

Child sexual abuse (CSA)

“Sexual abuse” almost always refers to the sexual mistreatment of a child by an adult (Reber & Reber, 2001, p. 675). Both the *New Dictionary of Social Work* (Terminology Committee for Social Work, 1995, p. 9) and the Children’s Act (38 of 2005) define child (sexual) abuse as a phenomenon whereby children are the victims of parents, guardians, or caregivers who sexually abuse them or allow them to be sexually abused by others.

Child

According to the Children’s Act (38 of 2005) a “child” means:

“... a person under the age of 18 years”

This is supported by Montgomery (2009, p. 53), who notes that a child could be anyone between the ages of 0 and 18 years, but adds that at either end of the scale it could be replaced with more age-specific terms like baby, infant, toddler or teenager. Montgomery (2009, p. 53) also notes that the term “child” could be taken to refer to any person who has not yet reached social maturity.

**CAREGIVERS' PERCEPTIONS OF DESENSITISATION AMONG
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CHAPTER 1: INTRODUCTION AND ORIENTATION TO THE STUDY

1.1 INTRODUCTION

Child sexual abuse (CSA) is an international and local concern. Despite problems in determining accurate prevalence rates of CSA, this is both an international and local concern. International literature questions the reliability of incidence reports, but cannot deny the existence of child sexual abuse as a problem. In South Africa, CSA affects many children who may be placed with caregivers other than their parents, such as foster parents, grandparents, family members or other persons.

In discussion with social workers from the Department of Social Development's Gugulethu local office, and through personal observation in line of duty as a social worker in the said department, the researcher has noticed that some children appear to be less severely affected by exposure to sexual abuse. The abuse was reportedly accepted as "a normal occurrence" in some of these instances.

Available literature identifies a number of psychological resilience factors, such as those discussed by Van Rensburg and Barnard (2005, pp. 2-5) that include individual, family, and social factors. These factors are taken in this study as elements influencing desensitisation. The children in the community in which the phenomenon was observed were held as seldom having access to sources of resilience, thus an explanation of these sources of resilience influencing desensitisation, was deemed incoherent. Another possible explanation for what was observed and interpreted as apparent desensitisation, may be apathy or associated sexual abuse symptoms that may link with Post Traumatic Stress Disorder (PTSD) (Pollio, Glover-Orr & Wherry, 2008, p. 90). There was, however, a reservation on the part of the researcher as to whether the children are psychologically resilient or displaying symptoms associated with PTSD.

The caregivers of children with a CSA history were deemed to be in a somewhat privileged position because of their ongoing proximity, perceptions, observation and interaction of and with these children. Hence they were of particular interest to the researcher, to provide information surrounding the phenomenon of desensitisation. Their valuable insights and perceptions regarding desensitisation, thus served as a starting point in exploring and describing the phenomenon.

1.2 LITERATURE REVIEW

The precise incidence of child sexual abuse, as well as its prevalence, is not known, as it is seldom reported. Evidence suggests considerable variability caused by methodological differences used in research, measurement, sampling and reporting (Berliner & Elliott, as cited in Intebi, 2003, p. 8; Fergusson & Mullen; Paolucci, Genuis, & Violato; Peters, Wyatt, & Finkelhor, as cited in Priebe & Svendin, 2009, p. 20).

CSA is a comprehensive social problem in South Africa. Statistics from the Child Protection Unit of the South African Police Service for the period January 2000 to January 2001 show that 32 000 reports of CSA and attempted CSA were made (Simons, as cited in Britz & Joubert, 2003, p. 27). No data more recent than this could be acquired, which is an indication of the problems with reporting and recordkeeping that surrounds the problem. Townsend and Dawes (2005, p. 55) point out that reports of sexual abuse of children under the age of 12 years have increased, but question this, as higher reporting may bring about greater rates of awareness, not necessarily an actual increase in incidence. They nonetheless conclude that both possibilities may be true. As with international trends, issues regarding reporting, methodology, sampling, and measurement make it hard to establish prevalence in South Africa (Townsend & Dawes, 2005, p. 61).

Symptoms of sexual abuse have been noted to be multiple emotional, personality and behavioural problems. These problems include social withdrawal, depression, anxiety, and in some instances the development of PTSD. Other associated symptoms such as an increase in sexualised behaviour (promiscuity), suicidal ideation and attempts, substance abuse and anti-social behaviour, have been widely reported in the literature (Berliner, 2003, p. 13; Verduyn & Calam, as cited in Britz & Joubert, 2003, p. 27). Significant long-term effects include guilt, anxiety, decreased self-worth, apathy, stigmatisation, decreased moral judgment, trust issues, sexual promiscuity, and other forms of sexual maladjustment (Faller; Finkelhor; Glaser & Frosh; Green, as cited in Van Rensburgh & Barnard, 2005, p. 1).

On the one hand, desensitisation overlaps with symptoms of sexual abuse, particularly those symptoms associated with PTSD. Symptoms such as apathy and diminished affect, along with psychological numbness and a lessening of feeling of involvement with the world around one (Reber & Reber, 2001, p. 551), may be seen as desensitisation in some instances. It is believed that up to half of the children who have been sexually abused develop PTSD

(Berliner, 2003, p. 13). Berliner (2003, p. 13) moreover indicates that a CSA history is also linked with other mental health issues, relationship problems, and re-victimisation in adulthood, all of which have a great effect on the adjustment and functioning of the child. A study conducted by Green (as cited in Pollio *et al.*, 2008, p. 90) has found a number of symptoms in reaction to sexual abuse that are common to the symptoms exhibited in PTSD. In addition, the aforementioned study indicates that between 40% and 60% of children who have been sexually abused develop PTSD. Reliable and valid clinical measures for children are, however, generally lacking (Green, as cited in Pollio *et al.*, 2008, p. 90).

In contrast, some children are known to react differently to sexual abuse, or appear to exhibit fewer symptoms in comparison with other victims of abuse. These are regarded as desensitised children, who are taken to be more resilient. Van Rensburgh and Barnard (2005, pp. 1-2) assert that resilient children are in the minority. Desensitisation, then, could be taken to imply good functioning in spite of specific traumas, risks, and environmental hazards crossing an individual's path (Van Rensburgh & Barnard, 2005, p. 2). Children who are not resilient do not have access to such sources of resilience in their lives. They do not have these protective factors referred to by Van Rensburgh and Barnard (2005, p. 1) to a degree where they counteract the development of the common symptoms associated with sexual abuse.

Children in South Africa often find themselves in alternative care settings, where they are cared for by a caregiver such as a foster parent (Richter, Dawes & Higson-Smith, 2005, p. 461). This may be due to a range of factors such as poverty, homelessness, physical abuse and neglect, the loss of parents to HIV and, of course, sexual abuse (Pasztor, Hollinger, Inkelas, & Halfon, 2006, p. 34; Richter *et al.*, 2005, p. 461). Dimcan and Brooks-Gunn; and Fein and Maluccio, (as cited in Pasztor *et al.*, 2006, p. 34) mention that these children are in need of a stable and therapeutic living arrangement in order to address their traumas.

Caregivers of sexually abused children have to contend with a number of issues that may emanate from the child's sexual abuse history (Farmer & Pollock, 2003, p. 101). These children have been found to exhibit far more mental health problems than non-sexually abused children in foster care (Bilaver, Juardes, Koepke, & Goerge, as cited in Pasztor *et al.*, 2006, p. 35).

Farmer and Pollock (2003, p. 102) have noted that very little research has been done on the management of sexually abused children in alternative care settings. Caregivers interact with these children on a daily basis and perceive them from a vantage position. They could thus provide valuable information about if and how these children exhibit desensitisation.

1.3 PROBLEM STATEMENT

From the foregoing discussion it is evident that sexual abuse is a concern both internationally and in South Africa, despite methodological problems surrounding accuracy of incidence and prevalence rates (Townsend & Dawes, 2005, p. 61). Even so, society cannot deny the existence of CSA. Children react differently to sexual abuse. Some are impacted extremely negatively and develop a range of dire symptoms such as emotional, relationship, behavioural and personality problems suggested by Pullins and Jones (2006, p. 3); Van Rensburgh and Barnard (2005, p. 2); Berliner (2003, p. 13) and Britz and Joubert (2003, p. 27). Other children appear to be more resilient and exhibit fewer of these symptoms over the long term (Van Rensburgh & Barnard, 2005, p. 2).

A grey area exists because resilience factors are deemed inadequate to explain desensitised behaviour in sexually abused children. There is an overlap between symptoms associated with sexual abuse, such as apathy, withdrawal, depression, and specific PTSD symptoms as noted by Green (as cited in Pollio *et al.*, 2008, p. 90). The researcher deemed it necessary to undertake a qualitative study to explore and describe what caregivers' perceptions are of desensitisation among sexually abused children.

1.4 RESEARCH QUESTION

What are caregivers' perceptions of desensitisation among sexually abused children?

1.5 GOAL AND OBJECTIVES

1.5.1 Goal

To explore and describe caregivers' perceptions of desensitisation among sexually abused children.

1.5.2 Objectives

To explore what caregivers' perceptions are of desensitisation among sexually abused children, by means of focus group interviews

1.6 RESEARCH APPROACH

A qualitative research approach was proposed for this study. Qualitative research is regarded as an approach that locates the observer (researcher) in the world, and consists of a set of interpretative, material practices that makes the world visible (Denzin & Lincoln, 2003, p. 4). It turns the world into a number of observations that are depicted in the form of mostly written or spoken language, or in the form of observations that have been recorded in language (Durrheim, 2006, p. 47). It is furthermore a research approach that sees the researcher make an interpretation of observations which cannot be separated from the researcher's own background, history, context and prior understandings of the problem (Creswell, 2007, p. 39). Creswell also states that this approach attempts to give a holistic account of the problem under scrutiny.

The data collected in this approach, is analysed by identification and categorising of themes within it. Qualitative methods allow the researchers to study selected issues in depth, as they identify and try to understand the categories of information that emerge from the data (Durrheim, 2006, p. 47). Qualitative researchers believe that rich descriptions of the social world are valuable (Denzin & Lincoln, 2003, p. 16). Qualitative research is often undertaken when it is desired to explore a problem (Creswell, 2007, p. 39).

1.7 RESEARCH DESIGN

Creswell (2007, p. 15) notes that the research design process in qualitative research starts with philosophical assumptions that a researcher makes in deciding to undertake a qualitative study. The author further notes that the researcher brings his/her own set of assumptions, worldviews and beliefs into the research setting, which inform and influence the undertaking of writing up of the qualitative study. According to Babbie (2004, p. 89), the primary purpose of many social research studies is the description of situations and events; this is reportedly done by the researcher who observes and then describes what he/she observed in a careful, deliberate, scientific manner.

Explorative and descriptive design was used for this study. An explorative study aims to generate new information and make preliminary investigations into a relatively unknown phenomenon (Durrheim, 2006, p. 44). Explorative studies often include pilot studies which are done to establish preliminary facts, and to uncover interesting patterns (Mouton, 2001, p. 103). The study is planned to be iterative as it needs to be flexible and non-sequential, as is

often found with qualitative explorative studies (Durrheim, 2006, p. 35). Descriptive studies, on the other hand, aim to make accurate descriptions of phenomena (Durrheim, 2006, p. 44). This study, therefore, set out to explore and describe what the caregivers have in common and how they differ in terms of their perceptions around desensitisation among sexually abused children in their care.

1.8 METHODOLOGY

1.8.1 Population

A study population is defined as by Durrheim and Painter (2006, p. 133) as “the larger pool from which our sampling elements are drawn, and to which we want to generalise our findings”. According to Babbie (as cited in Durrheim, 2006, p. 41) the unit of analysis in social science research often consists of individuals, groups, organisations and social artefacts. Finding appropriate cases is said to be the central challenge in qualitative research (Kelly, 2006, p. 288). The participants who were identified to form the unit of analysis (population) of this study were caregivers of children who had a sexual abuse history. The participants were affiliated to the Department of Social Development’s local offices in Gugulethu and Paarl. These typically included biological parents, grandparents, foster parents, or other primary caregivers. Chapter 3 provides a deeper discussion into the methodology of the study, and issues of the population, sampling, data collection and analysis are discussed in greater detail.

1.8.2 Sampling

Purposive sampling was proposed, selected cases were wanted that could shed light on the phenomenon being studied. This method is often used in qualitative research (Durrheim, 2006, p. 50) and is regularly used with focus group interviews in order to select and examine a particular type of participant (Kelly, 2006, p. 304). The identified caregivers were asked to partake voluntarily in the study. Those willing to participate were included in a pilot study as well as three focus group interviews. The focus group interviews were convened at a venue, date and time negotiated with each voluntary participant.

1.8.3 Data collection

Focus group interviews are often used when interviewees have similar experiences and are likely to cooperate with each other, and also when their interaction is likely to yield rich information about the phenomenon (Krueger; Morgan; Stewart & Shamdasani, as cited in Creswell, 2007, p. 133; Kelly, 2006, p. 304). Focus group interviews usually follow a semi-structured interview format (Kelly, 2006, p. 305). Greeff (2005, p. 296) notes that with a semi-structured interview the researcher has a predetermined set of questions on an interview schedule, but the interview is only guided by these, and open-ended questions would be used. The researcher made use of interview skills to facilitate the focus groups and to elicit more information from the participants.

The groups took place in the board room of the Gugulethu and Paarl local offices of the DSD as well as the public library's conference facility in Mbekweni (Paarl). The time and dates of the focus group interviews were convened at a time and date conveniently arranged and agreed to by each participant. The focus groups were facilitated by the researcher in English and Afrikaans, and a Xhosa-speaking social worker assisted as interpreter where the participants were Xhosa-speaking. The setting was conducive to the interview process, as it was a relaxed environment that ensured no interruptions occurred, as advised by Greeff (2005, pp. 294-295). The use of an interpreter allowed the participants to communicate in their primary language.

Permission to include clients from the Department of Social Development was obtained from the Social Work Managers of the Gugulethu and Paarl Local Offices. The Western Cape Department of Social Development is responsible for rendering services to children and families in the Western Cape. The local offices of Gugulethu and Paarl service areas in their geographical proximity. Gugulethu local office serves areas including Gugulethu, Nyanga and Phillipi, whilst the Paarl local office serves the urban, semi-urban and rural areas including Chicago and Mbekweni. The Social Work Supervisors and the social workers under their control were willing to assist the researcher in arranging and setting up the focus group interviews. They assisted in identifying participants from their caseloads and invited voluntary participation from those identified. Assistance was also given with logistical arrangements to securing a venue for the focus group interviews.

The identified participants were briefed on the aims and objectives of the study as well as to the risks and benefits of their participation in order for them to make an informed choice to partake. They needed to consent to a translator assisting with facilitation of the interview; to the interview being recorded, and to the dissemination of information. They were informed of their rights to withdraw from the study at any time, as well as the methods for protecting their identity and privacy.

The researcher ensured that all participants were given an equal chance to partake in the group discussions, and guarded against domination of the conversation by one or two group members, as proposed in the literature (Creswell, 2007, p. 133). The interviews were recorded by using a tape recorder and then transcribed by the researcher. Copies of the interviews were made as backups, and the participants' names were masked in the recordings, as proposed by Christians (2003, p. 218). The collected data was stored in a safe place to which only the researcher had access. The transcripts of the interviews were not linked to the identity of the participants, so as to protect their anonymity. A storage and retrieval system was developed to locate and identify information for the study as described by Creswell (2007, p. 143).

1.8.4 Data analysis

Babbie (2004, p. 369) asserts that qualitative data analysis is a non-numeric assessment of observations, content analysis, in-depth interviews and other qualitative research techniques, with their own set of logic and techniques. The collected data was subjected to qualitative data analysis, which often involves an analysis of themes (Creswell, 2007, p. 75).

Firstly, it was planned to bracket the researcher's own experiences, which was seen as an attempt to set aside one's own experiences (Creswell, 2007, p. 159). Secondly, the data was analysed by going through it and highlighting significant statements, sentences or quotes that gave an understanding of what experiences of the phenomenon were held by the participants (Creswell, 2007, p. 61). This was at the same time seen as staying close to the data in order to assist induction (Henning, 2004). Thirdly, these were then grouped into themes, which constitute coding (Creswell, 2007, p. 148; Henning, 2004, p. 104). The themes were subsequently used to compile a description of what the participants' experiences were, as well as depicting what the settings or contexts were (Creswell, 2007, p. 61). From these

descriptions the researcher formulated a general or combined description which was representative of the essence of the phenomenon (Creswell, 2007, p. 62).

1.8.5 Validity

Qualitative research is often compared and evaluated along criteria designed for quantitative studies, but the nature and purpose of qualitative research differ from quantitative research and thus needs to be evaluated differently (Krefting, 1991, p. 214). Henning (2004, p. 147) describes validity as a measure to see if one is really investigating that which one claims to be investigating; and whether it is being done accurately and precisely (Sarantakos, 2005, p. 83).

One way to see if an observation is valid is to ask other people, especially the participants (Henning, 2004, p. 149). This method is identified by Creswell (2007, p. 208) as member checking, which is noted by Lincoln and Guba (as cited in Krefting, 1991, p. 219) as done by controlling with the respondents how accurate the researcher's data, analytic categories, interpretations and conclusions are, which ensures accuracy in transcribing, recording and relaying observations. This strategy is said to be more easily employed at an early stage, during data collection, rather than a later stage as when the researcher has started making conceptual analysis when it may be hard for the participants to understand that higher conceptual analysis is then needed (Krefting, 1991, p. 219). The researcher summarised the main points that were made by the participants after each question on the interview schedule was covered. This summary was communicated to the participants and they were given a chance to correct, elaborate on and verify the accuracy and acceptability of their interpreted responses, thus ensuring its trustworthiness. This made out the iterative part of the research.

Guba is said to have identified another confirmatory strategy aimed at making research more credible, named 'audit strategies', which typically involve an external auditor attempting to follow through the natural process of the study to see if they arrive at findings, interpretations and recommendations that are comparable and congruent with that of the researcher and what he/she found (Krefting, 1991, p. 221). This could have been done by asking a Xhosa-speaking external moderator to assist in transcribing some of the data, to check that the interpreter has translated the participant responses verbatim and that they have been transcribed accurately. A Xhosa-speaking external moderator was, however, not asked to review the collected data or to conduct independent coding, analysis and interpretation of the

focus group interviews owing to limited resources. This would have been a process that aligned with the external audit process (Creswell, 2007, p. 209).

1.8.6 Self-reflexivity

Creswell (2007, p. 178) indicates that a researcher is no longer regarded as omniscient and distant, but as involved and inseparable from the study. Krefting (1991, p. 218) explains that reflexivity is an assessment of the influences that the researcher's own beliefs, perceptions, history and worldview have on the research process. According to Agar (as cited in Krefting, 1991, p. 218) a researcher's background dictates the framework from which he/she approaches, organises, studies and analyses findings in a study, and is often reflected in that researcher's roles while involved in the study.

Self-reflexivity is defined by Creswell (2007, pp. 243-244) as delineating that the writer is conscious of the biases, values, and experiences that he/she brings to a qualitative study, by making it explicit in the text (Hammersley & Atkinson, as cited in Creswell, 2007, p. 244). Moustaka (as cited in Creswell, 2007, p. 189) indicates that self-reflexivity is often undertaken, such as casting or setting their initial problems statement in an autobiographical context.

I, the researcher thus understand that my education and career as a social worker may have influenced my perceptions, approach and understanding of the topic under investigation. I understand that the topic was of a very sensitive nature. I also understand that the participants may have found sharing these personal experiences hard and that they may have experienced difficulties which they attributed to the phenomenon under scrutiny. I undertook to be as empathetic to these participants as my ability allowed. I further undertook to ensure that my research assistant shared this goal. I was aware that I too might be affected on an emotional level by the sensitive nature of the topic, and undertook to seek consultation and debriefing from my supervisor if I became affected by the sensitive issues. I planned to regularly share my experiences with my supervisor in order to safeguard myself from unseen issues that might affect me. I was aware that my perceptions about sexually abused children might be altered and might be influenced to take on new information. I guarded against allowing my own perceptions and preconceptions to affect the interpreting of the results, but I was aware that it would have an influence on the interpretation of the study and was under no false belief that I could remain fully neutral.

1.9 ETHICAL CONSIDERATIONS

Wassenaar (2006, pp. 60-79) mentions that ethical matters pertaining to autonomy and respect for dignity of persons, nonmaleficence, beneficence and justice need to be considered during any study. Access to the participants was gained through the official procedures and with the needed permission from the Department of Social Development.

Informed consent - Henning (2004, p. 73) notes that informed consent is extremely important as the participants need to know and understand what the research study involves before deciding to participate. They further need to know and understand issues of privacy, sensitivity and dissemination of the information (Henning, 2004, p. 73).

The participants were informed prior to being included as participants verbally as well as in writing; of their participation as voluntary and that no obligation existed for them to form part of the study. They were informed that they could withdraw from the study at any point. The possible risk and advantages of the study was presented to the participants along with a warning of possible negative emotions and secondary trauma that they might encounter if they agreed to participate in the study.

Written consent was further required for recording the interview and making use of a translating facilitator where needed. The participants were thus in a position to make an informed decision to partake in the study and had the freedom to withdraw at any stage should they so desire.

Respect for autonomy – According to Wassenaar (2006, p. 67) a philosophical principle underlying research in social science is the one of autonomy specifically linked to voluntary informed participation. A translator was employed to ensure that the participants' individuality and autonomy was respected, as they might be unfairly restricted if they were to be interviewed in a language other than their primary language. Their autonomy was further be respected by mutually agreeing on a suitable time and date to conduct the interviews.

Confidentiality– Babbie and Mouton (2007, p. 523) note that confidentiality entails respecting the privacy of the participants and could be enhanced by an awareness of ethical responsibilities by the researcher and research team. They also note that the names and addresses of participants should be masked in the transcripts as soon as possible to enhance

confidentiality (Babbie & Mouton, 2007, p. 523). The participants' identity was protected as far possible in this study. Because many participants were resident in the same area they knew one another in some of the cases. They were asked to keep the discussions confidential and not to disclose any information to other parties. The identities of the participants were further masked in the transcripts of the focus group interviews upon transcribing them. The transcripts and data were stored in an access-controlled manner on the personal computer of the researcher where only the researcher had access to it.

No harm to subjects – Babbie and Mouton (2007, p. 522) note that social research should never harm the persons being studied, regardless of their voluntary participation. No child survivors of sexual abuse were harmed during the study. If the children were included in the study, they would have been extremely susceptible to secondary trauma and were thus excluded from the study. The researcher ensured that the caregiver participants were not harmed during the study, by attempting to make the interview setting as friendly as possible. Ethical clearance was obtained from both the University of The Western Cape's Faculty of Community and Health Sciences and from the Higher Degrees Committee. This is in line with the institutional review process described by Christians (2003, p. 219). The potential risks to the psychological wellbeing of the clients were identified early and steps taken to mitigate these risks. The participants were encouraged to attend parent support groups in order to provide debriefing and ongoing support to them, owing to the sensitive nature of the topic. If participants thus became traumatised through their participation in the study, plans were in place to address these issues. Some of the participants made a suggestion to form a support group of their own especially for caregivers of sexually abused children. This suggestion was forwarded to the Social Work Supervisor in the area where the participants reside in order to facilitate such a programme on a voluntary basis. These programmes have already been rolled out.

1.10 CONCLUSION

This chapter has provided a general orientation and introduction to the study. The literature on the subject was briefly outlined and the research question was stated. The planned process that was followed during the execution of the study was outlined in a discussion of the methodology. The different strategies planned and the logic behind them in areas of sampling, data collection, analysis and validity, were further discussed. Attention was given to the ethical issues that were pertinent to the study, along with issues of self-reflexivity in

order to position the researcher in the arena of the study. In Chapter 2 a more detailed account of the literature will be given to set the stage for the subsequent chapters of the study.

CHAPTER 2: REVIEW OF PROMINENT LITERATURE PERTAINING TO CAREGIVERS OF CHILDREN WITH CHILD SEXUAL ABUSE HISTORY AND ISSUES OF DESENSITISATION

2.1 CAREGIVERS OF CHILDREN WITH CHILD SEXUAL ABUSE HISTORY AND ISSUES OF DESENSITISATION

2.1.1 INTRODUCTION AND DEFINITION OF THE CAREGIVER CONCEPT

Many children in South Africa find themselves in alternative care settings with a foster parent, grandparent, aunt or other family member (Richter *et al.*, 2005, p. 461). Some of these children are in foster care because of sexual abuse (Pasztor *et al.*, 2006, p. 34). Section 150 of The Children's Act (38 of 2005) identifies a child in need of care and protection for a number of grounds. These grounds include a child that: "(e) has been exploited or lives in circumstances that expose the child to exploitation", (f) lives in or is exposed to circumstances which may seriously harm the child's physical, mental or social well-being, or (i) is being maltreated, abused, deliberately neglected or degraded by a parent, or caregiver...". Once a child has been shown to be in need of care, such as being sexually abused, the child may in accordance with Section 156 (1) of the Children's Act (38 of 2005), be placed in a number of care settings including being returned to parental care, kinship foster care, cluster foster care, a neutral foster care setting, a child care facility, a treatment centre or a child and youth care facility. Dimcan and Brooks-Gunn; and Fein and Maluccio (as cited in Pasztor *et al.*, 2006, p. 34) mention that these children are in need of a stable and therapeutic living arrangement in order to address their traumas.

A caregiver is defined in the Children's Act (38 of 2005) as:

"... any person other than a parent or guardian, who factually cares for a child and includes— a foster parent; a person who cares for a child with the implied or express consent of a parent or guardian of the child; a person who cares for a child whilst the child is in temporary safe care; the person at the head of a child and youth care centre where a child has been placed; the person at the head of a shelter; a child and youth care worker who cares for a child who is without appropriate family care in the community; and the child at the head of a child-headed household"

The term "caregiver" is thus not as exclusive as the term "parent". It could be taken (and is in the context of this study), to include both biological parents, grandparents, older siblings,

aunts, uncles, foster parents and in general any person whom assumes the responsibility of caring for a child. The term is not one that needs to be conveyed by a court ruling to a person, such as the title of foster parent or guardian, yet does not exclude these persons.

2.1.2 CAREGIVERS AND THE CSA CHILD

According to Farmer and Pollock (2003, p. 102) there has been very little research done on the management of sexually abused children in alternative care settings. Caregivers interact with these children on a daily basis and perceive them from a vantage position and could arguably provide insight on how these children exhibit CSA symptoms or desensitisation to the effects of CSA.

On the other hand, Pullins and Jones (2006, pp. 15-16) argue the contrary. They have studied parental knowledge about CSA symptoms and suggest that parents and caregivers have very limited knowledge of common symptoms of CSA, particularly of the symptoms most indicative of and specific to CSA, i.e., unusual sexual knowledge, unusual sexual behaviour, or medical symptoms, as was the focus of their study. One study, by Berrick (as cited in Pullins & Jones, 2006, p. 4) reportedly found that parents often postulate a number of generalised instead of specific indicators when describing CSA symptoms among their children. Yet, Pullins and Jones (2006, p. 4) noted that few international studies have examined what caregivers know and understand about CSA symptoms.

A more recent assertion made by Kouyoumdjian, Perry, and Hansen (2009, p. 43) claims that adults may hold stereotyped expectations and beliefs of how sexually abused children are to behave. These expectations may influence the children in actually exhibiting behavioural responses incongruent with how they actually feel. This could link up with what Pullins and Jones (2006, p. 4) referred to as generalised reports of CSA symptoms which they could identify. Kouyoumdjian *et al.* (2009, p. 54) point out that caregivers' expectations of sexually abused children may be internalised by these children and they may act in accordance with what is implicitly expected of them. There is thus held to be an interactional effect of caregiver expectations on actual child behavioural outcomes. Caregivers' actual perceptions of specific desensitisation of sexually abused children need to be explored, in order to better understand what their expectancies are of the children, and to see how these could possibly serve to describe desensitisation, resilience and/or symptomatic behaviour.

Society holds a range of assumptions and opinions about CSA. Collings (as cited in Stevens, Tolond & Collings, 2004, p. 20) identified a number of socially mediated beliefs and attitudes said to have the potential of influencing social perceptions of abuse. They are: restrictive stereotypes, denial of abusiveness, and blame diffusion. Some researchers have explored adult perceptions and presumptions of CSA and how these impact on the functioning of child survivors of CSA. Results have been mixed in this regard.

Caregivers of sexually abused children have to contend with a number of issues emanating from these children's sexual abuse history (Farmer & Pollock, 2003, p. 101). According to Bilaver *et al.* (as cited in Pasztor *et al.*, 2006, p. 35), these children exhibited significantly more mental health problems than their non-sexually abused counterparts in foster care. It is no easy task to be a caregiver to a sexually abused child because of the effects their CSA history may have on their functioning.

Most foster parents in a study by Farmer and Pollock (2003, p. 111) were deemed to manage children's reactions to sexual abuse. Thus some caregivers are succeeding in handling these children's manifestations of CSA. Numerous studies have supported the link between parental support and better or more positive outcomes for the CSA surviving child (Elliott & Carnes; Kendall-Tackett *et al.*, as cited in Bolen & Lamb, 2007, p. 34). Bolen and Lamb (2007, p. 44) assert that the current conceptualisation of parental support may be inadequate to capture such a complex phenomenon. They indicate that caregiver support is an inconsistent predictor of a child's outcome after sexual abuse. Parental support could be generalised, as it is done in this study, to include caregivers, as they take over the roles and functions of parents. Of course, they are not always the child's true parents, which may have some implications for attachment, trust and communication.

Farmer and Pollock (2003, p. 111) have identified four central areas of good (foster) parenting by caregivers. These are to supervise such children closely; educate them about sex; treat their inappropriate behaviours adequately, and seek therapy for the children's unresolved deeper issues in order to view their behaviours in context.

There is a vital role that caregivers have to play in the detection of CSA, which is to have a good understanding of age-appropriate developmental symptoms (Pullins & Jones, 2006, p. 13). Many studies have shown that caregivers are only able to come up with five or fewer

symptoms of CSA on their own (Berrick; Fontes, Cruz, & Tabachnick, as cited in Pullins & Jones, 2006, p. 13). Pullins and Jones (2006, p. 13) report that in comparison with the aforementioned studies; their study found that caregivers could only identify one or two symptoms per developmental age group. Caregivers often identified more emotional and behavioural examples than physical or sexual symptoms.

International authors such as Benedict, Zuravin, Brandt, and Abbey (as cited in Breno & Galupo, 2007, p. 98) have identified an increase in the number of children entering the alternative care settings. On a local level, Richter *et al.* (2005, p. 461) notes a similar trend. They assert that increasingly more children are being left orphaned and vulnerable, which also sees them making their way into alternative care such as foster care and residential alternative care.

Gallinetti (2005, p. 214) stresses that sexually abused children in South Africa often end up in the legal and social welfare systems, such as being placed in foster care or in a children's home. Sexually abused children are sometimes returned to the care of their biological parents (Gallenetti, 2005, p. 214), which is provided for in Section 156 (1) (c) of the Children's Act (38 of 2005), and is permitted if it is judged to be in the best interest of the child.

Another local study conducted in Kwazulu-Natal has found that 40% of child callers calling Childline have lost their biological parents and are living with caregivers other than their parents (Van Niekerk, 2005, p. 267). This is an indication that caregivers are no longer to be assumed to be the traditional person, namely the child's biological parents.

According to a study referred to by Higson-Smith, Lamprecht and Jacklin (2005, p. 339) it was found that almost 7% of sexually abused children who visited the Teddy Bear clinic were in institutional care, which the author deems is alarmingly high.

2.2 AN OVERVIEW OF CHILD SEXUAL ABUSE (CSA)

Children often experience other forms of abuse than sexual abuse (Dawes, Richter & Higson-Smith, 2005, p. 2). According to these authors, CSA is not new to South Africa nor the rest of the world as there are documented accounts of it reaching back to ancient Roman and Greek times (Khar, as cited in Richter & Higson-Smith, 2005, p. 23). Townsend and Dawes (2005, p. 55) are of the opinion that the incidence of CSA is on the increase, but that it is hard to

know if there is a real increase or if it could be attributed to increased reporting due to heightened awareness.

The question then arises: Why is CSA such an attention-grabbing phenomenon? Dawes *et al.* (2005, p. 3) note that it may be due to the high levels of distress caused by the act of sexually abusing a child. They indicate that it causes a profound disturbance of the child's physical, social, emotional, moral and intellectual development, and often has far-reaching negative effects that are felt deep into adulthood. CSA has been receiving increased attention over the past three decades, as Pierce and Bozalek (2004, p. 829) indicate. The public is thus becoming increasingly aware of it.

Pierce and Bozalek (2004, p. 829) also indicate that from their research and in discussion with state social workers it has become apparent that the problem is of particular concern in rural areas. Social myth and stereotype surrounding HIV/AIDS may contribute to the problem surrounding CSA. So-called "Virgin cleansing" was identified as a possible reason behind the increases in CSA reports. This involves the false belief that having sex with a virgin (child) may cure an HIV infection, and goes to show that although consensus of the wrongness of CSA has been reached, some adults still view children as objects for use (Pierce & Bozalek, 2004, p. 829).

According to Pierce and Bozalek (2004, p. 820), CSA is under close scrutiny in South Africa as well as receiving more attention as a research area. They indicate that completed studies on CSA are not always published. This hampers the expansion of knowledge surrounding CSA. The expansion of knowledge is also restricted due to methodological problems such as inconsistency of its definition, bad record keeping, and ineffective reporting structures (Pierce & Bozalek, 2004, p. 820; Priebe & Svendin, 2009, p. 20).

2.2.1 DEFINING CSA IN THE LOCAL AND INTERNATIONAL CONTEXTS

It has been noted that problems exist in defining and containing the term "Child Sexual Abuse". Some definitions are either too vague and too inclusive, or too specific and thus too exclusive. Both of these may pose a threat when wanting to draw inferences, calculate prevalence rates or make generalisations about populations.

Townsend and Dawes (2005, p. 179) note that a leading researcher in the field of CSA, Finkelhor, agrees with their point that definitions of CSA are often vague in research studies. Finkelhor agrees that social service organisations reporting sexual abuse are not always comparable. His idea is that CSA has two basic elements, namely contact and non-contact elements. Contact forms involve physical contact during the act of CSA, ranging from genital and non-genital touching to vaginal and anal intercourse (Milner, as cited in Townsend & Dawes, 2005, p. 58). Non-contact CSA may range from exhibitionism to being a non-contact agent in the use of children in pornography or prostitution (Milner, as cited in Townsend & Dawes, 2005, p. 58).

Richter and Higson-Smith (2005, p. 21) note that CSA has a subjective nature, and this causes it to vary across event, experience of the child, duration of abuse, age of child, circumstances under which abuse takes place, and effects of abuse on the child and family.

Pierce and Bozalek (2004, p. 828) have found in their study on how South African people (lay persons, social workers, human service workers and the child protection unit) define child abuse and neglect, that all participants ranked CSA as the most serious form of child abuse and maltreatment. Thus there is at least consensus on this point.

It is noted by Dawes *et al.* (2005, p. 3) that sexual abuse as a term is culturally constructed, with each culture or societal groups deciding on what constitutes sexual norms as well as what constitutes the contravening of these norms. An example to illustrate the cultural effect of defining CSA is Townsend and Dawes' (2005, p. 59) example of a father bathing with his daughter. This act may be viewed in some cultures as normal, innocent and non-incestuous, and in others as inappropriate. Similarly, hearing of a priest touching an infant boy's genitals may be met with hostile, suspicion if the priest is catholic, but may be routine if he is a Jewish Rabbi performing a ceremonial circumcision of the infant.

Defining the term Child Sexual Abuse is thus a complex issue which requires attention to culture and its effects. Finkelhor (as cited in Dawes *et al.*, 2005, p. 3) was noted as stating that the important element in defining CSA is that it (the act) is primarily intended to be sexually stimulating or arousing to the perpetrator. The precise intention of the perpetrator is, however, hard to establish, and the meaning of act thus always remains open for interpretation.

Pierce and Bozalek (2004, p. 820) refer to Lachman when examining South African challenges to the definition of child abuse in an African context, and alludes to variation in cultural attitudes as the base of the problem. Abuse is viewed by many as a private, closed issue, and they are unwilling to discuss it.

Sexual abuse almost always refers to the sexual mistreatment of a child by an adult (Reber & Reber, 2001). Both the *New Dictionary of Social Work* (1995, p. 9) and the Children's Act (38 of 2005) define child (sexual) abuse as a phenomenon in which children are the victims of parents, guardians, or caregivers who sexually abuse them or allow them to be sexually abused by others.

Heissler (2001, p. 11) used the United Nations definition of CSA which defined it as:

“...contacts or interactions between a child and an older or more knowledgeable child or adult (a stranger, sibling or person in a position of authority, such as a parent or caretaker) when the child is being used as an object of gratification for an older child's or adult's sexual needs. These contacts or interactions are carried out against the child using force, trickery, bribes, threats or pressure. Sexual abuse can be physical, verbal or emotional...”

Bayley and Kings (as cited in Madu and Peltzer, 2001, p. 312) held child sexual abuse to be:

“When an adult or person significantly older or in a position of power interacts with a child in a sexual way for the gratification of the older person.”

The Children's Act (38 of 2005) should probably be taken to be the authoritative definition of what CSA is to mean in the South African context. It defines sexual abuse in relation to a child as:

“Sexually molesting or assaulting a child or allowing a child to be sexually molested or assaulted; encouraging, inducing or forcing a child to be used for the sexual gratification of another person; using a child in or deliberately exposing a child to sexual activities or pornography; or procuring or allowing a child to be procured for

commercial sexual exploitation or in any way participating or assisting in the commercial sexual exploitation of a child”

It is taken by the researcher that the Children’s Act adheres to an over-inclusive approach to defining CSA. This is perceived to be necessary to protect children as far as possible and not tie up the hands of the court and professional persons who aim to protect children from being abused. A very narrow definition which, for example, excludes non-contact forms of CSA, will be detrimental to children’s wellbeing from a legal point of view, but hinders research into the area because of the vagueness of the construct.

2.2.2 INCIDENCE AND PREVALENCE OF CSA

The term “incidence” refers to the number of reports or occurrences across a time period (Dawes, Borel-Saladin, & Parker, 2005, p. 180). “Prevalence” refers to the number of persons, experiencing the phenomenon, often expressed per 100 000 of the population or in percentage of the population studied (Dawes *et al.*, 2005, p. 180). Numerous challenges have been noted as impacting the trustworthiness and accuracy of prevalence statistics and incidence reports both nationally and internationally.

The precise incidence and prevalence of child sexual abuse is not known, as it is seldom reported, and evidence suggests considerable variability owing to methodological differences concerning measurement, sampling and reporting (Berliner & Elliott, as cited in Intebi, 2003, p. 8; Townsend & Dawes, 2005, p. 55; Fergusson & Mullen; Paolucci, Genuis, & Violato; Peters, Wyatt, & Finkelhor, as cited in Priebe & Svendin, 2009, p. 20).

As was discussed earlier, the definition of CSA poses a particular challenge that spills over into the calculation of its prevalence and incidence. Differences in measurement have been reported on by Townsend and Dawes (2005, p. 55) who indicated that reports showed that CSA of children under the age of 12 years had increased, but questioned this, as higher reporting may be linked to greater rates of awareness and not an actual increase in incidence. They settled to conclude that both possibilities may be true.

Diversities of samples have been shown to be challenging to keeping track of incidence and prevalence rates of CSA. Priebe and Svendin (2009, p. 20) noted that cultural effects and

differences between countries, with either multicultural populations or inter-country differences, were at play.

Dawes, *et al.* (2005, p. 178) asserted that cross-cultural comparisons of prevalence cannot be done accurately because of the vast difference in methodology and measurement instruments used. They further believed that the populations were not equivalent or comparable.

Priebe and Svedin (2009, p. 20) report that according to Paolucci *et al.* international prevalence rates are often estimated at between 15 and 20% of the general population, with up to 50% being exposed to CSA in international context. Priebe and Svedin (2009, p. 25) studied Swedish adolescents that had a CSA history and found that CSA incidence was significantly more frequently reported by females than males.

Collings (as cited in Kolbe, 2005, p. 33) noted that the prevalence rate of CSA in South Africa was two to four times higher than comparable rates in the United States of America. Salzwedel (as cited in Smit, 2007, p. 19) questioned the trustworthiness of prevalence and incidence statistics in South Africa. He also noted that statistics were extremely hard to come by in South Africa, as was experienced by many researchers.

According to Pierce and Bozalek (2004, p. 819) historically, especially under the apartheid regime, children of colour were excluded from statistics of CSA victims. It was white, and later coloured children (not black) who made up statistics of prevalence. This resulted in a lack of a common system of reporting and recording CSA or linking victims with services.

Most of the South African studies on child sexual abuse made use of data from the Child Protection Unit (CPU) of the South African Police Service (SAPS), since disbanded. According to Pierce and Bozalek (2004, p. 819) many cases went unreported to institutions keeping record of it, such as the South African Police Service, and many were only reported to social workers or health care workers whose intervention provided services. The only published versions of statistics that could be traced throughout literature searches were those that were published in 2001. These statistics from the CPU of SAPS, illustrated that 32 000 reports of CSA and attempted CSA were made for the period January 2000 to January 2001 (Simons, as cited in Britz & Joubert, 2003, p. 27). It goes without saying that these statistics

are old and out of date. Pierce and Bozalek (2004, p. 820) noted that the CPU, however, was the only national keeper of such data at the time of their study.

Local studies have provided prevalence statistics, although these are often challenged by newer studies. Madu and Peltzer (2001, p. 312) reported that the target populations of many CSA studies in South Africa were university students providing self reports on their CSA history. They found that prevalence rates for CSA among a sample of female university students was 30.9% for contact forms of CSA in Levett's study and 34.8% for Collings' study. For a combination of contact and non-contact forms, prevalence estimates were placed at 43.6% for female university students in South Africa by Levette (in Madu & Peltzer, 2001), whilst Collings (as cited in Madu & Peltzer, 2001, p. 312) found prevalence rates amongst male university students to be 28.9% for both forms of CSA.

In her literature review, Kolbe (2005, p. 33) reported a 12% increase in incidents of CSA as obtained from statistics of the CPU over 1999/2000. She however acknowledged that these statistics only reflected cases reported to and dealt with by the CPU. Cases handled by other SAPS units and other institutions went unrecorded.

Salzwedel (as cited in Smit, 2007, p. 19) estimated that half a million South African children were sexually abused annually, and reported that according to Child-Line South Africa, 33% of girls and 16% of boys were sexually abused in South Africa before attaining the age of 18 years. POWA (an NGO group) quantified the prevalence of CSA in South Africa as 25% for girls and 20% for boys before the age of 16yrs (Salzwedel, as cited in Smit, 2007, p. 19).

Madu and Peltzer (2001, p. 314) found in their study of adolescents (grade 11 and 12 pupils) in the Northern Province of South Africa that CSA had a prevalence rate of 54.2%. Of these victims 76.4% were black, 17.3% were white and 4% were coloured. One has to keep in mind that the demographics of the Western Cape are likely to be much different from the Northern Province, because it is not as highly populated and is more rural than the larger cities of the Western Cape. Yet, a township area such as Gugulethu, Mbekweni or Chicago may be similar as they too are rural in appearance and may be exposed to similar social issues such as poverty, unemployment, housing shortages, and HIV.

Collings (2005, p. 25) noted that boys are often overlooked and ignored as victims of CSA. The author reported that survey findings pointed to an increase of the sexual abuse of boys in peri-urban communities in South Africa. He noted that these increases were associated with breakdown in family support networks within the context of urbanisation.

The new Children's Act (38 of 2005) came into effect in April 2010. This legislation made provision for mandatory and standardised record keeping in the form of the national child protection register (Children's Act, 38 of 2005). It will hopefully be put to good use in the near future in recording incidences of child abuse, including sexual abuse across various institutions, NGO's and government departments. The National Child Protection Register's use is still not thought to have been spread throughout the various child protection bodies (government and NGO's). This register would arguably take over from the previous register kept by the CPU.

2.2.3 THE AFTERMATH OF CSA

The effects of child abuse have been studied in depth by various authors. When conducting a review of literature concerning CSA and its associated symptoms, consequences or effects, the classic works of Finkelhor emerge time and again. Van Der Merwe (2009, p. 25) noted that Browne and Finkelhor made important contributions to the understanding of the effects of sexual trauma. They delineated four trauma-inducing factors, namely traumatic sexualisation, stigmatisation, betrayal of trust, and powerlessness. These studies have been central to most studies concerning CSA and are cited by most researchers at some point.

According to Pullins and Jones (2006, p. 2) over the past 20 years, CSA and its effects have been widely examined. Symptoms of CSA have been found to compromise both long- and short-term effects. The most prevalent symptoms of sexual abuse are: multiple emotional, relationship and behavioural problems. These have been grouped and categorised by various authors and in various combinations with one another. These symptoms (or categories of symptoms) often overlap with one another. Britz and Joubert (2003, 27) reviewed literature and case studies which they reported as pointing towards a range of emotional, personality and behavioural problems suffered by child victims of CSA (Verduyn & Calam, as cited in Britz & Joubert, 2003, p. 27). Support for this has also been voiced by Kolbe (2005, p. 19), who noted that studies conducted, by Beitchman, Zucker, Hood, Da Costa and Akman, found

a strong link between CSA and symptoms dubbed “sexual abuse specific”. These symptoms correspond generally to those mentioned earlier.

Long-term effects are hard to attribute to a single variable, as an immense number of factors may impact on the child’s overall development and progress. Research in this field has accordingly found it extremely difficult to attribute specific behaviours, which occur later in life, exclusively to CSA (Van Rensburgh & Barnard, 2005, p. 1). Nonetheless intense long-term effects have been reported in the literature, according to Van Rensburg and Barnard (2005, p. 1). These include depression, guilt, low self-esteem/worth, phobias, nightmares, enuresis, social sensitivity, stigmatisation and a decrease in moral judgment (Brits; Doyle; Draucker; Finkelhor; Glaser & Frosh; Knight; Middleton; Robertson; Shaw, as cited in Van Rensburg & Barnard, 2005, p. 1).

2.2.3.1 Physical consequences (Medical issues)

The physical or medical symptoms associated with sexual abuse have been indicated to be physical injury caused by forced intercourse, urinary tract infections and diseases contracted due to sexual acts such as Sexually Transmitted Diseases (STD’s) (Wurtele, 2009, p. 3). These are short-term effects or direct medical effects, which may require treatment (Thakkar & McCanne; Madu & Peltzer, as cited in Barnard & Van Rensburg, 2005, p. 1). These symptoms are often present directly following, or soon after, the abusive act has occurred. It does not serve as a gold standard for CSA as Pullins and Jones (2006, p. 3) noted the physical symptoms may be caused by events other than sexual abuse. These physical symptoms are not the focus of this study, however, and are merely provided for a more comprehensive understanding of the phenomenon.

2.2.3.1 Psychological and Behavioural manifestations

Pullins and Jones (2006, p. 3) cite numerous studies that indicate that sexually abused children exhibit more psychological and behavioural issues than their non-abused counterparts. These problems have been found to take on the form of both internalising and externalising symptoms such as those reported by Pullins and Jones (2006, p. 3). Wurtele (2009, p. 3) also supports this notion, and elaborates that psychological symptoms often encountered are: depression, anxiety, anger, impaired sense of self, sexuality problems, cognitive disturbances such as concentration problems, inattentiveness, disassociation, academic and school issues, and behavioural problems/conduct disorders. Wherry, Graves

and Rhodes King (2008, p. 47) found support for convergent validity of various psychological conditions (anger, sexual concerns, anxiety and depression) being present in children with a CSA history.

Many children exposed to CSA were noted to have nightmares, be socially withdrawn, be prone to mental illness, and show regression in developmental levels (Kendall-Tackett *et al.*, as cited in Kolbe, 2005, p. 19). Prolonged untreated trauma may be internalised and become part of the personality. Long-term effects of CSA have been depicted by Lewis (as cited in Kolbe, 2005, p. 20) as delusions (distorted beliefs), self-destructive behaviours and the adoption of a victim mentality or identity. It also holds a great risk for future development of psychopathology.

Johnson, Cohen, Brown, Smailes and Bernstein (as cited in Kolbe, 2005, p. 20) conducted a study of adolescents and CSA. Their findings concluded that CSA can be associated with higher personality disorders such as borderline personality disorder and histrionic personality disorders, as well as mood disorders such as depression.

Symptoms or impacts of CSA have been recognised by Van Der Merwe (2009, pp. 29-38) as having an effect on the victim's self-esteem. They may become socially withdrawn, appear apathetic, and lack motivation or interest. They may also be involved in violence, either being bullied or themselves bullying others.

Self-blame and powerlessness are psychological issues often experienced by CSA victims and are believed to be associated with lowered sense of self-efficacy, anxiety, fear, depression and taking on a victim identity (Finkelhor & Browne; James, as cited in Van Der Merwe, 2009, pp. 31-32). Behavioural manifestations include nightmares, regression, aggression, sleep disturbances, and suicidal ideation as identified by Van Der Merwe (2009, p. 32). Some CSA victims view themselves as having a diminished self-image, self-esteem and self-efficacy following abuse (Berliner & Elliott, as cited in Misurell, Springer, & Tyron., 2011, p. 15). This has been reportedly linked to higher levels of self blame and misattribution of negative life events (Mannarino, Cohen, & Berman, as cited in Misurell *et al.*, 2011, p. 15).

Externalising problems has been noted to include anger, aggression, conduct problems, defiance, delinquency, and school problems. (Kendall-Tackett, *et al.*; Pereda, Guilera, Forns, & Gomez-Benito, as cited in Misurell *et al.*, 2011, p. 15). Substance abuse has been found to occur in adolescent CSA victims as well as teen-runaways, eating disorders, teen pregnancy, social dysfunction, and promiscuity (Misurell *et al.*, 2011, p. 15).

2.2.3.3 Inappropriate sexualizations and relationship problems

Pullins and Jones (2006, p. 3) elaborate on the so-called unusual sexual knowledge and behaviour often exhibited by CSA victims. They referred to numerous studies that suggest the development of inappropriate sexual knowledge or behaviour following CSA when compared to non-sexually abused children. They refer to a study done by Beitchman *et al.* (as cited in Pullins & Jones, 2006, p. 3), who found that adolescents who were sexually abused were more likely to act out sexually, be promiscuous, and had same-sex contact.

Finkelhor and Browne (as cited in Van Der Merwe, 2009, p. 34) note that confusion regarding sexuality, sexual norms and avoidance of sexual activities sometimes occurs in CSA victims. Spies (as cited in Der Merwe, 2009, p. 35) pointed out that apart from exhibiting promiscuous behaviours, the CSA victims at times even attempt to gratify non-sexual needs through sexual acts.

Interpersonal problems that have been noted is less social competence, more aggression, less trusting, and withdrawal (Wurtele, 2009, p. 3). Relationship problems identified in Kolbe's literature review include sexual intimacy problems, negative self-image, substance abuse disorders and anxiety disorders as reported by various authors such as Fleming, Mullen, Sibthorpe and Bammer as well as Stein, Golding, Siegel, Burnam and Sorenson (as cited in Kolbe, 2005, p. 20). Trust issues, sexual promiscuity and other forms of sexual maladjustment are further associated with CSA (Faller; Finkelhor; Glaser & Frosh; Green, as cited in Van Rensburgh & Barnard, 2005, p. 1).

Regarding experiencing feelings of loss and betrayal, it has been found that the psychological impact in this area includes numbing of affect, guilt, rage, denial, suppressed longing and intense distrust of others (James, as cited in Van Der Merwe, 2009, p. 32). This will obviously have an effect on the individual's abilities to form and sustain relationships with other persons. Relationship problems, detachment, somatic reactions, withdrawal, inability to

concentrate, hoarding, mutism and clingy/needy behaviour are further implicated by Van Der Merwe (2009, p. 32).

2.2.3.4 Post Traumatic Stress Disorder (PTSD)

Post Traumatic Stress Disorder (PTSD) has been linked with CSA in numerous sources of literature. Kolbe (2005, p. 19) examined studies conducted by Beitchman *et al.* who identified a strong link between CSA and PTSD.

Finkelhor's study (in Kolbe, 2005, pp. 19-20) and that conducted and reported by Carey, Walker, Rossouw, Seedat and Stein (2008, p. 97) lend further support to the inferred correlation between CSA and PTSD. They found that their sample of CSA survivors demonstrated high levels of PTSD and associations with disorders related to depression (mood disorders) such as major depression, adjustment disorder and dysthymia, which they hold as indicative of co-morbidity of PTSD.

Misurell *et al.* (2011, p. 15) note that CSA victims have been found to exhibit numerous combinations of internalising and externalising behavioural and psychological problems. Some of the common internalising behaviours have been found to resemble those associated with PTSD including elevated anxiety, depression, nightmares, sleep disturbances, withdrawal, hyper vigilance, avoiding certain experiences/situations, somatic complaints and feelings of shame, and guilt (King *et al.*; Maikovich, Koenen & Jaffee; Nurcombe, Wooding, Marrington, Bickman, & Roberts, as cited in Misurell *et al.*, 2011, p. 15). Thus an overlap may be present between many of the known symptoms of CSA and those of PTSD.

2.2.3.5 Meta-analysis studies

Meta-analysis studies covered by Kolbe (2005) in her literature review include those of Paulucci, Genius and Violato. These authors found a great variation in the prevalence rates due to inconsistencies and differences in definition, measurement, sampling methods and reporting methods. This yet again spills over and affects the way in which the impacts and the severity of CSA are reported and perceived.

Core symptom theory is referred to by Kolbe (2005, p. 21) as holding that a CSA victim exhibits a noticeable syndrome of symptomatology that includes sexualised behaviour and PTSD. Paulucci *et al.* found no increased risk for the development of negative outcomes

according to Kolbe (2005, p. 21). This indicates that there is debate around issues of desensitisation and/or resilience to CSA and whether it is a real phenomenon. Crowley (2008, p. 74) studied the links between types of memories and psychological distress due to CSA. He found that studies produced mixed results in this area too. This further contributes to the uncertainty in this regard.

It is important to note that Pullins and Jones (2006, p. 3) cite Kendall-Tackett, Williams, and Finkelhor who reviewed various studies and found that 20-30% of sexually abused children did not exhibit emotional symptoms at any point following their sexual abuse. Behavioural and emotional symptoms and their presence should thus not be taken at face value as indicative of CSA, as other life stressors or even psychopathology may be the main underlying issues, and not CSA.

2.3 DESENSITISATION AND RESILIENCE AMONG SEXUALLY ABUSED CHILDREN

Reber and Reber (2001, p. 192) define desensitisation as “any decrease in reactivity or sensitivity”. Desensitisation is seen on the one hand as a symptom associated with the trauma of sexual abuse, which includes depression, apathy and PTSD (Van Rensburgh & Barnard, 2005, p. 1). On the other hand, it could point towards psychological resilience associated with personality traits, positive family factors and social support systems that have a positive influence on the child (Van Rensburgh & Barnard, 2005, p. 5).

Children are occasionally known to react differently to sexual abuse, or appear to exhibit fewer symptoms in comparison with other children who have experienced sexual abuse (Kendall-Tackett & Simon; Rutter; Shaw; Thakkar & McCanne, as cited in Van Rensburgh & Barnard, 2005, p. 1). These are regarded as desensitised children who are at times more resilient. Kolbe (2005, p. 26) cites Constantine who reviewed 30 studies and reportedly found support for the inferences drawn by Conte (as cited in Kolbe, 2005, p. 26) that sexual abuse appears to affect some victims but not others, and that some were more resilient to the devastating effects of CSA.

Van Rensburgh and Barnard (2005, pp. 1-2) believe that resilient children are in the minority. Desensitisation could be taken to imply good functioning in spite of specific traumas, risks, and environmental hazards crossing an individual’s path (Van Rensburgh & Barnard, 2005,

p. 2). Children who are not resilient do not have such sources of resilience in their lives or do not have these protective factors to a degree which counteracts the development of the common symptoms associated with sexual abuse such as the multiple emotional, personality and behavioural problems referred to earlier.

Himelein and Mc-Elrath (as cited in Van Rensburgh & Barnard, 2005, p. 2), defined psychological resilience as a person's ability to resist the negative impact of trauma. Psychologically resilient children master stage-specific developmental tasks, and there is an absence of clinical or diagnostic levels of psychopathology.

Resilience is not determined by a single factor, but results from a number of interactional factors that go beyond genetic predisposition, temperament, personality traits, intelligence, skill and self-esteem (Anon, as cited in Van Rensburgh & Barnard, 2005, p. 2). Van Rensburg and Barnard (2005, p. 5); Lynskey and Fergusson (as cited in Hilarski, 2008, p. 37) and Reyes (2008, p. 52) have all noted the significant impact that factors such as personality traits, the nuclear family and social support systems have in facilitating psychological resilience.

2.3.1 FACTORS IMPLICATED IN INCREASED FUNCTIONING

2.3.1.1 Individual properties

Individual or personality characteristics that may serve as sources of resilience that may assist desensitisation include effective interpersonal skills, sound intra-psychic functioning, adjustment, stress control, and general satisfaction with life (Freitas & Downey; Masten & Coatsworth, as cited in Van Rensburg & Barnard, 2005, p. 2).

Hilarski (2008, p. 40) indicates that an internal locus of control may be a protective factor for CSA victims as reported by Pearce and Pezzot-Pearce. It is held that persons with an internal locus of control hold positive beliefs about inner strengths and resources that may be drawn on to overcome the stresses experienced with being a victim of CSA (Luthar; Luthar & Blatt, as cited in Hilarski, 2008). This coping mechanism and world view has been shown to correlate with lower levels of depression, possessing and using more social support, and having better problem-solving strategies (Banyard, as cited in Hilarski, 2008, p. 40).

2.3.1.2 Family factors

The second category that may bring about resilience or desensitisation, is family factors such as the child being valued, cherished and accepted in the family, positive bonding, good techniques for handling stress and coping, and good parenting practices. These have a stabilising effect on the family and lead to them being sound and supportive. Supportive factors found as expediting the abatement of CSA symptoms were supportive family environments as well as maternal support (Kolbe, 2005, p. 28). An international study done by Leon, Ragsdale, Miller and Spacarelli (2008, p. 77) found a number of protective factors at various levels including the level of the foster family with greater changes in trauma symptoms over time among highly disadvantaged youths in foster care.

According to Hilarsky (2008, p. 37) the family, too, suffers the negative consequences of CSA, in a similar way to the child. Focus is reportedly placed on the family's strengths and capacity to cope with life stages and hardships or crises (Norman, as cited in Hilarski, 2008). Hilarski (2008, p. 37) sees resilience as inseparable from the family.

Caregivers who are older, educated, have a predominant internal locus of control, possess reasonably high self-efficacy and self-esteem, who have an optimistic attribution style, mature defences, efficient coping, an ability to empathise, hold rational expectations, and have an accurate understanding of a child's development, are ideal protective agents for their children (Carr, in Hilarski, 2008, p. 37). The caregiver's strengths support and characterise the family system as flexible, connected, adaptive, with shared values, goals, priorities, expectations, and worldviews (McCubbin & McCubbin, as cited in Hilarski, 2008, p. 37).

2.3.1.3 Social support factors

Social support factors have been found to be an important contributing factor to resilience. Van Rensburg and Barnard (2005, p. 4) refer to protective agents such as psychologists, teachers, supervisors of school aftercares, sports coaches, mental health care workers and others who assist through service rendering. They divide social support into three main categories, namely peer group, the school, and role models.

Supportive environments are thought to give children better coping abilities and ways to deal with stress (Ruggiero, Del Ben, Scotti, & Rabalais, as cited in Hilarski, 2008, p. 39).

Secure attachment styles reportedly correlate with having an optimistic outlook and consider personal attributes in a positive light (Shapiro & Levendosky, as cited in Hilarski, 2008, p. 39). Resilient traits are acquired from interactions with primary caregivers with whom these children are likely to have secure attachments (Cassidy, in Hilarski, 2008, p. 39). They are reported to maintain close relationships and function well in peer groups (Sroufe, Carlson, Levy, & Egeland, in Hilarski, 2008, p. 39).

2.3.2 DESENSITISATION AND ITS OVERLAP WITH CSA SYMPTOMATOLOGY

Desensitisation could overlap with symptoms of sexual abuse, particularly those symptoms associated with PTSD. Symptoms such as apathy and diminished affect, along with psychological numbness and a decreased feeling of involvement with the world around one (Reber & Reber, 2001, p. 551) may be seen as desensitisation in some instances.

Pollio *et al.* (2008, p. 90) mentions a study conducted by Green that indicated a number of symptoms in reaction to sexual abuse that are common to the symptoms exhibited in PTSD. This study also indicated a prevalence rate of between 40% and 60% for children who have been sexually abused to develop PTSD, although it has been noted that valid and reliable clinical measures for children are greatly.

Van Der Merwe (2009, p. 25) mentioned that exposure to CSA can leave long term psychological effects on victims, whom developed powerful and often functional defence and coping mechanisms which at times overpower their core selves. Van Der Merwe (2009, p. 28) also noted that it is debatable that many of the defences found in the coping patterns of victims can be seen as internalisations or traumagenic states such as minimising, rationalising, denial and control issues and escape strategies, addictions, compulsions and isolation as drawn from authors such as Bass and Davis and Roos (as cited in Van Der Merwe, 2009, p. 28).

James (as cited in Van Der Merwe, 2009, p. 32) describes the pathological side of desensitisation, or what may be falsely seen as it. Psychological numbing of affect, guilt, rage denial, suppressed longing and distrust of self and others are indicated by James (as cited in Van Der Merwe, 2009, p. 32) are examples of such desensitisation.

2.3.3 CHALLENGES TO RESILIENCE AND ABATEMENT

According to Kolbe (2005, pp. 28-29) many longitudinal studies have shown the abatement of symptoms of CSA and the general improvement of functioning of the victim. They reported that internalising behaviour diminished and that externalising behaviours, such as aggression, increased. Tackett *et al.* (as cited in Kolbe, 2005, p. 29) cautioned that the abatement theory should be taken with the needed apprehension as symptoms often only took on new manifestations but did not disappear. Kolbe (2005, p. 28) noted that the symptoms reported to disappear the fastest were phobias and somatisations, while aggression and sexual preoccupation remained or increased.

Rojas and Kinder (2009, p. 363) challenged the notion that sexually abused children may become more social anxious adults, as the authors reported that Feerick and Snow found no differences between levels of anxiety for undergraduate females with a CSA history when compared to those without a CSA history. They were, however, found to be more likely to report distress in a social situation, when compared to their counterparts without a CSA history. Young and Colleagues (as cited in Rojas & Kinder, 2009, p. 363) found no differences in social anxiety scores across the sexes. Agreement in the area is thus lacking.

The children in the community in which the phenomenon has been observed rarely have access to such sources of resilience or coping mechanisms and the like. These families are often impoverished, have only one parent or multiple alternative caregivers, make use of harsh punitive disciplinary measures, have one or both biological parents engaging in substance abuse, have a lower education and social economic status, may have a greater history of mental health issues (e.g. depression) and are more at risk for further child maltreatment (Adams; Brown, Cohen, Johnson, & Salzinger; Carson, Gertz, Donaldson, & Wonderlich, as cited in Hilarski, 2008, p. 37).

Another possible explanation for what has been observed may be apathy or associated symptoms resulting from exposure to abuse; which may hold links with progressive PTSD (Pollio *et al.*, 2008, p. 90).

2.4 CONCLUSION

Indications are that many children end up with caregivers after being sexually abused, many in alternative care settings. The challenges faced by caregivers of the CSA child have been

touched on during this outline of literature. It is noted that little research is available on the caregivers and their experiences of caring for CSA victims.

CSA has been unpacked with a specific focus on the prevalence and incidence issues surrounding the topic. The difficulties surrounding prevalence and incidence issues that overlap with methodological and definitive problems have been indicated. The often encountered consequences and symptomatic symptoms of CSA have been discussed and shown to include various forms and combinations of physical, psychological and behavioural problems. The areas of disagreement regarding the interpretation of these symptoms have also been shown, especially relating to PTSD. PTSD and the possible overlapping that its features may have with those found with the CSA survivor has been noted in the literature.

Desensitisation in its two forms has been depicted as either a process of adjusting and coping by drawing on sources of resilience, or of progressing symptoms, such as apathy, depression, withdrawal, isolation and so on, which may be part of the PTSD symptoms.

In Chapter 3 the methodology that was employed in the study will be unpacked to reveal how the research plan proposed in Chapter 1 was undertaken. It will also indicate what challenges were faced and how these were negotiated throughout the research process.

CHAPTER 3: DISCUSSION OF METHODOLOGY EMPLOYED IN THE STUDY

3.1 INTRODUCTION

A brief overview of the methodology of the study has been discussed in Chapter 1. The overview served as a blueprint for the study in terms of sampling, data collection, data analysis, ethical considerations and limitations of the study. Chapter 3 will outline the procedures followed in executing the study. The different methodological aspects employed and their application will be discussed and the reason for their selection will be given.

The study followed a qualitative approach with an explorative and descriptive design. Qualitative approach allows the researcher to study selected issues in depth as they emerge from the data (Durrheim, 2006, p. 47). The explorative and descriptive design was implemented as the researcher aimed to generate new information of a relatively unknown phenomenon (Durrheim 2006, p. 44), namely to explore and describe caregivers' perceptions of desensitisation among sexually abused children.

3.2 RESEARCH QUESTION

All research begins with the identification and formulation of a research problem expressed as a question (Babbie & Mouton, 2007, p. 73). Ratele (2006, p. 540) notes that a research question is what the study seeks to answer. According to Creswell (2007, p. 105) a research question in a qualitative study takes on dual parts, namely a central question and/or sub-questions.

The research question is said to guide the research design (Babbie & Mouton, 2007, p. 74). It is thus important to align the study design with the research question in order to ensure that the question can be answered appropriately. The research question in this study is: What are caregivers' perceptions of desensitisation among sexually abused children?

3.3 RESEARCH GOAL

Social research has as a general role the generation of knowledge, specifically regularities in social processes (Sarantakos, 2005, p. 11). A study in the qualitative method with an explorative and descriptive design seeks to generate new information about a specific topic

(Durrheim 2006, p. 44). This study has as goal to explore and describe caregivers' perceptions of desensitisation among sexually abused children.

3.4 RESEARCH OBJECTIVES

In order to attain the abovementioned goal it is necessary to do the following:

- Explore what caregivers' perceptions are of desensitisation among sexually abused children by means of focus group interviews.

3.5 RESEARCH DESIGN

Research design as described by Babbie and Mouton (2007, p. 74) serves as a blueprint of how a study is to be conducted. Explorative and descriptive design has been implemented in this research. Information regarding this topic is needed to find a better understanding by means of exploring and describing caregivers' perceptions of desensitisation among sexually abused children, which is a relatively unknown subject area.

An explorative study aims to generate new information and make preliminary investigations into a relatively unknown phenomenon (Durrheim 2006, p. 44). Babbie and Mouton (2007, p. 80) indicate that explorative studies often lead to insight, but lack descriptive powers. Descriptive studies aim to make accurate descriptions of phenomena (Durrheim, 2006, p. 44). They make generalisations and associations and indicate patterns (Mouton, 2001, p. 103). These studies are more organised than explorative studies, with the purpose of attaining a deeper understanding of a phenomenon or to achieve rich data that could possibly inform an accurate description of the phenomenon (Durrheim, 2006, p. 44; Babbie & Mouton, 2007, p. 80).

The researcher decided to combine the two design paradigms so as to use the strengths of both. In other words, combining the two types of studies (descriptive and explorative) is done to arrive not only at information about a phenomenon, but to also arrive at a greater level of understanding of the phenomenon. Participants were encouraged to share their perceptions as caregivers of children with a sexual abuse history with regard to desensitisation among those children. This was done in order not merely to gain information, but to have sufficient understanding to provide a working description of their perceptions.

3.6 RESEARCH METHODOLOGY

Research methodology is a research strategy that translates ontological and epistemological principles into guidelines that indicate how the research is to be executed (Sarantakos, 2005, p. 31). Babbie and Mouton (2007, p. 75) define research methodology as the process to be undertaken as well as the tools and procedures to be used. Research methodology is said to be the total set of means that a researcher uses to attain the goal of their research (Mouton, 2001, pp. 35-36), in other words what protocol will be followed and how it will be done. It is thus the procedures to employ when conducting the study.

A qualitative approach was followed in this study. Qualitative studies are attempts at getting a so-called insider's view of the phenomenon, with a focus on describing rather than explaining or making predictions (Babbie & Mouton, 2007, p. 53). This approach allows the researchers to study selected issues in depth (Durrheim, 2006, p. 47).

Qualitative researchers want to answer questions regarding how social experiences are created and given meaning, as opposed to quantitative inquiry which seeks to emphasise measurement, and analysis of causal relationships among variables and not processes (Denzin & Lincoln, 2003, p. 13). This type of methodology allows the description and exploration of a phenomenon (Creswell, 2007). This then fits with the research goal and objectives which are explorative and descriptive.

3.6.1 Population and sampling

A population refers to the group about whom the researcher wants to draw conclusions (Babbie & Mouton, 2007, p. 100). Durrheim and Painter (2006, p. 133) note that a population comprises the larger group from which a sample is taken to be representative and to which findings are to be generalised. The population of this study consisted of those caregivers of children with a sexual abuse history who lived in the service delivery areas of; Gugulethu, Chicago and Mbekweni, and made use of the services of the Western Cape Provincial Department of Social Development's Paarl and Gugulethu Local Offices.

Sampling refers to a process that involves the selection of observations, according to Babbie and Mouton (2007, p. 164). Sampling needs to adhere to the purpose of the study in qualitative inquiry (Babbie & Mouton, 2007, p. 288). Henning (2004, p. 71) notes that the

method of using persons that comply with predetermined and desirable criteria that is influenced by the researcher's knowledge of the subject and available theory around the topic, is known as purposive sampling. Purposive sampling is used in qualitative research to select cases that can purposefully shed light on the research problem (Creswell, 2007, p. 125).

Purposive sampling implemented in this study owing to the researcher's consulting available literature and the aims of the study calling for the selection of cases that adhere to specific criteria, namely:

- That each participant resides within the service area of the Gugulethu, and Paarl local offices of the Western Cape Provincial Department of Social Development
- That the participants receives or in the past received services from the Department of Social Development
- That each participant has exposure as a caregiver of a child with a CSA history
- That the participants are willing to partake in the study.

The reason for selecting the criteria:

Firstly the criteria corresponded with the sampling method used. The participants were purposefully selected along the criterion of geographical proximity to simplify logistical arrangements for them to attend the focus group interviews and make it more convenient for them and the researcher.

Secondly, the criterion of affiliation with the Western Cape provincial Department of Social Development's Local offices of Gugulethu and Paarl was selected because the researcher was employed by this Department in the role of social worker, first at the Gugulethu office and then later the Paarl office. The researcher thus had well-established networks with the Department and its staff, which were used to access the participants. It allowed the researcher to save on time and effort to source the participants. The reason for limiting participants to those who received services from the Department of Social Development was to ensure that the participants had been provided with services and to re-establish networks with the participants to continue to receive further services, especially if they were to be traumatised by the study.

Each participant had to be a caregiver either presently or in the past, of a child with a sexual abuse history. This links up with the purpose of the study, as it is the perceptions of such caregivers which form part of the subject under investigation. Lastly the criterion of voluntary participation is included to ensure that participation occurs out of the own free will of the participants.

Permission to include the participants in the study was obtained from the respective senior managers from the Department of Social Development in the Gugulethu and Paarl local offices. After permission for using the clients of the Department of Social Development was obtained, purposive sampling was undertaken. Social Work supervisors from the Department of Social Development's Gugulethu and Paarl offices (rendering services in Gugulethu, and Mbekweni and Chicago respectively) were asked to identify cases where the children had a known history of sexual abuse. The social workers rendering services to each of the cases were subsequently asked to invite the caregivers of such children to form part of the study on a voluntary and informed basis. The persons who indicated a willingness to form part of the focus group interviews were then included in one of the three focus group interviews or the pilot interview. Some problems were experienced in accessing the participants, as not all social workers adhered to the proposed time frame for identifying participants, which resulted in postponing the focus group interviews on a two occasions.

3.6.2 Data collection

Focus group interviews were selected as means of data collection for the study. Focus group interviews are defined as by Sarantakos (2005, p. 194) as a loosely constructed group discussion in which the researcher guides the discussion. They are also known as group discussions as they focus not on one member but on the group as a whole (Kruger, as cited in Sarantakos, 2005, p. 195).

Babbie (2004, p. 302) states that focus group interviews allow the researcher to question a number of individual persons in a systematic and simultaneous fashion. Babbie (2004, p. 302) further indicates that they are used to bring people together to discuss a topic in a guided manner. Focus group interviews are often used with participants that have some similarities or commonalities between them, and when their interaction is likely to generate a rich depiction of information about a phenomenon (Kelly, 2006, p. 304; Krueger; Morgan;

Stewart & Shamdasani, as cited in Creswell, 2007, p. 133). Sarantakos (2005, p. 195) also noted that it is just as effective as any other method of data collection.

Focus group interviews were chosen over one-on-one interviews because the researcher believed that the interaction between participants in such a setting may stimulate in-depth participation and not only elicit minimalistic answers. In doing so, much more detailed information may be gathered in a shorter space of time. The process followed in using this method to collect data is discussed below:

3.6.3 Pilot study

Prior to conducting the focus group interviews the researcher used a pilot study to test that the study design was effective, and used it to point out problematic areas of the proposed interview guide, which allowed the researcher to adapt it, and make it more efficient. Sarantakos (2005, p. 256) indicates that a pilot study is a small scale replica or a dress rehearsal of a larger study to follow. The author explains that it is used to test the accessibility of the respondents and whether the venue is convenient and appropriate, whether data collection techniques employed will result in adequate data, and it may indicate if the research plan is well constructed or if any alterations may be required. Strydom and Delport (2005, p. 331) mention that the pilot study in qualitative research is usually done in an informal way with a small number of participants possessing the same characteristics as the main subjects and is done purely to discover certain trends. Mouton (2001, p. 103) supports this, and indicates that pilot studies often attempt to establish if there are interesting patterns within the data.

The same sampling procedure was employed for the pilot study as in the main study. Only five of the eight invited participants participated in the pilot study. This was seen as an early indication that participants might be reluctant to partake in the study in some instances, and logistical issues might be problematic. The pilot study yielded usable information such as preliminary themes relating to perceived symptoms of CSA, perceived desensitisation and resilience as well as preliminary discussion and perceived reason behind such improvement. The pilot study also pointed out ambiguity in some of the guiding questions set out in the interview guide, which could be adjusted for the focus group interviews that followed. .

3.6.4 Organising and setting up the focus group

Sarantakos (2005, p. 196) puts the optimum number of participants per focus group at five to ten participants, while Kelly (2005, p. 304) puts it at between six and twelve. During the purposive sampling process, possible participants were invited to partake in the study. Ten participants from each of the three residential areas were invited to an arranged venue on a time and date that they agreed to. Turnout of participants varied among the three focus groups. Only four participants arrived to partake in the Gugulethu focus group, eight for Chicago, and six for Mbekweni. The possible reasons for the poor turnout in some of the focus group interviews may have been the cold and rainy weather that was experienced on the day of the Gugulethu focus group interview.

The venues used for the focus groups were selected according to availability and proximity to the respondents' residences to eliminate any major logistical complications. The reasons for drawing participants from the areas of Gugulethu, Mbekweni and Chicago were discussed under sampling. The Gugulethu focus group interview took place in the Department of Social Development's boardroom. With the Mbekweni focus group interview, the Mbekweni library's conference room was used as venue. The Chicago group interview could not be held in the community because there was no appropriate venue available at the agreed time and date. The board room of the Paarl local office of the Department of Social Development was used, and transport was arranged for the participants, as it was further away from their residences. Small incentives such as tea and biscuits were provided by the researcher during each of the focus group interviews. The settings were conducive to the interview process, as it was a relaxed environment that ensured no interruptions, as prescribed by Babbie (2004, p. 303), Greeff (2005, pp. 294-295) and Sarantakos (2005, p. 197). The researcher interacted with the participants in an informal manner, so as to relax the atmosphere and get the respondents settled before starting the interviews.

Some of the participants in each of the groups were familiar with each other as they came from the same geographical areas. The participants were prepared for the focus group interviews by verbally explaining the objectives of the study as well as their rights. A written copy of the aim, objectives and their rights was handed to each participant. Ethical issues were discussed with each participant and they were informed of the confidentiality implications, their right to refuse to partake or to withdraw at any time and consent to the translator serving as facilitator and the recording of the interview by means of a voice

recorder. The risk involved in the study, specifically on an emotional and secondary trauma level, was discussed in detail with participants. They were informed that they will not be rewarded for participation, nor will they be penalised for choosing not to participate in the study. The dissemination of the information was also discussed with the participants. The participants themselves were also obliged to give written consent to indicate their voluntary participation. The aforementioned align with the ethical issues that were discussed in Chapter 1.

3.6.5 Conducting the focus group interviews

The services of two Xhosa-speaking facilitators were employed during two of the focus group interviews. The facilitators were qualified social workers with four and eight years' experience respectively. They thus had sufficient experience to assist in the role of facilitators. They were clearly instructed to provide a verbatim translation of the responses by the Xhosa-speaking participants who felt more comfortable to express themselves in Xhosa than English or Afrikaans.

The sessions started out with a discussion of the goal and objectives as well as the risk and benefits along with the ethical considerations of the study. This was followed in each session with the negotiation of group norms and values in the form of setting house rules that would guide interaction between the different participants and with the research team.

Each member was required to give their opinion and input. They were required to listen to the other participants and had to respect the views of others. They were requested to speak one at a time in order to not distort the audio recording. They were asked to indicate whether they agreed with the researcher's summary of what had been given as answers at the end of the discussion of each point.

It was explained that the audio recording was merely used to ensure accurate transcription of the data. The recordings would be destroyed as soon as the data was transcribed. It was explained that the access to the data was strictly controlled by means of password protection on the personal computer of the researcher.

Upon concluding the introductions and informing all participants about how the process was to unfold, the researcher moved on to introduce the questions. Open-ended questions were

used to promote participant interaction. The researcher made use of interview techniques such as probing, paraphrasing, summarising and clarification in order to steer the interviews into the desired direction and to ensure that rapport was established with the participants. According to Babbie (2004, p. 266), probing is used to require participants to elaborate when an inappropriate or incomplete response is given to a question. Babbie and Mouton (2007, p. 289) also indicate that probes are useful for getting in-depth answers without prejudicing later answers, and advise the researcher to develop good listening skills.

The researcher posed the following questions/requests to the participants, as contained in the interview guide refined from the pilot study:

- Briefly share what happened to the child in your care. This request was asked only of the last group, as the second group exhibited a need to share this information. It assisted in setting the stage for the questions to follow and also helped the participants to relate to one another.
- Tell me about the behaviour and feelings of the sexually abused children in your care/How will one know that the child has been sexually abused?
- Tell me how the child deals with having been sexually abused.
- Are there any of the children in your care that deal better with the fact that they are sexually abuse than others? Why do you think so?

Once each question was answered by the focus group participants, the main points were summarised by the researcher before moving on to the next question. Upon concluding the questions the researcher asked if there was any further information that anyone would like to add, and if no such responses were given, the next question was presented to the group.

Field notes, in the form of observational notes, were used by the researcher to supplement the verbal information of the participants. Observations such as the tone of voice, emotional state, and physical actions of the participants were recorded in writing. It was also done to keep a record of which participant made which points. Observational notes are deemed vital to the accurate description of what transpired during an interview and are used to make empirical observations and table the researcher's interpretations of such comments (Babbie, 2004, p. 304).

The purpose of field notes was discussed with the participants before the start of the focus group interview. It was done in a manner that was least disrupting. The use of the field notes was to supplement the audio tape and to keep track of who is making what points. The utilisation of the tape recorder and notes was communicated to the participants beforehand.

The researcher guarded against the focus group interview being dominated by a single or group of persons by making sure more quiet participants were also given a chance to express their opinions, as suggested by Creswell (2007, p. 133).

Once all the focus group interviews were concluded the researcher proceeded to transcribe the audiotapes verbatim so that a word-for-word retelling of the participants' perceptions was documented. Copies of the transcribed interviews were made as backup and the participants' names and personal details were masked in the recordings, as proposed by Creswell (2007, pp. 142-143).

3.6.6 Data analysis

Data analysis in qualitative inquiry is described as a process that includes coding and analysing the data after it has been collected (Babbie, 2004, p. 345). Some basic analysis happens during data collection when the researcher makes notes, such as jotting down commonalities between participant responses (Sarantakos, 2005, p. 345).

Babbie (2004, p. 345) states that the fixed model of data analysis in qualitative inquiry is a analysis method that typically occurs once all data has been collected and transcribed and is done with the written accounts of the data (interview transcripts).

The practice of coding is a procedure of classifying or categorising individual pieces of data that are linked to a retrieval system (Babbie, 2004, p. 376). Codes are said to be made up by the researcher as he/she goes along, and the more familiar the researcher is with the data, the more competence in labelling the codes will be demonstrated (Strauss & Corbin, as cited in Babbie, 2004, p. 377; Henning, 2004, p.105). "Immersion" is the process of becoming thoroughly familiar with the topic and involves careful reflection and interpretation on an intuitive level as opposed to using analytical techniques (Terre Blanche, Durrheim & Kelly, 2005, p. 322). Immersion could further be assisted by the researcher transcribing the obtained data him/herself and will give a better feel for and understanding of the data because the

researcher was present when the data was collected (Henning, 2004, p. 76; Creswell, 2007, p. 61). The researcher read through all the transcripts a number of times to familiarise and immerse himself in the data.

The researcher's notes and field observations were used to guide the process of coding as proposed by Babbie (2004, p. 377). Significant themes were highlighted in the data with different coloured marking pens. Corresponding perceptions and themes were arranged together in columns with headings and sub-headings. These became known as themes and sub themes, as this constitutes coding the data (Creswell, 2007, p. 148). Data was thus put through a process of thematic analysis, as is often done in qualitative studies, according to Creswell (2007, p. 75). From these descriptions the researcher proceeded to formulate combined descriptions representative of the essence of the phenomenon, grouped into themes and sub-themes. This representation of data allowed the researcher to initiate discussion and debate around the finding as well as compare and contrast findings to other studies and the literature.

3.8 LIMITATIONS

The following limitations were identified either before, during or after the completion of the study. The study may be limited in that the findings only reflected perceptions of caregivers in the Gugulethu, Chicago and Mbekweni areas who were affiliated with the Department of Social Development's local offices serving these communities. The sample is thus too small to generalise findings.

- Difficulty was experienced in acquiring participants because of having to rely on other social workers and their supervisors to identify and link the researcher with prospective participants. Difficulty in accessing participants was experienced, and the pilot study was an indication of the challenge in this regard. The battle to identify and access participants was, however, negotiated successfully by the researcher as he remained flexible and rescheduled the focus group interviews on a number of occasions when it became apparent that too few participants were contacted and invited by their social workers. The researcher also arranged transport for the participants to attend the focus group session in Paarl, when the venue for the Chicago focus group was lost by postponing twice.
- The sensitivity of the topic was a further challenge as it was expected that some participants might become uneasy in engaging the topic under investigation. One participant withdrew from the study for just this reason. An issue that is adjacent to

this was the fact that some of the participants had very recently learned of the sexual abuse of the child in their care. In some instances the child was sexually abused a mere month prior to forming part of the focus group interviews. It was noted that they harboured intense feelings of guilt, anger and blame, which impacted the progress of the interviews. The researcher identified their need to ventilate their feelings, and provided such opportunity, which caused the interview sessions to become drawn-out in one focus group interview. All the participants were, however, linked with ongoing support services and further social work intervention services.

- The researcher's relative inexperience was another aspect that was evident from the outset. It was challenging to elicit good information from participants owing to this. The great volume of data that was sifted though was extremely time- consuming and intimidating to the novice researcher in its analysis and interpretation, as the researcher had limited resources to assist in streamlining this process.
- The participants were found to be fiercely protective in their attitude towards the children in their care. This may have caused them to downplay the child's coping out of fear of a decrease of services if coping was perceived as progressive.
- Feelings of guilt might have affected the way in which the caregivers depicted themselves and their levels of commitment and assistance given to the children in their care.
- The low levels of education of some of the participants was an obstacle faced during the interviews as it took them longer to understand some of the questions asked of them.

3.9 CONCLUSION

The researcher selected a qualitative study design with an explorative and descriptive research design in an attempt to answer the research question. The methods employed made it possible to execute the study and to gather relevant information on the perceptions held by caregivers of children with a CSA history on desensitisation among these children. This data could be used to approximate an answer to the research question as the study explored and described the aforementioned perceptions held by the caregivers.

Purposive sampling enabled the selection of participants that yielded specific information in their perceptions. Data collection methods involved focus group interviews which gave a

more complete picture to the perceptions of the persons and also encouraged debate around the topic between participants. Transcribed interviews served as data that was subjected to fixed model analysis procedures typically found in qualitative inquiry, and resulted in a number of themes and sub-themes being identified. Data verification occurred through the method of member checking, which involved the participants checking the data for accuracy and congruency with their perceptions. Ethical responsibilities of the researcher were adhered to throughout the study and issues such as confidentiality, informed participation, respect for autonomy and non-malevolence were addressed and upheld throughout the study.

In Chapter 4, the data that was collected and analysed will be discussed. It will provide detailed picture of the identified themes as well as comparing and contrasting the findings with available literature in an attempt to explore and describe what perceptions were given by the caregiver participants regarding desensitisation among the sexually abused children in their care.

CHAPTER 4: RESEARCH FINDINGS

4.1 INTRODUCTION

This chapter sets out to address the research goal in exploring and describing what perceptions are held by caregivers of desensitisation among the sexually abused children in their care. Firstly, the relevant demographic data of the participants are presented and discussed. Secondly, the researcher presented and discussed the findings of the focus group interviews in themes and sub-themes, and compares and contrasts the findings with available literature.

Data was collected by means of focus group interviews conducted in the Gugulethu District Office of The Department of Social Development, and in Mbekweni and Chicago, which fall under the Paarl District Office of The Department of Social Development. The participants were sourced from case loads of fellow social workers at two district offices of the Department of Social Development. A pilot test was done in Gugulethu to test and streamline the open-ended questions presented to the participants during the focus group sessions. The participants were informed of the objectives of the study by means of an information sheet which was read through and explained to them. Informed consent was obtained in a form from each participant.

4.2 DEMOGRAPHIC DETAILS OF PARTICIPANTS

A brief outline of demographic data gathered during the focus group interviews is presented in the following section. A demographic profile form was filled in by each participant at the start of every focus group interview.

A total number of 17 persons formed part of the three focus group interviews, as one person withdrew from the study for personal reasons and their details were removed from all records. Four participants came from Gugulethu, seven from Chicago and six from Mbekweni. These areas are all sub-economic and previously disadvantaged. The socio-economic status of the participants was not included in the questionnaire. Table 4.2.1 summarises the demographic data obtained from the participants.

Table 4.2.1 (Display of Demographic data of caregiver participants)

Focus group	Sex	Age	Ethnicity	Language	Residential area	Education level	Number of children in household
1	F	34	African	Xhosa and English	Gugulethu	Gr. 11	4
1	F	44	African	Xhosa	Gugulethu	Gr. 4	1
1	F	40	African	Xhosa	Gugulethu	Gr. 6	3
1	F	39	Coloured	Afrikaans	Gugulethu	Gr. 12	1
2	F	38	Coloured	Afrikaans	Chicago	Gr. 11	4
2	F	58	Coloured	Afrikaans	Chicago	Gr. 5	1
2	F	59	Coloured	Afrikaans	Chicago	Gr. 7	1
2	*	*	*	*	*	*	*
2	F	40	African	Xhosa and Afrikaans	Chicago	Gr. 9	4
2	F	56	African	Xhosa and Afrikaans	Chicago	Gr. 1	1
2	F	44	Coloured	Afrikaans	Chicago	Gr. 9	1
2	F	29	Coloured	Afrikaans	Chicago	Gr. 10	2
3	F	43	African	Xhosa	Mbekweni	Gr. 6	1
3	F	23	African	Xhosa	Mbekweni	Gr. 9	2
3	F	34	African	Xhosa	Mbekweni	Gr. 12	1
3	F	31	African	Xhosa	Mbekweni	Gr. 11	2
3	F	37	African	Xhosa	Mbekweni	Gr. 11	2
3	F	55	African	Xhosa	Mbekweni	Gr. 6	1

4.2.1. Caregiver information***Gender***

All the participants in the study were female. No males were identified during sampling. No literature could account for the unequal proportion of caregiver participants being predominantly female.

Age

The ages of the participants who took part in this study, ranged from 23 to 59 years. Two participants were in their 20's, six in their 30's, five in their 40's and four in their 50's. The majority of the caregivers were thus older than 30.

Language

Eleven of the participants were predominantly Xhosa speaking. Two Xhosa first-language speakers, however, chose to speak in Afrikaans and another one in English during the interviews. Six participants were Afrikaans speaking. The language used by the participants during the interview, apart from two participants from Gugulethu, usually kept to the dominant language spoken in their residential area.

Education

The education level of the respondents was relatively low. Seven participants had not completed primary school and a further eight did not complete high school. The lowest grade which one participant indicated to have passed was Grade one. Three participants left school after completing Grade 9 and four dropped out after Grade 11. Only two of the participants completed high school (Grade 12) successfully.

Number of children in the household

Most of the participants were caregivers to a single child under the age of 18, but four were caregivers to 3 to 4 children under the age of 18 years. All of the participants had their own children who were not necessarily the CSA child victims that are referred to in the study. The majority of the participants had children who were over the age of 18 years in addition to the minor children in their care.

Table 4.2.2 is a representation of the demographic data obtained regarding the sexually abused children in the care of the participants. The information was gathered along with the information contained in table 4.2.1, but is displayed separately in order to simplify its representation and discussion.

4.2.2 CSA victim information

Age of the CSA child in the care of the participant

The current average ages of the children on who the participants' perceptions are based were 12 years of age. The youngest child was 6 years old and the oldest was in actual fact now an adult of 22. Two participants were currently over the age of 18 years and thus no longer minor children; they were, however, still seen as children by the participants who played parent to them. One of the children was murdered after being abducted and raped, thus her current age was not reflected. The following table serves as a display of the demographic information about the sexually abused child in the care of the participants, as provided by the participants themselves.

Table 4.2.2 (Display of demographic information on Children in caregiver's care)

Focus group	Age of CSA child	Age when CSA occurred	Gender of CSA child	Professional services accessed
1	7	6	Female	Yes
1	10	10	Female	Yes
1	14	3	Male	Yes
1	14	13	Male	Yes
2	22	12	Female	No
2	9	9	Female	No
2	6	6	Female	No
2	*	*	*	*
2	17	15	Female	Yes
2	8	7	Female	No
2	-	6	Female	-
2	12	11	Male	No
3	19	16	Female	Yes
3	7	5	Female	Yes
3	11	9	Female	Yes
3	10	7	Female	No
3	13	11	Male	No
3	17	15	Female	No

The ages when the CSA occurred varied greatly. The youngest child was three years old at the time of being abused and the eldest was 16. Half of the children were ten years and younger when the CSA occurred while the other half were 11 and older. On average the age

when CSA occurred among the CSA victims in the care of the participants was nine-and-a-half years.

Sexual abuse in the form of penetration involves force in all cases of pre-pubertal children (Richter & Higson-Smith, 2005, p. 24). Jaffe and Roux (as cited in Richter & Higson-Smith, 2005, p. 23) report that as many as 88 cases of rape of children under the age of 13 years were reported in a tertiary hospital in South Africa more than 20 years ago. Current data is lacking owing to the methodological and recording issues discussed in Chapter 2.

Pierce and Bozalek (2004) refer to statistics of The Office on the Rights of the Child of The Presidency (as cited in Pierce & Bozalek, 2004, p. 819) when asserting that at the time of their study approximately 41 million persons lived in South Africa of which more than 40% were children. They further state that 16 % of the population was under the age of 5 years and a further 23% were between the ages of four and 16 years in 2001 when these statistics were reported.

Gender of CSA victims

The majority of the CSA victims that were currently being cared for by the participants were female children. Thirteen girls and only four boys were indicated to be in the care of the participants.

Guma and Henda (2005, p. 104) notes that CSA is often more associated with female children than males. Collings (2005, p. 23) indicates that few studies have examined the patterns of CSA amongst boys, especially in South Africa where his was a ground-breaking study. According to him, the prevalence rates for girls and boys differ only marginally. This is further supported by Salzwedel (as cited in Smit, 2007, p. 2) who notes that POWA's statistic showed that 25% of girls in South Africa are sexually abused before the age of 16 and 20% of boys.

Access to professional services

Half of the children in the care of the participants had accessed professional intervention services and the other half had not. It later became apparent through the focus group interviews that more than half of the children did receive some sort of intervention service.

4.3 FINDINGS RELATING TO CAREGIVER PERCEPTIONS OF DESENSITISATION AMONG SEXUALLY ABUSED CHILDREN

Four themes are identified during this discussion of findings. Some sub-themes have been identified in a number of instances to better organise and demonstrate the findings. The inclusion of some sub-themes further helps to explore and discuss the research findings in a coherent and comprehensible manner.

It is known that CSA is a local and international concern and has notable negative impacts on children, as is often found in literature. Children react differently to sexual abuse. Some are influenced negatively and others appear to be more resilient and exhibit fewer symptoms (Van Rensburgh & Barnard, 2005, p. 2). We hold this as desensitisation in our study, which points to decreased reactivity to CSA, meaning less development of commonly associated CSA symptoms.

According to Kouyoumdjian Perry, and Hansen (2009, p. 42) research indicates adults' expectations of children have a strong influence on their functioning. Kouyoumdjian *et al.* (2009, p. 43) note that little research has been done into the effects that parental or caregiver expectations may have on the CSA victim and the associated symptoms that take on an internalising and/or externalising form. Parents are said in some studies referred to by Kouyoumdjian *et al.* (2009, p. 43) to often hold more negative or deleterious expectations for the outcomes of the CSA child victim.

Finkelhor (1990, p. 328) indicates that since the mid 1980's significant studies have been done into the conceptualisation of the impact that CSA has on the child victim. According to Kendall-Tackett (2003, p. 228) responses of a child to CSA depended greatly on the child, the family, whether it was reported to the authorities and what support was available following disclosure. Hewitt (as cited in Intebi 2003, p. 9), notes that parental attitudes and commitment such as being cooperative, respectful, able to put child's needs first, not attempting to control or dictate to the child are important as low-risk factors that affect the child's vulnerability. Thus it can be put forth that caregivers' characteristics, attitudes, perceptions and expectations may be of extreme importance to better understand the CSA child victim.

Firstly, the symptoms that are both expected and perceived or witnessed by the caregivers are discussed. The first theme is a grouping of the externalising displays that form part of the

symptomatology of the CSA child as well as a discussion of how the children in the care of the participants measured up. Secondly, the internalising symptoms shown by these children are discussed and debated on. Thirdly, the perceived desensitisation in light of coping and functioning is discussed. Lastly, reasons for possible desensitisation or coping and better functioning as it is operationalised is explored and discussed. Table 4.3.1 serves as a visual summary of the themes and sub-themes which will be discussed.

Table 4.3.1 Themes and sub-themes

THEME	SUB-THEMES
<p>1. Perceived externalising manifestations among the CSA child victims by caregivers</p>	<ul style="list-style-type: none"> • Caregivers’ perceived anger, aggression and violence among the CSA victims • Caregivers’ perceived deceitfulness and a disrespectful attitude among the CSA victims • Caregivers’ perceived scholastic conduct issues among the CSA victims • Caregivers’ perceived sexual deviance among the CSA victims • Caregivers’ perceived substance abuse among the CSA victims • Caregivers’ perceived suicide attempts among the CSA victims • Caregivers’ perceived physical and physiological implications among the CSA victims • Caregivers’ perceived somatic manifestations among the CSA victims
<p>2. Perceived internalising manifestations among the children with a CSA history by caregivers</p>	<ul style="list-style-type: none"> • Caregivers’ perceived fears, anxiety and panic among the CSA victims • Caregivers’ perceived sleep disturbances among the CSA victims • Caregivers’ perceived decreased social participation among the CSA victims • Caregivers’ perceived academic and concentration problems among the CSA victims
<p>3. Perceived desensitisation, coping and current functioning of the CSA Victims</p>	<ul style="list-style-type: none"> • Marginal desensitisation of CSA victims perceived by the caregivers • Unwillingness to portray children as approximating desensitisation
<p>4. Reasons perceived by caregivers to influence desensitisation, positive changes and resilience</p>	<ul style="list-style-type: none"> • Caregiver effects perceived to influence desensitisation, positive changes and resilience • Family effects perceived to influence desensitisation, positive changes and resilience • Personal characteristics perceived to influence desensitisation, positive changes and resilience • Social effects perceived to influence

	desensitisation, positive changes and resilience <ul style="list-style-type: none"> • Intervention services effects perceived to influence desensitisation, positive changes and resilience • Perpetrator consequences perceived to influence desensitisation, positive changes and resilience
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4.3.1 Theme 1: Perceived externalising manifestations among the CSA victims by caregivers

Externalising behaviour or manifestations is a grouping of symptoms with an outward display. Externalising displays noted among sexually abused children throughout the literature are displays of aggression, anger, violence, delinquency, regression, running away, self-harming and maladaptive or risky sexual behaviour and even addiction (Kolbe, 2005, p. 19; Van Der Merwe, 2009, p. 35).

Finkelhor (1990, p. 326) notes that a distinction between internalisation and externalisation was often encountered when attempting to group CSA symptoms. The previous author also noted that differences existed between the sexes, with boys tending towards externalising and girls towards internalising reactions to CSA. The majority of CSA child victims in this study were girls, as is mentioned earlier under the demographic information, What is more, Kendall-Tackett (2003, p. 227) indicate that the types of symptoms that children manifest in reaction to CSA may further vary according to the child’s age, which is clear from the large range of ages when CSA occurred as reported in the demographic information.

There is, however, believed to be a large degree of overlap between internalising and externalising behaviour, which makes up theme 1 and theme 2 of this study. Wherry, Berres, Sim and Friedrich (2009, p. 234), for example, link sexual risk-taking behaviour (an externalising behaviour) with other internalising symptoms, which they note often occurs with a CSA child.

Possible links with PTSD are also believed to be present in the children as derived from some of the perceptions of the participants. Kolbe (2005, p. 19) alludes to this when she mentions a study conducted by Beitchman, Zucker, Hood, Da Costa and Akman in which it was noted that most common symptoms associated with CSA pre-schoolers were internalising and externalising manifestations common in PTSD. School-going age children were reported in this study to most often exhibit fear, aggression, nightmares and school problems. For

adolescents the study found depression, withdrawal, suicidal ideation, self-injury and self-defeating behaviours such as running away from home and substance abuse. The symptoms of nightmares, depression, withdrawal, mental illness and aggressive behaviour were said to dominate reports (Kendall-Tackett *et al.*, as cited in Kolbe 2005, p. 19).

4.3.1.1 Caregivers' perceived anger, aggression and violence among the CSA victims

Anger and aggression are repeatedly identified throughout various literary sources as common associated manifestations of CSA. Kendall-Tackett *et al.*, (in Kolbe, 2005, p. 19), Pullins and Jones (2006, p. 15), and Ferreira, Ebersöhn and Oelofsen (2007, p. 71) note that sexually abused children often exhibit more externalising manifestations such as anger and behaviours deemed aggressive and violent.

The participants frequently indicated the children in their care had outward displays of aggression, anger and violence. The children were described as harbouring feelings of anger, often engaging in verbal and physical altercations with other persons including their caregivers, and even resorting to physical violence. This is congruent with what the literature holds as displays commonly encountered with the CSA child.

The following statements serve as evidence of the abovementioned deductions:

“She has a lot of anger... She is very disrespectful; she is fighting with me a lot.”

“Ja, sy is baie opstandig en baie aggressief”

Their perceptions also included expected behavioural and psychological manifestations that were not at present being displayed by the children, or which they described as decreasing over time.

There were respondents who perceived the externalising manifestations such as anger, and aggression to diminish to a degree among the children in their care.

“Later van tyd toe was sy lyk my nou nie meer kwaad nie”

“Daar is baie verbetering daarin ja (agressie)”

Kolbe (2005, p. 28) notes in her review of literature that externalising behaviours such as aggression did not decrease or disappear very swiftly, but that it rather remained or at times increased, whilst manifestations such as fears and somatisations often disappeared faster. The abovementioned do not fully support this literature referred to by Kolbe (2005, p. 28).

4.3.1.2 Caregivers’ perceived deceitfulness and a disrespectful attitude among the CSA victims

Dishonesty and lying were reported as perceived among the CSA children in the care of the participants. The children were depicted as sly, manipulative and untrustworthy because they were often lying and being deceitful. Spies (as cited in Van Der Merwe, 2009, p. 35) notes that recent studies have found destructive behaviours that may take on the form of lying and stealing amongst CSA victims. The participants did identify such issues which are exemplified by the following:

“Maar later van tyd, ek staan in my werk in en ek hoor nêe sy was nie skool toe nie en later aan toe begin sy nou te lieg.”

“Kinders wat gemolesteer is is baie skelm.”

Many children were described as having a bad attitude, or being disrespectful towards their caregivers and other persons. This perception was often implied in the demeanour and disappointed tone of voice of the participants, as going against the social norms and values held by the participants.

“Yes disrespectful it is not her behaviour before this”

“... then she was... she is also cheeky”

A few of the respondents, however, perceived externalising displays of disrespect and rudeness to diminish to a degree among the children in their care. This is not often reported by the caregivers and is displayed in the following quotation:

“... the cheekiness has also lowered down now a bit”

Improvement in this regard may be under-reported. Positive changes may have gone unnoticed by the parents. It seemed that the caregivers could more easily identify negative behaviour, than note when no such negative behaviour was present, or when changes have started leaning in the direction of more positive behaviour.

4.3.1.3 Caregivers’ perceived scholastic conduct issues among the CSA victims

Scholastic adjustment, conduct and dropout are other outward displays noted by the respondents. They often told of the children’s misbehaviour in school and conduct problems manifesting at school. The children reportedly misbehaved in school as they were involved in altercations with other children and teachers. Many of the participants indicated that the children in their care were reluctant to attend school or had a tendency to drop out of school. Ferreira *et al.* (2007, p. 71) refer to sexually abused children displaying outward manifestations in the school setting, such as behavioural conduct problems, defiance, absconding or running away. This is also supported by Kendall-Tackett *et al.* (as cited in Kolbe, 2005, p. 19). The following narratives serve as support of this statement:

“... Because she hits other children, and I have constantly got to go to the school”

“... myne is die een wat glad nie wil skool gaan nie ...”

Very few improvements in the area of conduct problems in school have been reported. It may be noted that those that did report conduct problems in the school setting seldom felt that their children’s behaviour and scholastic adjustment improved. The children were depicted as eventually dropping out of school despite the caregivers’ best efforts to keep them in school. This is evident in the following:

“I would love my child to change her behaviour like she is very violent and that causes a conflict between me and the other parents as they don’t understand the situation as I do of what happened in the past”

“daar is nog net die saak nog. Die terug skool toe, daar het ek n bietjie nog friction met haar. Maar haar al haar ander goeters is normaal” [referring to the child who refuses to return to school after dropping out]

Conduct issues in school, wanting to abscond as well as dropping out of school, are externalising manifestations that support the interpretation of the literature by Kolbe (2005, p. 28), who identifies this as often being the case.

4.3.1.4 Caregivers’ perceived sexual deviance among the CSA victims

Sexual deviance such as promiscuity, preoccupations with sex, inappropriate sexual behaviour and inappropriate age-related sexual knowledge, have been reported by the participants as both expected and current behaviour of the CSA child. Such current behaviour was not as prominent in reports as expected behaviours were. The following quotation serves as example of the aforementioned:

“The child would be someone who likes like sugar daddies, that men and everything. The child will not be stable, not be staying in a stable family she will go around with other people, go around with other men.”

Wherry *et al.* (2009, p. 234) indicate that, in particular, adolescents with a CSA history were frequently engaged in risk-taking behaviour when compared to their non-CSA counterparts. Risk-taking behaviour is described by Wherry *et al.* (2009, p. 234) as sexual activity with multiple partners, early experimentation with sex, sexual aggression, and prostitution. Van Rensburg and Barnard (2005, p. 1) also include promiscuity in their review of literature on the CSA symptoms. The aforementioned statements are thus congruent with the available literature on matters of sexual risky behaviours and self-defeating manifestations.

Van Der Merwe (2009, p. 34) notes that sexual identity confusion, inappropriate sexual behaviour, social norm confusion, fetishism and risky sexual behaviour may be linked to CSA. This is supported by Finkelhor (as cited in Kolbe, 2005, p. 20) who indicates that CSA victims often suffer psychological and behavioural problems as a result of traumatic

sexualisation and stigmatisation which may lead to sexual role confusion. Some of the perceptions of the caregivers support this notion.

“Daar is wat ek gesien het in dat hy b.v. nou in vroumens klere in wil wees. Vroumens skoene, en die valse hare wat hulle dra, hy wil meestal net meisie nou wees. Soos hy sal nou die dogtertjie se goedjies vat en dan speel hy daarmee, pophuis daarmee, sulke sort goeters.”

“...en sy speel nie meer met my niggie se kind nie, sy speel nou met die seuns albasters.”

Inappropriate sexual behaviour has been encountered in minimal reports. This may be due to the cultural effects of many of the Xhosa speaking participants who communicated that talking about sex and sexuality is a taboo in their culture. According to Van Der Merwe (2009, p. 34) victims may become pre-occupied with sexual issues, for instance looking for opportunities to watch erotic films, and engage in inappropriate sexual activities with other children (acting out). Sexually inappropriate behaviours often involve boundary problems and age-inappropriate sexual knowledge as unique characteristics of CSA (Baker, Schneiderman, & Parker; Friedrich; Friedrich *et al.*, as cited in Pullins & Jones, 2006, p. 15).

Kolbe (2005, p. 28) has reviewed literature and indicates that sexual preoccupation reportedly lingered or increased among CSA victims over time. Reports surfaced of children that displayed sexual behaviours deemed socially inappropriate or demonstrating inappropriate sexual knowledge for their age. These were still regarded as problematic by the participants and are congruent with the aforementioned literature.

“...but she still watches those other adult movies on E.T.V... She like to watch the movies, she does not like to sleep during the night...”

“I never stayed with the child before this thing happened, but after the incident when the child is playing she will like to like... sexual demonstrate what the guy did with the other children...”

“En *Maria weet wat is seks, *Maria ken dit. En hulle is so klein dan weet hulle al die soort dinge” [referring to knowing what sex is]

“... en sy vertel, nou sy is agt [jaar oud] en sy weet en sy vertel nou nog so...” [referring to the child knowing what sex is]

One of the participants indicated that she perceived a decrease in promiscuous behaviour in her child.

“With my daughter before it happened she had a lot of boyfriends. But now she is only focussing on one person who is the father of her second child”

This exception is incongruent with the larger part of the findings. It may be that what was seen as promiscuity was present before the incident of CSA, as the participant implied. It may not have been influenced directly by desensitisation.

4.3.1.5 Caregivers’ perceived substance abuse among the CSA victims

Substance abuse was indicated by the participants as an extreme manifestation or reaction to sexual abuse. This was indicated as an outward manifestation of a child that had not come to terms with being sexually abused. None of the participants indicated that the children in their care were currently involved in substance abuse, but held it as a powerful indicator of maladaptive reactions to CSA. The following serve as examples:

“Maybe the child will be now [be] on drugs...”

“Others they will abuse, obviously, drugs to escape. They thinking that they are escaping just maybe for that minute you are escaping... just drunk a lot. After that the reality will come back.”

No children were noted as actively engaging in substance abuse at present. This may be due to the relative young age of most of the CSA children in the caregiver participants' care. Only four children in the care of the participants were older than the age of 15 years. According to Kendall-Tackett (2003, p. 227) the types of symptoms that children manifest in reaction to CSA vary according to the child's age, and these authors link substance abuse with adolescents. A single example that could be indicative of ongoing self-defeating behaviour is reported by one participant of her sister who was at the time of the study an adult, but was sexually abused over a long period as a child.

“Sy het nou, om dit so te stel, sy het nou haar toevlug na drank toe gevat, sy het nou haar toevlug geneem, waarvan my ma vir haar se dit gaan nie jou probleme weg vat of verminder nie, dit vererger jou probleem. Gelukkig gebruik sy nou nie drugs nie, want dit is nie in ons gene om dit te neem nie.”

According to Carey *et al.* (2008, p. 94) many CSA victims go on to later develop substance abuse problems and this has been repeatedly demonstrated in research findings. Van Der Merwe (2009, p. 31) and Pullins and Jones (2006, p. 15) also implicate substance abuse as a common behavioural manifestation of CSA. According to Kendall-Tackett (2003, p. 228) substance abuse is a type of avoidance behaviour that is aimed at tension reduction, which goes hand-in-hand with other behaviours such as promiscuity, suicidal ideation and -attempts and self-mutilation among other.

4.3.1.6 Caregivers' perceived suicide attempts among the CSA victims

Self-harming tendencies and suicidal ideation have been reported along with the aforementioned, as current in only a few cases, but as expected manifestations of the CSA child, in many. Kendall-Tackett *et al.*, (as cited in Kolbe, 2005, p. 19) as well as Pullins and Jones (2006, p. 15) identify suicide attempts and ideation as often encountered with victims of CSA. The following statements serve as examples of where such congruence between literature and respondents perceptions was forthcoming:

“Selfmoord, ja baie sselfmoord neigings... Of gedurig moet jy sommer keer, hier is sy sal sommer jump met pille. Sê mar iemand maak haar kwaad dan is dit sommer hier met n klomp pille. Jy moet gedurig kyk na sulke goed.”

“Maybe the child will still [be] suicidal.”

The abovementioned shows that suicidal ideation and attempts are both experienced and expected areas of concern to the participants. Carey *et al.* (2008, p. 94) list self-harming behaviours and suicide attempts as externalising behaviour that is associated with CSA. Herman (as cited in Van Der Merwe, 2009, p. 35) notes that self-injury including self-mutilation and suicide were part of the daunting reality of the CSA aftermath. Van Der Merwe (2009, p. 31) point out that self-harm such as suicide or cutting/self-mutilation is an example of outward behavioural manifestation of inward feelings such as self-blame.

4.3.1.7 Caregivers’ perceived physical and physiological implications among the CSA victims

Physical injuries sustained through the act of sexual abuse, such as genital injuries, were reported by the participants as both expected and current issues implied with CSA. According to the literature, urinary tract infections and sexually transmitted diseases (STD’s) (Wurtele, 2009, p. 3) are some of the physical and physiological implications that CSA may have. These types of consequences are usually short-term effects or direct medical effects, and may require treatment (Thakkar & McCanne; Madu & Peltzer, as cited in Van Rensburg and Barnard, 2005, p. 1).

Physical complaints that have been noted and attributed to the CSA incident include problems with walking, internal injuries and needing medical operations to repair damage caused by CSA.

“The first thing I notice was when I wash. She was like very hurt, sore on the private parts. An also the child was like very tense, and also could not walk like normally. She ran like very slowly. Walks very slowly.”

“There is a neighbour’s child who will never be able to conceive because the womb, the womb is messed up, I think my child is in a better position”

Richter and Higson-Smith (2005, p. 24) noted that sexual abuse in contact form may be violent and extremely damaging to the genitals of a female child victim, especially under the

age of 12 years. They noted that the younger the child the more brutal and damaging the act becomes. Some of the participants who reported the more serious medical problems such as needing an operation to reconstruct part of the genital area are indicative of such physical injuries that may have been sustained. Half of the children in the participants' care with a CSA history were under the age of 10 years when the sexual abuse occurred. They could thus have sustained severe injuries through the traumatic acts. This concurs with the above literature.

Physical and physiological complaints of the CSA children have been ongoing in some reports by the participants. This can be seen in the following two quotes:

“She is going to ask me what happened to my stomach, because had to have this operation in Tygerberg. That operation is going to ask me what happened to me mamma.”

“Maar vir *Maria moet ek by n private Dr. Kry, Wat moet vir *Maria baie deeglik by haar vroulike dele goed ondersoek en dan sal ek ook baie te vrede voel.”

The caregivers indicated feelings of distress, worry and guilt towards the child needing medical procedures to address injuries or suspected injuries which they attribute to the CSA.

4.3.1.8 Caregivers' perceived somatic manifestations among the CSA victims

Killian and Brakarsh (2005, p. 371) and Misurell *et al.* (2011, p. 15) note somatic complaints in their reviews of literature and overview of common CSA-related complaints. Physical injuries do not always exist, but complaints about them may be somatic in nature, as Pullins and Jones (2006, p. 3) note that physical symptoms may be caused by events other than sexual abuse. Loss of bladder control and constipation have been indicated by Kolbe (2005, p. 19) as somatic complaints noted with children with a CSA history. These two issues have also been reported by the participants of this study as perceived among the CSA children in their care. These issues may have medical causes such as damage to the internal organs of the child, or somatic causes linked to the psyche.

“Upon receiving the child the first thing I see is that the child go pee standing up and also do number 2 standing up. She wet the bed every night for long time. Then I make her take off all the duvet and put it in the washing. It go on for long time I don’t know how long, 3, 4 months.”

“En dit is nou my belangrike punte, sometimes kla sy baie en dan sal sy se haar maag is seer, ek kan nie aah nie, my maag is seer.”

“Toe se die juffrou maar sy hou nou net aan met die pee. En gister toe se sy [die juffrou] nou maar wat eet die kind dan nou? Wat drink die kind dat die kind so baie nou net wil toilet toe wil gaan om te gaan pee-pee.”

Some somatic manifestations are reported to be displayed by the children. They are perceived to have stopped bed wetting in some instances or are gaining weight and are deemed healthy, which are all perceived as positive indications. Some of the older children are however reported to still have to urinate very often or are constipated. The caregivers further indicated that they had ongoing concerns for the physiological well-being of the child regarding injuries.

“... like now she is able to go to the toilet, no more of the bed wetting.”

“... but in terms of the physical aspects she is better off. And in terms of the other aspects she has gained weight, and is healthy.”

“... En een dag toe kan sy nie meer opelyf kry nie, want van die opelyf toe weet ons nou al van die, toe was ons net so bekommerd gewees. Toe die mos nou weer met die seep steeltjies nurse gespeel en goeters. Maar die next dag toe is sy nou weer oraait op die skool, praat sy so.”

Carey *et al.* (2009, p. 97), link somatic complaints to depression in reaction to CSA and suggest that physiological causes be examined and disproved before considering complaints as truly somatic. According to Van Der Merwe (2009, p. 32) feelings such as loss and

betrayal are linked to behavioural manifestations that may take the form of somatic reactions among other manifestations.

Many externalising symptoms are perceived as manifestations in both boys and girls, despite literature placing more emphasis on their occurrence with boys. The caregiver perceptions were based on more female child victims of CSA than on males. Great variation in what types of symptoms are displayed is known to be expected across the varying age groups of the children. This was evident throughout the findings, and can be especially seen when referring to substance abuse which was an event largely expected by the caregivers. The perceptions on this issues were however poorly associated with current substance abuse activities, possibly due to the young age of many of the CSA child victims in the participants' care.

An apparent overlap of many of the symptoms was found as one may flow into the other, or even later progress to become the other, for example school conduct problems may progress to school dropout. There is also believed to be a considerable overlap with the internalising manifestations that will be discussed in the following section.

The following theme will be focusing on the internalising manifestations that are encountered with the CSA child victim. This theme goes together with the current theme and may even have a large degree of overlap. It will be discussed in a similar fashion to the current theme with appropriate divisions into sub-themes.

4.3.2 Theme 2: Perceived internalising manifestations among the children with a CSA history by caregivers

Internalising manifestations that stem from a CSA history are the second theme identified in this study. The first theme regarding externalising manifestations has served as introduction to this theme. The overlapping issues that exist between these two themes has also been noted. According to Kolbe (2005, p. 19) internalising symptoms may take on the form of withdrawal, depression, fearfulness and anxiety. Van Der Merwe (2009, p. 27) refers to Wieland, who conceptualised an internalisation as “the assimilation and processing of the meaning of outer experiences as they relate to the self.”

Van Der Merwe (2009, p. 28) notes that many of the internalisations exhibited by CSA child victims may be seen as defences found in coping patterns of these victims. She refers to

minimising, rationalising, denial, repression, avoidance, dissociation and isolation as examples of this noted by various authors (Bass & Davis; Roos, as cited in Van Der Merwe, 2009, p. 28).

Misurell *et al.* (2011, p. 15) further indicate that common internalising displays encountered with the CSA child victim could commonly be associated with PTSD. As has been noted, there is a perceived link with this disorder and many of the CSA symptoms. The symptoms resembling PTSD-type symptoms highlighted by Misurell *et al.* (2011, p. 15) when referring to numerous literary sources included anxiety, sleep disturbances/nightmares, social withdrawal, conduct and school problems. Many of these were noted to a degree by the respondents in the current study.

4.3.2.1 Caregivers' perceived fears, anxiety and panic among the CSA victims

Fearfulness, anxiety, panic attacks, and clinginess are well documented internalisations associated with CSA (Kendall-Tackett *et al.*, as cited in Kolbe, 2005, p. 19; Carey, *et al.*, 2008, p. 94; Rojas & Kinder, 2009, p. 355; Van Der Merwe, 2009, p. 31). Rojas and Kinder (2009, p. 355) refer to numerous authors to support the notion that CSA is often linked to “deleterious outcomes” in areas including anxiety (Beitchman *et al.*; Calam, Horne, Glasgow, & Cox; Gold, Lucenko, Elhai, Swingle, & Sellers, as cited in Rojas & Kinder, 2009, p. 355). The participants of the study made reference to anxiety and fear and associated behaviour such as clinginess or not wanting to be alone, fear of going to certain areas or of a certain type of people. Other indications of nervousness such as biting nails and shivering also became apparent. This is evident in the following quotes:

“Ek kan onthou van so kind, ek dink my niggie, sy is ene kou op haar naels...”

“...and its like always the time not stable, like shivering, nervous...”

“Baie bang, veral as hulle daai persoon sien, dan sal daai kind baie bang wees en jy sal sommer dit kan sien. Byvoorbeeld die kind speel in die pad nou kom daai man, nou hardloop die kind sommer in die huis in. en daai daai bang gevoel.”

The exhibition of anxiety, fear and associated behaviours was also reported as still being present. Fears were mostly situation-bound or linked to the perpetrator consequence, namely: if he was still in the area or if legal action had been commenced against him.

“... it is only that she is scared of this person and scared to go to that area...”

“There was a positive coping before... when the perpetrator was in jail. But now everything is back to where it was before because the perpetrator is now back in the community. So the child is afraid and she does not even want to see this guy’s girlfriend. When the guy’s girlfriend visits their house, she is scared, she cries.”

“After it happened there was no problem. She was just happy that they person who did this was caught, but now because the guy is now back, she is does not want to go to Langabuya where the incident... she does not want to go there anymore.”

Finkelhor (1990, p. 327) refers to a 12-month follow-up study conducted by Conte and colleagues of CSA children and who found that on the behaviour profile test administered, improvement was shown by the victimised children in areas of PYSD symptoms and especially fearfulness. Kolbe (2005, p. 28) also found in her review of literature that the symptoms disappeared the fastest were phobias and somatisations, but this is not the case with a number of the perceived reactions in the area of fear being largely unchanged.

4.3.2.2 Caregivers’ perceived sleep disturbances among the CSA victims

Sleep disturbances and nightmares were a commonly identified manifestation throughout the participant reports. Van Rensburg and Barnard (2005, p. 1) refer to numerous authors (Brits; Doyle; Draucker; Finkelhor; Glaser & Frosh; Knight; Middleton; Robertson; Shaw, as cited in Van Rensburg & Barnard, 2005, p. 1), when they indicate sleep disturbances such as nightmares as forming part of internalising manifestations. Misurell *et al.* (2011, p. 15) also indicate sleep disturbances as commonly associated with CSA.

The respondents made reference to sleep disturbances such as sleep deprivation, insomnia or difficulty in falling asleep as well as the occurrence of nightmares. The following statements serve as evidence of this:

“Always like tired.”

“Even now she does not sleep well...”

“This one also has nightmares...”

“She had nightmares and I thought maybe it was because she was thinking of that knife. The big knife that the guy had...”

The perceptions held by respondents of the study are largely in agreement that sleep disturbances are currently experienced and are a generally expected children’s reaction to CSA. Sleep disturbances are reported to have subsided in some instances, but have been brought on again in some instances where the perpetrator was released out of prison or returned to the area where the child resides.

4.3.2.3 Caregivers’ perceived decreased social participation among the CSA victims

The majority of caregivers indicated that the children were markedly less socially interactive; they were often withdrawn, isolated and very quiet. Withdrawal, isolation and elective mutism are often encountered within the literature (Kendall-Tackett *et al.*, in Kolbe, 2005, p. 19; Carey, *et al.*, 2008, p. 94; Van Der Merwe, 2009, p. 31) as prominent symptoms of the CSA child. This is evident in the following statements which serve to agree with the literature:

[What still needs to improve] “Speaking... she will not keep comments inside her. She will open up. Play with other children, also go to toilet independently, closing the door behind her, not leaving it open... Like washing not being afraid to be washed by me. Afraid to touch her private parts, and kissing not be afraid to let me kiss her.”

“... dan kom daar nou weer n staduum dat sy se ne man mammie ek wil nou nie meer praat nie. Sommer net so en dan gaan sy nou weer uit... maar ek sal se dat sy nou, sy het op daai staduum gekom om ook maar daarmee saam te lewe.”

“... nou in die Mei en June maand is *Maria net weer terug getrokke, sy het weer daai probleem, sy is net weer terug getrokke. Dis hoekom ek se something is somewhere wrong.”

“She is still scared to be touched, so she will use any measures to avoid being touched.”

Little improvement in the area of social participation which incorporate withdrawal, isolation and elective mutism has been perceived by the caregivers. Their children are still withdrawn and are still largely electively mute, i.e. they do not communicate freely. Finkelhor (1990, p. 327) indicated that in their 12 month follow-up study Conte and his colleagues found that factors such as withdrawal, acting out and depression showed little or no change in the CSA child victims. There is thus congruence between the literature and the present study in this regard.

4.3.2.4 Caregivers’ perceived academic and concentration problems among the CSA victims

School progress and scholastic adjustment are known to be affected negatively by a history of CSA (Van Rensburg & Barnard, 2005, p. 9; Ferreira *et al.*, 2007, p. 78). Children that have been sexually abused often progress less well in school than their non-CSA counterparts. If one considers the internalising and externalising behavioural and psychological manifestations that have been discussed earlier and bears in mind the spill-over or overlap effect that has been noted between them, it seems that areas such as school adjustment may be adversely affected by aggression or withdrawal.

Van Der Merwe (2009, p. 32) notes that a child may regress to a former developmental stage or stagnate in one. This may hold dire consequences for academic progress. Preoccupation with somatic issues such as going to the toilet and even physiological complications such as bladder control may also hamper the children’s progress academically as they would miss large amounts of class time. The following statements are in support of the perceived decrease in academic performance:

“*Lisa is so bietjie stadig, maar oor die algemeen is sy nie erg slim kind nie, maar as jy die heelyd so by die toilet gaan dan kom jy nie by jou werk uit nie.”

“Weet jy my klonkie wat 8 jaar oud is doen beter as *Kate, wat standard 4 is”

“It’s like the behaviour of the child will be totally different to other children. The child would not work well in school

A few different scholastic changes have, however, been perceived by the caregivers. Most of the children were noted as doing well and as being intelligent. Scholastic behaviour was further indicated as being positive by some.

“... sy [is] ready vir haar ouderdom. En die juffrou se sy doen baie goed by die skool.”

“Nosisi’s grades I have not received any bad report from the school. she is doing fine...”

“She is doing fine at school...”

An inability to concentrate has been linked to CSA by authors such as Ferreira *et al.* (2007, p. 78) and Van Der Merwe (2009, p. 32). These symptoms undoubtedly will have a spillover effect on the academic progress of the child, as it will cause a drop in academic progress. The following statements are support for the diminished cognitive and concentration ability exhibited by CSA children:

“Nou dis wat die juffrou mos gese het. Die juffrou het opgelet voordat ons het...”
[Referring to school behaviour and concentration ability of the child]

“Sy konsentreer nie. Sy kyk, maar sy, sy konsentreer nie...”

“Haar kop werk nie...”

“His grades have improved in school, but now the only problem is he forgets a lot...”

Marginal improvements have been noted in regard to concentration. In the majority of instances, caregivers who noted concentration problems among the CSA child victims, continued to note the existence of such issues.

The perceived internalising displays that were reported on by the participants were mainly related to feelings of fear and anxiety, bad social interactions, scholastic and concentration problems. Fears were deemed situation-specific, with children fearing the perpetrator, a recurrence of the incident, and the place where the incident occurred. Fears are reported in the literature to decrease the fastest. This, however, was not the case of this study's findings. A perception was held by the participants that fear-symptoms often returned or remained, which contradicts some of the literature.

Sleep disturbances form part of the common symptoms of CSA. This was perceived largely as still present, which was linked to the stubborn lingering of fear-symptoms. Perceptions regarding socialisation of the CSA children were reported to be poor in some instances. The children were depicted as being quiet, isolated, withdrawn and showing little improvement in this regard. Conte (as cited in Finkelhor, 1990, p. 327) is in support of this notion that social problems were harder to subside. Scholastic problems noted in the study were mainly linked to poor concentration ability and could have stemmed from numerous externalising issues that may have spilled over.

The overlap of internalising and externalising displays may further agitate adjustment and concentration in school, forming a negative cycle which spirals out of control. Some marginal improvements have, however, been noted in some instances of internalisation.

Misurell *et al.* (2011, p. 15) further indicate that common internalising displays encountered with the CSA child victim could commonly be associated with PTSD. These issues will receive a little more attention in the following themes. The next theme will look at what perceptions were held by the caregivers in light of desensitisation, coping and function of the CSA children in their care.

4.3.3 Theme 3: Perceived desensitisation, coping and current functioning of the CSA Victims

The previous themes have served to identify the current and expected behaviours of the CSA child victims as perceived by the caregiver participants. Classic work conducted by Finkelhor (1990, p. 327) indicates that more consideration has been given in the research arena since the mid 1980's to children who escape CSA relatively unscathed, as almost every CSA study

has a subgroup of victims who were asymptomatic in comparison to their fellow victims. Van Rensburg and Barnard (2005, p.1) also note that numerous authors support the notion that some victims of CSA did not experience troubled functioning, but rather progressed to function relatively well after CSA. It is important to note that such children with more functional abilities after CSA are held to be in the minority.

In addition to the foregoing themes, the current theme examines some positive aspects also perceived by the caregivers. Issues that may be indicative of desensitisation, better coping and resilience will be pointed out, discussed and compared with available literature. A perception or unwillingness to portray children as desensitised or functioning relatively well will also be explored and interpreted with reference to available literature.

4.3.3.1 Marginal desensitisation of CSA victims perceived by the caregivers

The participants gave mixed responses in communicating their general beliefs surrounding coping and perceived functioning in light of desensitisation to the effects of CSA. A larger portion of participants indicated that the children in their care were coping somewhat better than before, but reports were situation-specific or only related to certain aspects, whilst other issues were still perceived to be unchanged or current. It could be put forward that at best the children were perceived as exhibiting marginal levels of desensitisation.

Covert distress, as it is termed by Edmund, Auslander, Elze & Bowland (2006, p. 19), is apparent coping or functioning, that is actually superficial, and is visible only in terms of external behaviours (Luthar *et al.*, as cited in Edmund *et al.*, 2006, p. 19). However, internal distress may be still present. According to Edmund *et al.* (2006, p. 19) some young people may appear resilient (or desensitised in this study's approach), because they function relatively well on one level, such as socially getting along with friends, following social norms or performing well in school, but may be experiencing internal turmoil such as anxiety, depression and so forth. This could be postulated from the following examples:

“Yes the child is seemingly coping”

“Ja sy cope nou al `n bietjie beter al...”

This study refers to the perceptions of lesser symptomatic displays or reactions as desensitisation. The caregiver perceptions are not convincingly interpreted by themselves as indicative of desensitisation among the CSA victims. According to Finkelhor (1990) some hypothesised that such children were in a “denial pattern” and that they would later become symptomatic. Some studies found support for this and even noted that they might be those that exhibited worse symptoms at an older age, for example the study by Tufts (as cited in Finkelhor 1990, p. 328). Some support for this is evident in the following quotation:

“There is no mayor changes, because before it happened and after it happened she did not give me many problems.”

This is however an exception and not the rule, which is in support of the notion that resilient children are in the minority (Van Rensburgh & Barnard, 2005, pp. 1-2). Finkelhor (1990, p. 328) further notes that it was children who were troubled after the CSA incident who often got worse. Meaning that their symptomatic responses or reactions to CSA became progressively more negative. A possible explanation is that those with lesser symptoms were those who were less severely sexually abused, and abused over a shorter period of time by a person other than a father figure in a less violent manner, in a relatively good family context, with supportive parent figures (Browne & Finkelhor, as cited in Finkelhor, 1990, p. 328). These aspects were not covered in the data collection of this study and can thus not be elaborated on.

“Maar tog sy het daardeur gekom, of nie eintlik nie, baie tye dan praat sy nog daaroor, maar so, sy sal net iets noem dan is sy alweer weg. Meeste van die tye is sy terug getrokke. Maar ons los haar nou maar so dat sy maar nou so aangaan.” [Indicating child is still withdrawn, but they have accepted this symptom display as her fate]

A portion of the participants indicated that they perceived the children in their care to be coping to a degree when compared to other children who also had a CSA history. In other words, who had noted the abatement of symptoms which they put forward as indications of desensitisation. They were quick to point out that these were marginal, and linked them to specific situation or instances, which made them situation-specific and not indicative of a general state. This is evident in the following:

“Ek moet vir jou se van daai tyd af tot nou toe is daar eintlik n groot verbetering.”

“But now the behaviour is now improving” [referring to levels of anger and cheekiness/disrespect]

“Now she stopped being scared. But she has days sometime that you see she... when the incident comes back...” [Fears have subsided, but return at times]

From the abovementioned it becomes evident that improvements did occur. How significant these are interpreted to be by the caregivers in light of the overall symptomatic response is hard to determine. Some indicate noteworthy improvements and other little to none. Some even indicate that no changes occurred from before the CSA occurred to the present, which was specifically related to problematic behaviour. What one can interpret from this is that the expectations held by parents was mostly negative; they were more on the lookout or cautious of negative behaviours which they expected to be manifested by the children, either internalising or externalising.

4.3.3.2 Unwillingness to portray children as approximating desensitisation

Although some caregivers indicated positive notions regarding the children’s levels of adjustment and coping, the majority were still reserved in the extent to which they would categorise such positive changes as being indicative of the child overcoming the CSA. Some indicated that changes had only begun recently and that they did not perceive the children as largely desensitised. Van Rensburg and Barnard (2005, p. 1) and Hilarsky (2008, p. 37) note that a smaller portion of children are affected to a lesser extent by CSA, but the majority exhibit long-term side effects. Most of the children had been sexually abused in the past two-and-a-half years, as the average age of the children was 12 years and they were sexually abuse at an average age of nine-and-a-half years. Thus the time span may be indicative of the onset of long-term side effects which go against the notion of overcoming short-term symptoms before they evolve into long-term side effects.

The participants perceived desensitisation among the children in their care as marginal, and said that in some cases it was not perceived, which is evident in the following:

“Mmmmm not 100%, but let’s say 80% or close to 90...”

“I would not say he has overcome but he is getting there...”

“Ek weet nie of hy het nie...” [referring to opinion whether the child has overcome the trauma of CSA]

“But now I cannot say negative or positive. But like [she] is behaving in school. Like at home she can play with her friends. While she was staying at home, she didn’t want to go outside to play, even here in the streets. I think she is more safer there.”
[Indicating that the child is better off residing in the Eastern Cape with her mother than with herself in Mbekweni]

Kouyoumdjian *et al.* (2009, p. 41) note that research has identified parental (caregiver) support after CSA that has been linked with how well a child recovers from CSA. For this study, parental support could be generalised to caregivers, who take on not only the role of parent but also all of their functions in many instances. According to Kouyoumdjian *et al.* (2009, p. 41) the presence of caregiver support can be linked to positive outcomes in CSA children following CSA. The absence of parental support is reported to be linked with an increase in both internalising and externalising difficulties (Adams-Tucker, as cited in Kouyoumdjian *et al.*, 2009, p. 41).

Caregivers hold perceptions and expectations of how a CSA child should and will behave, adapt, adjust and function. They in essence attach a label to the CSA child which has undertones of expectations. These expectations then “rub-off” on the child, and pressurise them to live up to expectations. This is referred to by various authors noted by Kouyoumdjian *et al.* (2009, p. 42), as a “self-fulfilling prophecy.

Kouyoumdjian *et al.* (2009, p. 42) note that adult expectations are powerful effective agents on vulnerable and gifted children, which is linked to positive and negative outcomes for CSA child victims in terms of both internalising and externalising. These assumptions that adults may hold tend to be negative in nature rather than positive, as reported by Holguin and Hansen, and Kouyoumdjian *et al.* (as cited in Kouyoumdjian *et al.*, 2009, p. 42).

“Nee ek sal nou nie se sy cope goed nie,.. Maar ek meen van daai tyd af na nou toe is daar darem ‘n verbetering”

“I think worse, but she is changing now, only starting now”

The above comments show that in their perceptions a negative undertone or expectation appears. The caregivers that made these statements may hold expectations of more negative outcomes and downplay improvement, which may in fact have an interactive effect on the actual outcomes and desensitisation of the CSA children in their care.

Sexual Abuse Symptoms depicted as or in the light of Posttraumatic Stress Disorder-type symptoms have also enjoyed some attention in the research for many years. Finkelhor (1990, p. 328) notes, however, that some critics are opposed to the PTSD-type analysis of CSA; it is deemed too limited in scope (as victims may suffer from PTSD-type symptoms but also have a number of others that do not squarely fit this label); it has misplaced focus on affect instead of also looking at the cognitive realm; and some CSA child victims exhibit totally different symptoms to those of PTSD. PTSD theory is thus held by Finkelhor as unable to adapt to the experiences of the CSA child victim. Finkelhor (1990, p. 329) has even noted that attempts have been made to classify CSA as a separate and distinctive disorder, and refers to Corwin as attempting so.

In view of the above literature compared with the participants’ perceptions of the behavioural and psychological manifestations exhibited by the children in their care, it can then be put forward that some of the children may at best be place at risk of later developing PTSD, although their current symptoms may overlap with those of PTSD.

The consensus is that desensitisation occurred on marginal levels, with most of the children still holding on and exhibiting some or the other negative symptoms. Coping thus is perceived to a certain degree. The caregivers have been noted to downplay their perceived levels of desensitisation and/or coping and resilience among the CSA child victims. The higher levels of desensitisation, coping and resilience are evident in minimal instances throughout the caregiver reports. This is in support of the literature referred to by Van Rensburg and Barnard (2005, p. 1) and Hilarsky (2008, p. 37). Literature has shown support for desensitisation, and it is taken in this study to mean that it may only occur on the surface, the so-called “covert coping” of Edmund *et al.* (2006, p. 19). The findings of this study may tend to support this notion.

Some have appeared unwilling or careful of depicting the children as better adjusted, desensitised or functioning well. This may be out of fear of losing what support they are receiving from professional services such as the Department of Social Development and other organisations. As opposed to embracing the desensitisation effect, it is replaced by conditions of better coping. This is done in that the caregivers indicated that noted improvements only started recently; were occurring but stopped or subsided; was small, un-noteworthy or insignificant; or were situation-specific, meaning they existed in only one area such as aggression, but withdrawal and fears still existed.

Kouyoumdjian *et al.* (2009, p. 42) mention a labelling and self-fulfilling prophecy effect that adult perceptions and expectations of the CSA child victim may have on both positive and negative outcomes, with more caregivers fostering negative outcomes. This too is in support of literature.

4.3.4. Theme 4: Reasons perceived by caregivers to influence desensitisation, positive changes and resilience

According to Finkelhor (1990, p. 328) since the mid 1980's significant studies have been done into the conceptualisation of the impact that CSA has on the child victim. Kendall-Tackett (2003, p. 228) note that responses of a child to CSA are greatly dependent on the child, the family, whether it was reported to the authorities, and what support was available following disclosure. Van Rensburgh and Barnard (2005, pp. 1-2) further note a range of factors that may serve as protective agents against the development of harmful symptoms in reaction to CSA. Various other authors, including Reyes (2008, p. 52) support this notion and identify factors such as personality traits, the nuclear family, and social support systems, as such.

According to Hewitt (as cited in Intebi, 2003, p. 9), parental attitudes and commitment such as being cooperative, respectful, able to put a child's needs first, that do not attempt to control or dictate to the child are important as low-risk factors that affect the child's vulnerability.

According to Intebi (2003, p. 9), high-risk parenting is identified as parents denying or minimising their own involvement or contribution to the CSA incident such as not believing the child, projection of anger onto others, and being domineering, insensitive, impulsive, angry, and lacking empathy.

Other issues that will be looked to as perceptions of desensitisation, or agents of coping, resilience and better functioning will be the effects of caregivers, families, the individual's character, social support systems, professional services, and the consequences or outcomes of the perpetrating individual.

4.3.4.1 Caregiver effects perceived to influence desensitisation, positive changes and resilience

Some of the caregivers in our study appeared highly attached, protective and involved in their children's lives. They often identified this notion of being present and involved as a measure for why they believed the child was coping better. Two caregivers even indicated that they left their jobs in order to spend more time attending to the child's needs.

“Ek het toe my werk ook gelos om nou te kan meer tyd aan *Maria te spandeer.”

They are also fiercely protective, and see themselves as taking personal responsibility for the child's ongoing care.

“Ek is enkel ouer, haar pa worry nie meer oor haar nie, ek is die een wat vir haar... en nou is dit ekke en my pa en my suster, wat vir haar sorg en wat vir haar help.”

“En, want.. ek was van daai ma's wat gesorg het vir my kind, klein kinders het ek soos my eie groot gemaak. Sonder kleurling sake se geld... ek was nie daai ouer nie, ek het gesorg vir hulle, ek het gewerk vir hulle. So het ek ook vir my kelinkinders gewerk.”

A positive person who fulfils the role of primary caregiver is deemed a significant factor contributing to a child's coping ability and therefore a contributing factor in desensitisation. It is noted by Van Rensburg and Barnard (2005, p. 7) that such a bond needs to be reciprocal as the child needs to identify with the caregiver and does not yearn or long for another person to occupy that role. Such attachment to caregivers is an important factor in resilience and coping. Bolen and Lamb (2007, p. 46) indicate that caregiver-child attachment is correlated with coping and thus also desensitisation. Poorer coping in terms of withdrawal and other internalising symptoms has often been reported with caregivers that were dismissing or

fearful. Bolen and Lamb (2007, p. 46) note that a child that exhibited greater anxiety symptoms, depression and dissociation had a heightened need for caregiver proximity or attachment.

Caregivers who are older, educated, with a predominant internal locus of control, have a reasonably high self-efficacy and self-esteem, an optimistic attribution style, mature defences, efficient coping, an ability to empathise, rational expectations, and accurate understanding of child development, are ideal protective factors for their children (Carr, as cited in Hilarski, 2008, p. 37). The caregiver's strengths support and characterise the family system as flexible, connected and adaptive, with shared values, goals, priorities, expectations, and worldviews (McCubbin & McCubbin, as cited in Hilarski, 2008, p. 37). Reyes (2010, p. 54) indicates that Morrison and Clarena-Valleroy have found sexually abused adolescents who see their mothers to be supportive, have a better self-concept and lower depression levels than those finding their mothers non-supportive. Poverty, more negative parenting strategies such as being controlling, using harsh punishment practices, and substance abuse are reported as parental characteristics or trends in the literature that are indicative of poorer outcomes for the CSA child (Hilarsky, 2008, p. 37).

Support from a significant other has been regarded as connected with resilience and better outcomes (Banyard, Williams, Siegel & West, 2002, p.54). Luster and Small (as cited in Edmund *et al.*, 2006, p. 4) indicate that adolescents with a CSA history were resilient against substance abuse and suicidal ideation when they had a supportive relationship with their caregiver/parents.

The caregivers in this study are considered to be older, but their educational levels were low. They often took on the role of protecting their child against the world and other persons, which may be seen as being controlling limiting and not giving the children age-appropriate room. They engaged other persons when their children were discriminated against or when they felt the child was being misunderstood or that the other parties lacked understanding for the child's conditions. The following highlights the aforementioned:

“En nou die ander kinders verstaan nie dit nie. Jy as ouer moet nou gedurig instaan en vir hulle se kyk hier julle moet nou verstaan dit het nou mos gebeur. En nou sy sal so

optree, so jy moet altyd in die... sodat hulle ook nou kan verstaan met haar... Jy moet kyk na sulke goed.”

“Toe vat ek nou die grote weg en ek stap toe ook nou n draai met haar sodat ek nou ook met haar kan praat dat sy nou nie so optree met haar nie.”

“En nou die dag toe vat die juffrou vir haar by my en se ek is te geheg aan haar. Ek se juffrou ek verstaan daai ek is te geheg aan haar.”

“En sy weet as n mansmens altyd hulle geslaan het dan het ek op die plek gestaan en gese dit is my kinders, hy is pa en ek is ma, want hier werk ek”

The caregivers often indicated that they were very open in communication and that they were involved in their children’s lives, meaning that they were present and reachable for whenever the child needed them, and offered support. Caregiver ability to give support and guidance in the face of stress and trauma is linked with positive coping outcomes (Van Rensburg & Barnard, 2005, p. 4). Children who perceived inadequate parent-child relationship in terms of emotional quality and communication often exhibited more anger, aggression, school and attention problems, and were at greater risk of developing delinquent externalising behaviour (Bolen & Lamb, 2007, p. 46). Wyman *et al.* (as cited in Van Rensburg & Barnard, 2005, p. 4) also note that caregivers should have a positive expectation for their child’s future, which may positively impact the child’s future coping. This sentiment is shared by Kouyoumdjian *et al.* (2009, p. 42). The parental expectations were not only positive, but negative too. The negative issues have been shown in the previous themes. The following is indicative of positive expectations that may have a good effect on functioning and desensitisation of the CSA child.

“Yes that is what I am encouraging for her to stand on her own two feet...”

“I think this because at first the child stayed with her father only and now there is a woman figure in the house. She feels that connection... [with me]”

“We as parents we must try to be close to our kids, as possible. Let’s talk about everything...”

“I am like her mother, like a mother to her. Someone who like brings her comfort...”

“I put myself in the shoes of the child so I am very vigilant, not like many other parents...”

Apart from caregiver influences, family members of the CSA victim were perceived to influence further positive aspects of desensitisation, affect positive changes, and contribute towards resilience of the victims.

4.3.4.2 Family effects perceived to influence desensitisation, positive changes and resilience

Van Rensburg and Barnard (2005, p. 7) indicate that the presence of clear rules and boundaries in a family at the same time allows for a degree of freedom and to develop a personal identity which is beneficial for coping by a CSA child. Resilience is linked to being raised in a stable home, with lesser disruptions in care situations (foster care) and lesser parental/caregiver substance abuse (Banyard *et al.*, 2002, p. 54). There was no control for caregiver substance abuse in this study. The majority of the caregivers were not the natural parents of the children in their care. They were rather grandmothers, aunts, sisters or foster parents. Mixed results have been reportedly obtained for linkages between PTSD and CSA. Dubner and Motta (as cited in Breno & Galupo, 2007, p. 100) have found higher prevalence rates of PTSD in alternative care, a prevalence for CSA and physically abused children, especially female child victims of CSA.

Perceptions held by some of the caregivers' were that they adopted effective parenting strategies and that used clear rules and boundaries within their family to guide behaviour. A degree of freedom was given as an example of encouraging a child to become more independent and to stand on her own feet. The following is in support of this:

“I can't allow him to go in an after-party of a grade 12. ...but he is claiming that his friends are going there I said I am not their mothers I don't know how they think or how they do things there. My rules are here my rules, finish and klaar.”

“I got help from my neighbour and my family members.... My brothers and sisters. They would visit and talk to her about her behaviour and its consequences.”

“The family now is also very supportive, we sit down with him and explain to him that he must not play far he must always be near to the house. Because what happened to him can always happen again.”

A family that communicates openly and effectively is beneficial for the child’s coping. Furthermore a family that gives support and is understanding of the needs of the child is also linked to improved coping. Family conflict and isolated families are regarded to be a negative influence on a child’s coping abilities (Van Rensburg and Barnard, 2005, p. 7). Supportive factors found as expediting the abatement of CSA symptoms were first and foremost supportive family environments as well as maternal support (Kolbe, 2005, p. 28). Positive family bonding is held as indicative of better stress handling and coping of children with a CSA history (Van Rensburg & Barnard, 2005, p. 3).

“And my family did talk about it ... and then I said to keep it a secret it is not good. You can also help other kids.”

“Dis omdat ons gee vir haar baie bystand. Want ek meen as ons nie vir haar die bystand gee nie dan sy sy nou erens beland het, miskien nou pille gedrink het of iets gedoen het...”

“Ok the sisters and the older sisters they don’t treat the child very well. So like the tone of voice they would use when they speak to the child. ... when they ask the child will you go fetch the milk, they talk so rough to the child. And now but I tried to communicate with them that this is not the right tone and talk politely then the child will go straight and fetch the milk.”

“... and then the family spoke with her and then now there was... how do you ... change of behaviour. Now she stopped being scared...”

The above statements are in support of the previously discussed literature. Communication is deemed open and free in the instances mentioned, but in other cases communication, especially regarding sex, is seen as a cultural taboo. Efforts to assist family interaction and communication by teaching, coaching and demonstration have been used by the participants in this study. Effective communication is identified as an agent of positive coping outcomes and purported as such by the participants. The families were indicated as drawing together and supporting one another, which is in support of the literature discussed.

4.3.4.3 Personal characteristics perceived to influence desensitisation, positive changes and resilience

Individual (personality) characteristics include effective interpersonal skills, sound intrapsychic functioning, adjustment, stress control, and general satisfaction with life (Freitas & Downey; Masten & Coatsworth, in Van Rensburg & Barnard, 2005, p. 2).

Hilarski (2008, p. 40) indicates that an internal locus of control may be a protective factor for CSA victims as reported by Pearce and Pezzot-Pearce (as cited in Hilarski, 2008, p. 40). Van Rensburg and Barnard (2005, p. 3) indicate that much literature points towards higher intelligence as a major resilience factor. In their study, Van Rensburg and Barnard (2005, p. 11) further find that female children with a CSA history who understand their situation and who approach dealing with it in a logical manner are much more capable of sustaining and progressively acquiring a sense of competence. Hewitt (as cited in Intebi, 2003, p. 9) notes that lower risk factors for re-victimisation of the CSA child are personal qualities such as clarity regarding boundaries, good communication skills, problem identification ability, being assertive and confident in communicating their views despite adult opposition, and being older than five years of age. Higher risk children are reported to be younger or older children who are passive, dependent, withdrawn, anxious, scared, and powerless, and have poor communication skills (Hewitt, as cited in Intebi, 2003, p. 9).

“Sy is baie slim...”

“...toe sê sy mammië ek kan tog nie vir altyd kwaad wees vir hulle nie. Hulle het iets verkeerd gedoen, want ek het nie vir hulle gegee nie, hulle het af gevat. Maar ek het vir die Here ook gevra om hulle te vergewe, en ek het vir hulle vergewe in my hart. Toe se ek nou vir haar as jy hulle vergewe het en jy loop af in die pad.”

“Ek sal sê ek en sy is so, laat ons dinge kan hanteer, en dat my ma nie altyd daar was nie, so ek sal sê sy het dit gehanteer want ons is so geleer. Want jy moet ‘n ding op jou eie kan hanteer tot daar iemand is wat vir jou kan help om saam dit deur te kan maak. So my ma hanteer vir haar, maar sy is net... maak nie saak nie...” [referring to the child exhibiting an apathetic, unmoved attitude]

“Want weet jy even sulke kinders kan weer hul maatjies help as hulle deur sulke dinge gaan. Sulke prosese en hulle moet hulle kan keer dat sulke goeters nie gebeur nie.”

“ Want sy pas vir haar orals aan, en daar is baie dinge wat sy nou al en wat ek sien in die afgelope tyd wat ek sien nee maar dit is my kind die en hoe ek my kind groot gemaak het. So sy begin nou weer raak soos wat sy voor die tyd was.”

The quotations above are indicative of the children being perceived as intelligent, having sound intra-psychoic functioning for example, for understanding they are not at fault or to blame for the abuse, and showing mature responses by forgiving others and making peace with what has happened to them. This neatly adheres to available literature as has been shown.

4.3.4.4 Social effects perceived to influence desensitisation, positive changes and resilience

Van Rensburg and Barnard (2005, p. 4) indicate that social support as well as a supportive social environment are associated with better coping amongst CSA children. They identify inter alia teachers, neighbours, peers and positive role models as protective agents.

Masten and Coatsworth (as cited in Van Rensburg & Barnard 2005, p. 4) note that peer acceptance and positive peer relationships enhance self-image, and are thus a protective factor contributing to resilience. They also note that poor peer group interaction and association may lead to inappropriate behaviour, externalisation, behavioural disorders, academic problems and problems associated with aggression.

Hilarsky (2008, p. 4) indicates that adolescents who seek social supportive relationships are more resilient. They note that even a single caring individual may be able to mitigate the negative effects of CSA as referred to by Perkin and Jones, (as cited in Hilarsky 2008, p. 4). Werner and Smith (as cited in Edmund, *et al.*, 2006, p. 4) are identified as conducting a pivotal study into resilience, and note that the absence of conduct problems in school and supportive resources such as the family, neighbourhood, school and community are important associations with resilience and better outcomes. Blundo (as cited in Edmund *et al.*, 2006, p. 4) co-documented the importance of social networks and community agencies such as schools, churches, clubs, and the like in bringing about resilience. Mental health and stress reduction are reported to be positively affected by social relationships (Edmund, *et al.*, 2006, p. 4).

School connectedness is deemed a major protective factor by Resnick *et al.* (as cited in Edmund *et al.*, 2006, p. 4). School success has been linked to fewer mental health and conduct problems by (Luster & Small, as cited in Edmund *et al.*, 2006, p. 4). Completing and attending school is indicated as a very good protective factor (Banyard *et al.*; Valentine & Feinauer; Grotberg, as cited in Van Rensburg & Barnard 2005, p. 4). This is however not the case with a few children as reported by the participants where their children either dropped out of school or wanted to drop out.

The responses by the participants indicated that such social effects may have been present. The caregivers identified that they themselves ensured that they maintained social contact with the child's school, and that they engaged community members and neighbours for support.

“I had consultation with the school teacher. Teacher said she is improving. She can take notes off the board, she can write on the board.”

“Toe bel ek weer skool toe en vra. Nee sy gan nou weer aan, ek was nog nie weer n draai gemaak by die skool nie.”

“... because the teachers at school called all his friends and sat down with them and spoke with them explaining that no they must play with him because what happened

was not his fault. So now they started accepting him back... started playing with him.”

Yet on the other hand some indicated that their children were still exhibiting behaviours that are regarded anti-social such as aggression, not wanting to attend school, being isolated, very quiet and withdrawn. These types of behaviours have been referred to in previous sections, such as dropping out of school, exhibiting anger and aggression in school, withdrawal from friends and social situations and the like.

4.3.4.5 Intervention services effects perceived to influence desensitisation, positive changes and resilience

The majority of the participants reported that the child in their care accessed professional treatment ranging from trauma counsellors to social workers, to psychologists. In the second focus group the respondents did not indicate much professional intervention in the demographic questions, but they did indicate that their children attended a camp for victims of sexual abuse that was organised by the social workers of the Department of Social Development in Paarl. Numerous positive responses were voiced regarding the benefit and impact of such interventions.

“I think it must be the help of the social workers because they used to see her at school when she was still in school last year. Also this year early this year, they also came to talk to her...”

“Yes the child is seemingly coping she is also receiving counselling from nearby social workers in NY 111 ag, in Jooste Hospital, you know in Jooste.”

“Ja and I did, we did take him to a psychologist...”

“Hulle het nou verlede keer vir my ook omdat my kind nou deel is van... het hulle nou mos n SOS kamp gereel en ...”

“Sy was op [the SOS camping trip] gewees, my kinders was saam...”

“Want weet jy even sulke kinders kan weer hul maatjies help as hulle deur sulke dinge gaan. Sulke prosese en hulle moet hulle kan keer dat sulke goeters nie gebeur nie.”

“ My kind was ook weg gewees...” [on the SOS camping trip]

Van Rensburg and Barnard (2005, p. 4) note that psychologists and other health care workers are sources of resilience. Hilarski (2008, p. 41) indicates that CSA children and their families should be involved in treatment programmes. Formal treatment is not regarded as necessary when the child does not display any or only a few symptoms; then only psycho-educational training may be sufficient as an intervention method (Berliner, 2003, p. 13). If symptoms do present, then it is recommended by Berliner (2003, p. 13) that a full assessment be done prior to deciding on a treatment methodology.

On the other hand, receiving abuse specific therapy is purported to not be significantly linked to resilience in CSA among African American women in a study by Banyard *et al.* (2002, p. 54).

They indicate that only a small portion of their population attended such therapy. Harvey (as cited in Banyard *et al.*, 2002, p. 54) notes that many victims of CSA who do not receive formal abuse specific treatment may find other ways to improve from its effects.

Stevens, Tolond and Collings (2004, p. 23) call for interventions that target social attitudes regarding CSA such as myth and stereotype, in order to create public awareness and a more accepting atmosphere for CSA victims. This could have a positive effect on the child's later coping.

4.3.4.6 Perpetrator consequences perceived to influence desensitisation, positive changes and resilience

The consequences or what became of the perpetrator were strongly identified as a contributing factor for, or a barrier against, the children's perceived coping and desensitisation. In their study, Van Rensburg and Barnard (2005, p. 7) report that they found when a perpetrator was immediately removed from the proximity or if future access to the

child was deemed prohibited, (e.g. the perpetrator is incarcerated, barred from the house or legal steps taken against him) it was linked to better resilience in molested girls in their study.

The following statements link perpetrator outcomes to positive coping and resilience.

“Ok first of all I have moved away from where the child was abused, so she is no longer in contact with the abuser.”

“I think it was because this guy was arrested few minutes after the incident happened so the child felt safe. And then he was away for a long time, it was 3 years and the she also felt safe because he is not there in the community anymore.”

“Hy is nou dood, so wat kan sy dan nou verder maak? Sy kan nou mos verder niks doen daaraan nie. So sy cope nou daar mee by die huis, want my ma is ook daar en wat nou so loer.”

Kolbe (2005, p. 27) indicates that the identity of the perpetrator being known, being a relative or acquaintance of the child as opposed to a complete stranger causes more serious symptomatology. This is supported by literature which notes that forceful or violent CSA has been linked to depression, anxiety, nightmares and better resilience found to be reported when CSA was not incestuous or intrafamilial in nature (Banyard, *et al.*, 2002, pp. 50-54).

“... of as sy hom sien dan se sy ouma, ouma daar loop die perd alweer, kyk hoe loer hy, kyk hoe staan hy. Sy wil he ek moet hom gaan slat, nou sy is daai houding.”

“Want my kind was soos sien dit was die buurman wat dit aan haar gedoen het, as sy vir hom sien sy is net, sy is nie haar self nie, sy is net in die huis en somtyds is sy besig, sy is my suster se kind, maar sy is nooit haar self nie.”

“There was a positive coping before... when the perpetrator was in jail. But now everything is back to where it was before because the perpetrator is now back in the community. So the child is afraid and she does not even want to see this guy’s girlfriend.”

“... maar nou nog as sy hom, vir die man sien wat daar is en dan sy is in die huis in...”

“After it happened there was no problem. She was just happy that they person who did this was caught, but now because the guy is now back, she is does not want to go to Langabuya where the incident... she does not want to go there anymore.”

In a number of cases the perpetrators were unknown, never arrested or were released from prison. This was indicated as a reason for the children not coping well and, relapsing, or for the advent of fears and avoidant behaviour. Perpetrator consequences are thus taken to be perceived as a direct indication to the caregivers of the child's desensitisation, coping and resilience. This is in support of the literature which has been reviewed.

4.4 CONCLUSION

The caregivers who took part in the study held perceptions that were largely consistent with available literature, yet contrasted on a few matters. Important and passionate areas uncovered were the caregivers' perceptions regarding their own efforts with regard to assisting the children and how this impacted the children's ability to cope or adjust and function better. The caregivers were passionate in reporting how committed, they were to helping, supporting and guiding the CSA children “back on track”. They were fiercely protective which may have been linked to guilt, and fear of reoccurrence of CSA.

The profile of the caregivers did not fit squarely into those depicted in literature as often enhancing resilience, but some of them did possess a combination of some of these characteristics, such as some of those discussed by Hilarsky (2008, p. 37) and Reyes (2010, p. 54).

The caregivers projected themselves and their families as positive environments fostering adjustment in many instances. They depicted clear rules, boundaries and communication strategies as resilience-enhancing factors. Their levels of support and encouragement as a family may have been inflated in order to come across as more positive, or to escape feelings of guilt that they may have harboured in many instances. This is derived from the heightened levels of emotion displayed by the caregivers when addressing such issues.

Perceptions were shared that saw the CSA child as having internal strengths and above-average intelligence. Although these are mere perceptions and have not been empirically investigated, it may sound true if shown to be empirically valid. Van Rensburg and Barnard (2005, p. 3) and Hilarski (2008, p. 40) have all indicated similar findings on an individual level of the CSA child that hold links with better functioning after CSA.

Caregivers perceived social support in the form of caring and involved teachers and neighbours to be present in the lives of the CSA children in their care. They further identified it as a possible protective factor. This is congruent with literature of Werner and Smith (as cited in Edmund *et al.*, (2006, p. 4). The caregivers were eager to maintain communication channels with the sources of social support and to continue networking and collaboration between them and the child and his/her family.

Limited resources and/or access to these resources may be issues that hamper better functioning of children coping with CSA. The participants indicated good access and availability of professional services. They were eager for more of these services to be made available to the CSA children in their care. The quality and impact that these may have had is however unknown.

Perpetrator consequences were a factor related by the caregivers to better or poorer outcomes for the CSA child. What became of the perpetrator and his/her relationship to the victim were emphasised as major factors that might push a CSA child in either a coping or dysfunctional course.

Possible explanations for better coping, adjustment and what is interpreted as desensitisation was eagerly shared by the participants. They gave insight into their perceptions regarding what or how to deal with a CSA child that could bring about positive adjustment and coping. Although most of the children were perceived as being marginally desensitised or only coping to a relatively lesser degree, participants still held powerful perceptions that were largely consistent with available literature on the subject. The accuracy of their self-reflection or perceptions regarding their own abilities and actual attempts at assisting the children cannot be accurately verified. They might merely be holding up a front to disguise their own feelings of incompetence, self-blame, guilt and anger.

CHAPTER 5: SUMMARY OF FINDINGS AND RECOMMENDATIONS

5.1 INTRODUCTION

In Chapter 4 a discussion was provided of the research findings compared with available literature. The study was conducted with the goal of exploring and describing caregivers' perceptions of desensitisation among sexually abused children. The data was analysed and the findings were presented along four main themes that were reflections of the caregivers' experiences of desensitisation among such children.

In this final chapter a brief summary of the foregoing chapters will be presented to reflect on the goal and objectives along with the actions executed in reaching them. The introduction to the study, the concise literature review, the methodology, operationalisation, data collection, data analysis and the presentation of the findings of the study will be briefly summarised.

The conclusions that were arrived at in the research findings will be summarised under each theme uncovered during the qualitative data analysis process. Finally, recommendations will be made that have been inferred by the researcher from the interactions with the participants, literature and the findings of the study itself. These findings will serve to guide the way forward for future actions to be considered.

5.2 SUMMARY

Chapter 1 provided the background and the blueprint for the research study. The researcher set the background by describing the research problem and referring to available literature in a preliminary literature overview. From the research problem, the research goal and objective were identified. The study had as its goal to explore and describe caregivers' perceptions of desensitisation among sexually abused children. The objective served to provide a vehicle or indication of how to attain the study goal.

The researcher decided to employ a qualitative approach and to make use of an explorative and descriptive design to realise the research goal and objectives. This was chosen as a

suitable approach as the researcher primarily wanted to uncover new data about caregivers' perceptions of desensitisation among sexually abused children. This is in line with literature on these two types of research approaches as indicated by Durrheim (2006, p. 44) and Babbie and Mouton (2007, p. 80).

The methodology selected was presented and motivation for its selection was discussed. The researcher's methodological approach incorporated purposive sampling, as sampling strategy, focus group interviewing as means of data collection, thematic analysis as qualitative data analysis strategy, and member checking as a validity strategy.

Emphasis was placed on the ethical issues which the researcher had to give the needed consideration in undertaking the research study. The steps taken in this regard were discussed in detail to show that caution was taken to ensure adherence to research ethics.

In Chapter 2 a concise review of relevant literature was presented. The researcher presented a working definition of caregivers, and discussed caregivers in the South African context as well as the international context. Literature on caregivers of children with a sexual abuse history was compared and contrasted along lines of their perceptions, knowledge and expectations of the CSA child and associated symptoms. It was pointed out that caregivers of CSA children faced a particular challenge and that they had to contend with numerous difficulties. The increase in numbers of children being cared for by caregivers other than their biological parents was addressed by referring to reviewed literature.

Child Sexual Abuse was the second issue reviewed. CSA in relation to international and local trends and research areas was indicated. It was shown from the reviewed literature that large-scale debate exists around issues such as definition and the calculation of incidence and prevalence rates, as well as methodological challenges to the validity research findings. A presentation of the commonly encountered symptoms of CSA was presented and unpacked. Psychological and behavioural manifestations, inappropriate sexualisations, and PTSD-type symptoms were discussed under the banner of symptoms of CSA.

Finally Chapter two saw the definition of desensitisation. Desensitisation was discussed along the line of resilience and above average coping. Factors which have been identified in literature as enhancing resilience were unpacked and discussed. The researcher showed that this study took desensitisation to be a bimodal term, on one hand referring to coping and resilience and on the other to pathology such as negative CSA symptoms and symptoms linked to PTSD. The overlap of CSA symptoms with PTSD symptoms in some instances, was also pointed out and discussed by the researcher.

Chapter 3 gave a deeper, step-by-step, description of how the study was executed, in other words, the methodology employed. The research design was motivated. The goal and objective were presented as a point of reference or a waypoint to check that the methodology adhered to and complied with the identified goal and objectives of the study.

The population and sampling procedure were discussed along with a description of how they were executed in practice during the study. The criteria employed and how they were done as well as the reasons behind doing them were explained. Purposive sampling was implemented in this study because the study design called for the selection of cases that adhered to specific criteria. These criteria were used to select the cases in which the researcher had a particular interest, and to purposefully include them in the study.

Data collection occurred via focus group interviews. Focus group interviews were selected as means of data collection as this corresponded with the design. As Sarantakos (2005, p. 195) notes, this method is often used to uncover information on reasons and explanations for attitudes and behaviour, and it is just as good as any other method of data collection.

The process followed in attaining the data was described as starting with pilot study, a redefinition and refining of the guiding questions, planning of the focus group interviews, arranging and organising the focus group interviews, setting up of the focus group interviews and actual conducting of sessions.

The strategies and techniques employed in data analysis were shown. Transcription was discussed as not only part of data collection but also as the initial data analysis technique combined with immersion in the data. An indication of how further strategies such as the coding, categorising, and systematising of the data into themes and subthemes were to be used were indicated and discussed.

The limitations of the study were pointed out in the final part of Chapter 3. It was indicated that mainly the generalisability of the study was restricted because the sample was too small. The study was further limited by the researcher's inexperience, the attitudes and feelings of participants and the sensitive nature of the phenomenon under investigation.

Chapter 4 saw the findings of the research displayed, along lines of themes and subthemes. Discussions ensued along with comparison with available literature. Prior to discussion of the themes, the geographical data obtained during the study was presented and discussed to give the reader a better understanding of the participants and their silhouettes. The conclusions reached in Chapter 4 will be presented in the following section.

5.3 CONCLUDING DISCUSSION OF FINDINGS

The results that were discussed at length in Chapter 4 will be drawn together and the most significant points will be discussed in conclusion.

Theme 1: Perceived externalising manifestations among the CSA child victims by caregivers

Under the first theme externalising behaviours were identified as perceived displays with an outward tendency.

The research findings indicate that expected externalising displays among the CSA children, in reaction to CSA corresponded greatly with literature. Perceived externalising behaviours

currently displayed by the CSA children in the care of the participants, which were identified, included anger and aggression, disrespectfulness, scholastic conduct problems, sexual deviance, substance abuse, suicide attempts, and physical, physiological and somatic issues. These displays, at times, corresponded with the caregivers' expected externalising behaviours of the CSA child. At other times similar symptoms were perceived among the CSA children but deemed not as severe.

Anger and aggression were identified as both an expected and perceived externalising display of a child that has been sexually abused. Some caregivers noted a marked decrease in the severity of externalisation of anger and aggression among the CSA children in their care. This decrease in sensitivity is in contrast with much of the literature reviewed, which indicated that aggressive behaviour lingers or increases over time (Kolbe, 2005, p. 28).

Perceptions surrounding a bad attitude and disrespectfulness were both expected and currently identified among the sexually abused children by the participants. No decrease in the display of this type of behaviour was reported by the caregivers. It is important to note that these findings may be underreported, as caregivers may pay more attention to the presence of such negative behaviour than being aware of a decrease or absence of it.

Scholastic conduct problems were also an expected and perceived externalising response to a CSA among sexually abused children by the participants. Caregivers indicated that the children in their care displayed conduct problems in school at times. These conduct problems were seldom reported to decrease or improve. It was noted that once such scholastic conduct problems were identified, they usually increased in severity and resulted in school dropout. No noteworthy improvement had been noted in this regard.

Sexual deviance was an expected behavioural response of the CSA child by the caregivers. They, however, did not report promiscuity as a current issue among the children in their care, despite holding strong expectations of CSA children to exhibit this manifestation. Other types of sexual deviance were indicated as being exhibited by the CSA children in the care of the

participants. Sexual deviance was reported to rather take on the form of inappropriate age-related sexual knowledge, sexual role confusion, preoccupation with sex, and sex-related imagery (pornography) and inappropriate sexualisation (sexualised play by the children). Cultural norms were put forward by some caregivers as impacting on the sexual issues. The caregivers indicated that in the Xhosa culture it was taboo for caregivers and older persons to speak to children about sex and sex-related matters. Some however disagreed with this cultural practice, and indicated that they themselves undertook to handle the situation differently and to be more open and approachable in their interactions and communication with the children about sex.

Substance abuse was regularly indicated as an expected behavioural manifestation of a CSA child by the participants. Substance abuse was, however, not reported among any of the minor children with a sexual abuse history cared for by the participants. Only a single adult child was engaged in substance abuse after adolescence. The reason indicated for this was that the children on whom the caregivers based their perceptions, were too young to engage in substance abuse. Literature is in support of this, as substance abuse in reaction to CSA was identified as a problem usually encountered in the adolescent developmental stage (Kendall-Tackett, 2003, p. 227), when children had more easy access to substances.

Suicide attempts were seldom reported, yet widely expected as a CSA child's behavioural manifestation of externalising behaviour in response to CSA. Caregivers however indicated that suicidal ideation and attempts was expected only for children who were severely affected and unable to come to terms with the CSA trauma. One caregiver gave a narrative of the child in her care who attempted suicide and whom she constantly needs to monitor and supervise to prevent future attempts.

Physical and physiological issues were identified both as expected and current reactions to CSA. The literature indicated that physical injuries were not uncommon, especially if the sexual abuse act involved penetration, particularly when the child was pre-pubertal. The majority of children in this study were indeed pre-pubertal at the time of being sexually abused, and some were indicated as having sustained physical injuries from the abuse. Some

were even indicated as needing medical operations to repair damage. Some children reportedly had current physiological complaints which the caregivers attributed to the CSA incident. Medical explanations were not always underlying their perceptions, as they indicated that they wanted to have the children examined in the future. Uncertainty on behalf of the caregivers as to the real cause of the physical complaints of the children is thus inferred.

Somatic manifestations were held to overlap with physical issues. Bladder control and constipation may have either physiological or psychological origins. These two manifestations were commonly reported among the CSA children in the care of the caregivers. Some improvement had been reported but relapses had also been noted and linked with other internalising symptoms.

There was also believed to be a considerable overlap with the internalising manifestations that will be discussed in the following section.

Theme 2: Perceived internalising manifestations among the children with a CSA history by caregivers

The second theme that was identified from the data was the perceived internalising behaviours among the sexually abused children. These internalising displays were divided into sub-groups in order to better display them. The indicated sub-groups consisted of fear, anxiety and panic, sleep disturbances, decreased social participation and academic and concentration problems.

Fears and anxiety were the first sub-theme discussed under internalising manifestations perceived among the sexually abused children. It became apparent that the caregivers regularly identified fears, anxiety and panic-related manifestations among the sexually abused children in their care. Their perceptions were in support of much literature such as Kolbe (2005, p. 19); Carey *et al.*, (2008, p. 94); Rojas and Kinder (2009, p. 355) and Van Der Merwe (2009, p. 31). Fears symptoms were especially notable CSA response. Caregivers indicated that it was an ongoing concern. They noted that it subsided among many of the children, but returned in many instances. The return of fears was linked by the caregivers to

outcomes or consequences relating to the perpetrator, for instance if he was released from prison, never arrested, and deemed to be in the area.

Sleep disturbances was the second sub-theme discussed. This sub-theme held a close tie to the aforementioned sub-theme of fears, anxiety and panic. Nightmares and insomnia were often reported and were perceived to occur at present which is congruent with various studies referred to by Van Rensburg and Barnard (2005, p. 1). In some cases sleep disorders and nightmares subsided but were brought on again, similarly to that of fears, anxiety and panic, because of factors linked to the perpetrator.

A decrease in social participation was the third sub-theme identified and discussed. It was shown to include issues such as withdrawal, isolation, a decrease in communication and social reactivity. Little to no change or positive improvement had been perceived by caregivers who identified the issue.

Academic and concentration problems were often encountered throughout the literature as internalising responses to CSA. The caregiver participants perceived academic and concentration aspects to have been negatively influenced among a few of the children in their care. The larger view in terms of perceptions surrounding academic performance and concentration was that most children were unaffected in this regard. This contrasts with most of the literature. Those few that were identified as exhibiting or experiencing such academic and concentration problems showed marginal improvements, but usually deteriorated. The researcher proposed that externalising problems and other internalising issues may in combination have an effect on a child's concentration ability, which in turn may impede their academic progress. It is thus proposed that a multiplying effect may be present.

Theme 3: Perceived desensitisation, coping and current functioning of the CSA Victims

The third theme provided a reflection on perceptions regarding desensitisation held by the caregiver participants. Firstly, the participants' perceptions were mixed surrounding the topic

of desensitisation. A portion of participants indicated that desensitisation was perceived, but that it was indicated through marginal improvement and better functioning among the CSA victims in their care. These reports were however situation-specific and were not generalised across the children's broad-spectrum coping and adjustment. Apparent desensitisation or an improved functioning and coping may be covert distress, as termed by Edmund *et al.* (2006, p. 19). In other words desensitisation may be superficial and only at one level.

The caregivers' perceptions were not interpreted as confirming the presence of desensitisation among the CSA victims in their care. Some instances of improvements perceived as desensitisation were nonetheless perceived by the participants. The significance of these perceptions is however questionable and deemed hard to establish. Mixed responses such as noteworthy responses and other perceptions indicative of little to no improvement were given.

It was identified that caregivers' perceptions usually took on a negative connotation, as they often easily identified negative behaviour and aspects among the children but seldom reported positive behaviour. This is believed not to be due to the absence of positive aspects, but to inattention given to the positive aspects as it is not as alarming as the negative aspects.

Secondly, the caregivers' perceptions were indicative of reluctance on their part to portray the children as approximating desensitisation. Caregivers were considered reserved in communicating their perceptions that might point to desensitisation. The caregivers often indicated that the children only recently started improving in terms of symptoms, and that the improvements were marginal.

Caregivers may hold expectations on how the children in their care will be affected by the CSA. This has been discussed under their perceptions noted in themes 1 and 2. More negative perceptions regarding desensitisation and functioning were purported by the caregivers. This over-reporting of negative perceptions and appraisals may be a downplaying of positive perceptions. It may also be that the interactional effect that perceptions could have on the

children's actual behaviours and functioning may influence the children to exhibit more negative functioning and lesser desensitisation.

The duration of time that has lapsed since the children were sexually abused may see them exhibit long-term effects as opposed to short-term effects of CSA. The greater negative perceptions regarding desensitisation and poorer functioning may then hold links with PTSD-type symptoms, which is taken to be a long term effect of CSA. This link was however not a focus of this study and could at best be noted as a possibility that may place the children at risk for developing PTSD or related symptomatology.

Theme 4: Reasons perceived by caregivers to influence desensitisation, positive changes and resilience

The final theme was a collection of perceptions on why desensitisation may and would occur among sexually abused children. The caregivers put forth their perceptions that were grouped into caregiver effects, family effects, personal characteristics, social aspects, intervention services and perpetrator consequences.

Among the caregiver effects, aspects such as caregiver presence, involvement, attitude, assumption of a primary caregiver role and being supportive were perceived as aspects that aided desensitisation and improved functioning. These aspects held congruence with much of the literature consulted. Aspects that were further identified among the caregivers' perceptions were over-protectiveness by the caregivers, as well as caregivers being controlling and restricting in some instances. These types of parental (caregiver) behaviour, is incongruent with literature indicative of positive outcomes for the CSA victim.

Family factors that were perceived by the caregivers as contributing to desensitisation and positive coping and functioning were such things as families that have clear rules, boundaries, routines and roles; positive and open communication; and people who are

supporting. These factors were described among the literature as indeed assisting better outcomes for the CSA victim.

Personal characteristics of the CSA victims were identified as factors that might influence and enhance desensitisation and coping. The children were depicted in the perceptions of the caregivers as being relatively intelligent, being mature, understanding, and having sound intra-psychic functioning. Available literature was greatly in support of the perceived personal characteristics as contributing towards more positive outcomes for the CSA victim.

Social aspects were perceived by caregivers as things they themselves lobbied for regarding the CSA victims in the social arena. They indicated that social support networks were established and made use of by engaging these systems and drawing on them for support.

Intervention services were indicated as a factor which could lead to better desensitisation and better coping. Most CSA victims accessed some sort of intervention and therapeutic services. The literature was contradictory with regard to motivating this issue. Some literature indicated that access to such services might indeed cause a positive outcome but some indicated that success rates could depend on other factors and that different interventions were needed in different instances.

Perpetrator consequences, in other words what happened to the perpetrator, was a regular factor perceived as having a major impact on CSA victim outcomes. Caregivers perceived that when a perpetrator was removed from the area, when he was identified, arrested and legal action taken against him, it would bring about a positive outcome. In instances when the perpetrator was released from jail, and never arrested or charged, the perceptions were that this could lead to negative outcomes, poorer coping and even relapse, as has been noted in theme 2.

5.4 RECOMMENDATIONS

- The study was limited in scope, as the sample was not highly representative of all caregivers of all children with a CSA history. A larger scale study may yield more comprehensive insights into the matter. It is therefore recommended that the research tradition be carried forward, and that more studies be undertaken to expand, confirm, challenge and/or validate the findings of the present study.
- Another limitation to the study as discussed in Chapter 3 was the fiercely protective instinct towards the CSA children presented by some of the caregivers and their concern about project themselves in a negative light as caregivers. It is thus of extreme importance that future research be cautious of this fact which may influence and distort findings. It is recommended that the needed care be taken in designing future studies that make use of similar populations. The design should put measures in place that will neutralise or compensate for the effect that (a) The protective instinct caregivers have towards the children in their care and (b) The defensiveness displayed by some caregivers as to distance, explain or justify themselves and/or their actions with regard to helping and assisting the CSA children or their omissions to do so.
- The researcher identified a need for caregivers to ventilate their feelings and to receive support in their roles and responsibilities that relate to caring for the CSA child in their care. It is consequently recommended that social workers from the Department of Social Development Paarl and Gugulethu Local Offices present debriefing and support group sessions to the caregivers of CSA children. In these groups the unresolved issues which many of these caregivers are deemed to have and the possible secondary trauma through which they have been put, can be addressed. Programmes should thus provide the space to ventilate feelings, discuss challenges faced, provide psycho-education about the special needs of the CSA child, and teach practical skills to caregivers which may assist them in caring for the children. CSA children and caregivers have urgent needs and special vulnerabilities which call for a competent and effective response.

- In light of the caregivers at times having limited knowledge of the vast effect that CSA may have on a child victim, it is recommended that organisations and government departments working with CSA victims and their caregivers, ensure that the caregivers receive adequate training on expected effects that CSA may have on the children. This could be specifically done with new foster parents who will resume the caregiver role in the lives of CSA victims.
- CSA appears to be an issue that is dealt with less than other forms of child abuse, as it occurs more seldom. Social workers may thus have less exposure to such cases, which may create misconceptions and stereotypes among these professionals. It is important to expose social workers to ongoing studies in the field of CSA in order to instil a deeper understanding of the challenges faced by the CSA child, as well as the persons caring for these children. If the social workers are better informed, it is argued that they will be in a better position to identify risk and problems early on, and put the needed corrective and preventative measures in place. For example, if a social worker understands that resilience is enhanced by certain parent-child interactional patterns, parental attitudes and the creation of a certain supporting environment, they could link the clients to the needed services or even develop appropriate interventions for them.
- Multiple subject areas have been touched on throughout the literature review, for example education, social work, psychology, medicine and psychiatry, sociology, community safety, policing, law and the legal system, to name a few. Cognisance should be created in other subject areas and among other professionals, departments, organisations, role players, and the like, to be aware of what the caregiver of a CSA victim experiences. This awareness should be used to make the needed adjustments in their various disciplines to assist and support the victims and caregivers in their dealings with them. For instance, the police could be trained on the worries and challenges that caregivers of CSA victims face and could be sensitised to their needs. The police could then be more cautious when working with these subjects in order to minimise secondary trauma which they may inflict. Specific studies into their various subject areas that relate to the CSA victim and their caregivers should be done in

order to inform how each organisation, department or institution could go about working with caregivers of CSA victims in the future.

5.5 CONCLUSION

The last chapter of the present study provided the reader with a summary and conclusion of (1) the background, motivation research problems, goals and objectives of the study; (2) a concise review of literature consulted; (3) the methodology followed during execution the study; (4) and the major findings of the study.

The researcher attained the goal and objectives of the study through qualitative enquiry, as he succeeded in exploring and describing caregivers' perceptions of desensitisation among sexually abused children. The researcher uncovered perceptions held by the caregiver participants regarding expected symptoms of the CSA victim, as well as perceptions of currently exhibited symptoms by the children in their care. Their perceptions regarding desensitisation, or a lack thereof, were shown and discussed. The caregivers' perceived explanations for the presence of desensitisation and better coping by some children were indicated and discussed and shown to include caregiver-, family-, individual-, interventions services- and perpetrator effects and consequences. The findings of the study thus provided insight and a better understanding into the caregivers' perceptions of desensitisation among sexually abused children.

Based on the findings, the researcher proceeded to make a number of recommendations for future study into the subject as well as practical considerations that may develop from the newly uncovered information and have a positive effect on caregivers and the sexually abused children in their care.

LIST OF REFERENCES

- Babbie, E. (2004). *The practice of social research* (10th ed.). Belmont: Wadworth.
- Babbie, E., & Mouton, J. (2007). *The practice of social research*. Cape Town: Oxford University Press.
- Banyard, V.L, Williams, L.M., Siegel, J.A. & West, C.M. (2002). Childhood Sexual Abuse in the Lives of Black Women: Risk and resilience in a longitudinal study. *Women & Therapy*, 25(3), 45-58.
- Berliner, L. (2003). Intervention in sexual abuse. *Child abuse research in South Africa*. 4(1), 12-15.
- Bolen, R. M. & Lamb, J. L. (2007). Parental support and outcome in sexually abused children. *Journal of Child Sexual Abuse*, 16(2), 33-54.
- Breno, A.L., & Galupo, M.P. (2007). Sexual abuse histories of young women in the U.S. child welfare system: A focus on trauma-related beliefs and resilience. *Journal of child sexual abuse*, 16(2), 97-113.
- Britz, L., & Joubert, J.M.C. (2003). 'n Voorgestelde intervensiemodel vir die seksueel misbruikte middelkinderjare-kind. *Child Abuse Research in South Africa*, 4(2), 27-35.
- Carey, P.D., Walker, J.L., Rossouw, W., Seedat, S., & Stein, D.J. (2008). Risk indicators and psychopathology in traumatised children and adolescents with a history of sexual abuse. *European Child and Adolescent Psychiatry*, 17(2), 93-98.
- Christians, C.G. (2003). Ethics and politics in qualitative research. In N.K. Denzin & Y.S. Lincoln (Eds.), *The landscape of qualitative research: Theories and issues* (2nd ed.) (pp.208-244). California: Sage.
- Collings, S.J. (2005). Sexual abuse of boys in Kwazulu-Natal South Africa: A hospital based study. *Journal of Child and Adolescent Mental Health*, 17(1), 23-25.
- Creswell, J.W. (2007). *Qualitative inquiry and research design: choosing among five approaches* (2nd ed.). London: SAGE.
- Crowley, M.S. (2008). Three types of memory for childhood sexual abuse: Relationship to characteristics of abuse and psychological symptoms. *Journal of Child Sexual Abuse*, 17(1), 71-88.

Dawes, A., Borel-Saladin, J., & Parker, Z. (2005). Measurement and monitoring. In L. Richter, A. Dawes & C. Higson-Smith (Eds.), *Sexual abuse of young children in Southern Africa* (pp. 176-206). Cape Town: HSRC Press.

Dawes, A., Richter, L., & Higson-Smith, C. (2005). Confronting the problem. In L. Richter, A. Dawes & C. Higson-Smith (Eds.), *Sexual abuse of young children in Southern Africa* (pp. 1-18). Cape Town: HSRC Press.

Denzin, N.K., & Lincoln, Y.S. (2003). Introduction: The discipline and practice of qualitative research. In N.K. Denzin & Y.S. Lincoln (Eds.), *The landscape of qualitative research: Theories and issues* (2nd ed.) (pp.1-46). California: Sage.

Durrheim, K. (2006). Research design. In M. Terreblanche, K. Durrheim & D. Painter (Eds.), *Research in practice: Applied methods for the social sciences* (pp.33-59). Cape Town: UCT Press.

Durrheim, K. & Painter, D. (2006). Collecting quantitative data: Sampling and measuring. In M. Terreblanche, K. Durrheim & D. Painter (Eds.), *Research in practice: Applied methods for the social sciences* (pp.131-159). Cape Town: UCT Press.

Edmund, T., Auslander, W., Elze, D. & Bowland, S. (2006). Signs of resilience in sexually abused adolescent girls in the foster care system. *Journal of Child Sexual Abuse*, 15(1), 1-28.

Farmer, E., & Pollock, S. (2003). Managing sexually abused and/or abusing children in substitute care. *Child and Family Social Work*, 8, 101-112.

Ferreira, R., Ebersöhn, L., & Oelofsen, M. (2007). An alternative way of assessing girls who have been sexually abused: Using Gestalt therapy for assessment purposes. *Child Abuse Research in South Africa*, 8(2), 69-80.

Finkelhor, D. (1990). Early and long-term effects of child sexual abuse: An update. *Professional psychology: Research and practice*, 21(5), 325-330.

Gallinetti, J. (2005). Legal definitions and practices in child sexual abuse. In L. Richter, A. Dawes & C. Higson-Smith (Eds.), *Sexual abuse of young children in Southern Africa* (pp. 209-226). Cape Town: HSRC Press.

Greeff, M. (2005). Information collection: Interviewing. In A.S. De Vos, H. Strydom, C.B. Fourie, & C.S.L. Delpoort (Eds.), *Research at grass roots: for the social sciences and human service profession* (3rd ed.) (pp. 286-313). Pretoria: Van Schaik.

Guma, M., & Henda, N. (2005). The socio-cultural context of child abuse: a betrayal of trust. In L. Richter, A. Dawes & C. Higson-Smith (Eds.), *Sexual abuse of young children in Southern Africa* (pp. 95-109). Cape Town: HSRC Press.

Heissler, K. (2001, November 4). *Good practices and priorities to combat sexual abuse and exploitation of children in Bangladesh*. Paper presented at the 2001 South Asia consultation for the second world congress against commercial sexual exploitation of Children, Dhaka, Bangladesh.

Henning, E. (2004). *Finding your way in qualitative research*. Pretoria: Van Schaik.

Higson-Smith, C., Lamprecht, L., & Jacklin, L. (2005). Access to specialist services and the criminal justice system: Data from the Teddy Bear Clinic. In L. Richter, A. Dawes & C. Higson-Smith (Eds.), *Sexual abuse of young children in Southern Africa* (pp. 335-355). Cape Town: HSRC Press.

Hilarski, C. (2008). Child and adolescent sexual abuse. In C. Hilarsky, J.S. Wodarski & M.D. Feit (Eds.), *The handbook of social work in child and adolescent sexual abuse* (pp. 29-50). Portland: Haworth Press.

Intebi, I. (2003). Sexual abuse: risk factors. *Child Abuse Research in South Africa*, 4(1), 8-11.

Kelly, K. (2006). From encounter to text: Collecting data in qualitative research. In M. Terreblanche, K. Durrheim & D. Painter (Eds.), *Research in practice: Applied methods for the social sciences* (pp. 285-319). Cape Town: UCT Press.

Kendall-Tacket, K. (2003). Sexual abuse. In J.J. Ponzetti (Ed.), *International Encyclopedia of Marriage and Family*, 1(2), 227-230.

Killian, B., & Brakarsh, J. (2005). Therapeutic approaches to sexually abused children. In L. Richter, A. Dawes & C. Higson-Smith (Eds.), *Sexual abuse of young children in Southern Africa* (pp. 367-394). Cape Town: HSRC Press.

Kolbe, C. (2005). *An investigation into the patterns of child sexual abuse and victim-perpetrator relationships amongst survivors of child sexual abuse at a university*. Master's Thesis. Cape Town: University of the Western Cape, Social Work Department.

Kouyoumdjian, H., Perry, A.R., & Hansen, D.J. (2009). Non-offending parent expectations of sexually abused children: Predictive factors and influences on child recovery. *Journal of Child Sexual Abuse*, 18(1), 40-60.

Krefting, L. (1991). Rigor in qualitative research: the assessment of trustworthiness. *The American Journal of Occupational Therapy*, 45, 214-222.

Leon, S.C., Ragsdale, B., Miller, S.A., & Spacarelli, S. (2008). Trauma resilience among youth in substitute care demonstrating sexual behaviour problems. *Child abuse and neglect*, 32, 67-81.

- Madu, S.N., & Peltzer, K. (2001). Prevalence and patterns of child sexual abuse and victim-perpetrator relationships among secondary school students in the Northern Province (South Africa). *Archives of Sexual Behavior*, 30(3), 311-321.
- Misurell, J.R., Springer, C., & Tyron, W. (2011). Game-Based Cognitive-Behavioural Therapy (GB-CBT) group program for children who have experienced sexual abuse: A preliminary justification. *Journal of Child Sexual Abuse*, 20(1), 14-36.
- Montgomery, H. (2009). *An introduction to childhood: an anthropological perspective to children's lives*. West Sussex: Wiley & Sons.
- Mouton, J. (2001). *Understanding social research*. Pretoria: Van Schaik.
- Pasztor, E.M., Hollinger, D.S., Inkelas, M., & Halfon, N. (2006). Health and mental health services for Children in foster care: The central role of foster parents. *Child Welfare League of America*, 85(1), 33-57.
- Pierce, L., & Bozalek, V. (2004). Child abuse in South Africa: An examination of how child abuse and neglect are defined. *Child Abuse and Neglect*, 28, 817-832.
- Pollio, E.S., Glover-Orr, L.E., & Wherry, J. N. (2008). Assessing Posttraumatic Stress Disorder using the Trauma Symptom Checklist for Young Children. *Journal of Child Sexual Abuse*, 17(1), 89-100.
- Priebe, G., & Svedin, C. G. (2009). Prevalence, characteristics, and associations of sexual abuse with sociodemographics and consensual sex in a population-based sample of Swedish adolescents. *Journal of Child Sexual Abuse*, 18(1), 19-39.
- Pullins, C.G., & Jones, J.D. (2006). Parental knowledge of child sexual abuse symptoms. *Journal of Child Sexual Abuse*, 15(4), 1-18.
- Ratele, K. (2006). Postcolonial African methods and interpretation. In M. Terreblanche, K. Durrheim & D. Painter (Eds.), *Research in practice: Applied methods for the social sciences* (pp. 538-556). Cape Town: UCT Press.
- Reber, A.S., & Reber, E.S. (2001). *Dictionary of psychology* (3rd ed.). London: Penguin Books.
- Reyes, C.J. (2008). Exploring the relations among the nature of the abuse, perceived parental support, and child's self-concept and trauma symptoms among sexually abused children. *Journal of Child Sexual Abuse*, 17(1), 51-70.

Richter, L., Dawes, A. & Higson-Smith, C. (2005). Are we any closer to solutions?. In L. Richter, A. Dawes & C. Higson-Smith (Eds.), *Sexual abuse of young children in Southern Africa* (pp. 452-466). Cape Town: HSRC Press.

Richter, L., & Higson-Smith, C. (2005). The many kinds of sexual abuse of young children. In L. Richter, A. Dawes & C. Higson-Smith (Eds.), *Sexual abuse of young children in Southern Africa* (pp. 21-35). Cape Town: HSRC Press.

Rojas, A., & Kinder, B.N. (2009). Are males and females sexually abused as children socially anxious adults? *Journal of Child Sexual Abuse*, 18(4), 355-366.

Sarantakos, S. (2005). *Social Research* (3rd ed.). Hampshire: Palgrave Macmillam.

Smit, A.H. (2007). *Adolescents' experiences of parental reactions to the disclosure of child sexual abuse*. Master's Thesis. Pretoria: University of Pretoria, Department of Social Work and Criminology.

South Africa. (2005). Children's Act. Act 38 of 2005. *Government Gazette of the Republic of South Africa*. Pretoria: Government Printer.

Stevens, M, Tolond, K, & Collings, S.J. (2004). The mediating effect of social myths and stereotypes on perceptions of child sexual abuse. *Child Abuse Research in South Africa*, 5(1), 19-25.

Strydom, H., & Delpont, C.L.S. (2005). Sampling and pilot study in qualitative research. In A.S. De Vos, H. Strydom, C.B. Fourie, & C.S.L. Delpont (Eds.), *Research at grass roots: for the social sciences and human service profession* (3rd ed.) (pp. 327-332). Pretoria: Van Schaik.

Terminology Committee for Social Work. (1995). *New Dictionary of Social Work*. Cape Town: CTP Books.

Terre Blanche, M., Durrheim, K. & Kelly, K. (2006). First steps in qualitative data analysis. In M. Terreblanche, K. Durrheim & D. Painter (Eds.), *Research in practice: Applied methods for the social sciences* (pp. 320-344). Cape Town: UCT Press.

Townsend, L., & Dawes, A. (2005). Individual and contextual factors associated with sexual abuse of children under the age of 12. In L. Richter, A. Dawes & C. Higson-Smith (Eds.), *Sexual abuse of young children in Southern Africa* (pp. 55-94). Cape Town: HSRC Press.

Van Der Merwe, M. (2009). Traumagenic dynamics as fundamental constructs in sexual trauma intervention: Beyond Finkelhor and Browne. *Child Abuse Research in South Africa*, 10(2), 25-40.

Van Niekerk, J. (2005). At the coalface: the Childline experience. In L. Richter, A. Dawes & C. Higson-Smith (Eds.), *Sexual abuse of young children in Southern Africa* (pp. 263-275). Cape Town: HSRC Press.

Van Rensburg, E., & Barnard, C. (2005). Psychological resilience amongst sexually-molested girls in the later middle-childhood: A case study approach. *Child abuse research in South Africa*, 6(1), 1-12.

Wassenaar, D. (2006). Ethical issues in social science research. In M. Terreblanche, K. Durrheim & D. Painter (Eds.), *Research in practice: Applied methods for the social sciences* (pp. 60-79). Cape Town: UCT Press.

Wherry, J.N., Graves, L.E., & Rhodes King, H.M. (2008). The convergent validity of the trauma symptom checklist for young children for a sample of sexually abused outpatients. *Journal of Child Sexual Abuse*, 17(1), 38-50.

Wherry, J.N., Berres, A.K., Sim, L., & Friedrich, W.N. (2009). Factor structure of the Adolescent Clinical Sexual Behavior Inventory. *Journal of Child Sexual Abuse*, 18(3), 233-246.

Wurtele, S.K. (2009). Preventing sexual abuse of children in the Twenty-First Century: Preparing for challenges and opportunities. *Journal of Child Sexual Abuse*, 18(1), 1-18.



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APPENDIX A: INFORMATION SHEET:

Project Title: Caregiver's perceptions of desensitization among sexually abused children

What is this study about?

This is a research project being conducted by Riaan Grobbelaar at the University of the Western Cape. We are inviting you to participate in this research project because you have been identified as a caregiver of a child with a sexual abuse history. The purpose of this research project is to explore and describe caregiver's perceptions of desensitization among sexually abused children.

What will I be asked to do if I agree to participate?

You will be asked to partake in a focus group interview where you would be required to share your perceptions regarding desensitization among sexually abused children. Desensitization refers to a process whereby the children become less sensitive and exhibit fewer symptoms associated with sexual abuse. The focus group sessions will take place at The duration of the focus group interview will be 2 to 3 hours. A possible follow up session may be required, but will be arranged with each participant.

During the focus group sessions you will be asked to discuss the behaviour of the sexually abused children in your care and to explain how one will know that the child has been sexually abused. You will also be asked to discuss in the group how the child in your care deals with having been sexually abused and indicate if and why some children deal better with the fact that they have been sexually abuse than others. You may be asked to describe what the behaviour of the children is, who deal better with the fact that they have been sexually abused. You will be requested to discuss the behaviour of the children who do not deal effectively with the fact that they have been sexually abused. Other related questions may arise during the focus group interviews.

Would my participation in this study be kept confidential?

We will keep your personal information confidential. To help protect your confidentiality, no persons other than the researcher will have access to your personal details. Your name will also be masked in the recording and you will be assigned an alias when coding and analysing the collected data. Thus: (1) your name will not be included on the surveys and other collected data; (2) a code will be placed on the survey and other collected data; (3) through the use of an identification key, the researcher will be able to link your survey to your identity; and (4) only the researcher will have access to the identification key.

If we write a report or article about this research project, your identity will be protected to the maximum extent possible.

In accordance with legal requirements and/or professional standards, we will disclose to the appropriate individuals and/or authorities information that comes to our attention concerning child abuse or neglect or potential harm to you or others.

This research project involves making audio tapes of your responses. The tapes are being made in order to ensure that everything you say is recorded by the researcher. It will also make it easier for the researcher to write the whole interview down after it has been conducted as eight to ten persons will be participating in the focus group at a time. The tapes will be digitally stored on the computer of the researcher which is password protected. The tapes will only be kept as backup for the researcher in order to transcribe the conversations between participants and researcher. The tapes will be destroyed once all data has been transcribed and backed up.

I agree to be audiotaped during my participation in this study.

I do not agree to be audiotaped during my participation in this study.

A Xhosa speaking Social Worker from the Department of Social Development will be used as a translator/facilitator for focus groups taking place in Gugulethu and Mbekweni. The reason for making use of such a person is to allow you to express yourself in the best way possible. The facilitator will not have access to any of the information recorded during the focus group sessions after the conclusion of the transcription of the focus group sessions.

What are the risks of this research?

There may be some risks from participating in this research study. The topic is of a very sensitive nature and may affect you emotionally. It may awaken feelings associated with secondary trauma such as feeling uncomfortable, embarrassed, guilty, sad and scarred.

What are the benefits of this research?

This research is not designed to help you personally, but the results may help the investigator learn more about caregiver perceptions of desensitization among sexually abused children. We hope that, in the future, other people might benefit from this study through improved understanding of caregiver's perceptions of desensitization among sexually abused children. Myths, stereotypes and possible new data may be uncovered that could prove important for further study. The data uncovered may also be used to inform Social Workers and other helping professions on possible behaviour among sexually abused children that might refer to desensitization.

Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify. If during the focus group interviews you wish to stop participating you may do so by letting the researcher know that you wish to stop participating. You will then be allowed to leave to group.

Is any assistance available if I am negatively affected by participating in this study?

You will be encouraged to join in one of the foster parent support groups that are planned in conjunction with the department of Social Development (Gugulethu and Paarl). This will provide you with a platform to be debriefed and to gain support from a trained professional as well as fellow foster parents.

What if I have questions?

This research is being conducted by Riaan Grobbelaar and the Department of Social Work at The University of the Western Cape. If you have any questions about the research study itself, please contact Riaan Grobbelaar at: Social Development Paarl, corner of Nuwe and Derken Streets, Paarl, 021 871 1682, or email: rgrobbel@pgwc.gov.za

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Head of Department: Social Work
Dean of the Faculty of Community and Health Sciences:
University of the Western Cape
Private Bag X17
Bellville 7535

This research has been approved by the University of the Western Cape's Senate Research Committee and Ethics Committee.



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APPENDIX B: CONSENT FORM

Title of Research Project:

The study has been described to me in language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way.

Participant's name.....

Participant's signature.....

Witness.....

Date.....

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact the study coordinator:

Study Coordinator's Name: Dr. Mariana De Jager

University of the Western Cape

Private Bag X17, Belville 7535

Telephone: (021)959-3696

Fax: (021)959-24670

Email: mdjager@mweb.co.za



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APPENDIX C

The Social Work Manager

Department of Social Development

Local Office: Gugulethu/Paarl

Dear Sir / Madam

RE: Permission to conduct research study with clients of the Local Office:

I hereby formally request permission to conduct a research study into Caregivers' perceptions of desensitisation among sexually abused children, as part of my Master's studies at the University of the Western Cape (UEC). Please find attached research proposal which sets out the aims and objectives of the study.

Please note that the study has been cleared by the University's ethics committee. Should you need any further clarification on the matter feel free to contact myself or my study coordinator, Dr. Mariana De Jager of the University of the Western Cape, Telephone: (021)959-3696, Fax: (021)959-24670, Email: mdjager@mweb.co.za.

Kind regards

Mr. Riaan Grobbelaar

(Social Worker)

Date: