THE EXPERIENCES OF CAREGIVERS WHOSE CHILDREN DISCLOSE CHILD RAPE

A Dissertation Submitted

TO

The School of Psychology at the University of KwaZulu-Natal, Howard College

IN

Partial fulfillment of the requirements for Masters Degree in Counselling Psychology

By

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September 2008

DECLARATION

I declare that this research project: "The experiences of caregivers whose children disclose child rape" is my own work. It is being submitted for the degree of master in counselling psychology at the University of Kwazulu-Natal, Durban, South Africa. It has never before been submitted for any purpose. All sources of information that have been utilised or quoted have been acknowledged by a complete reference.

BRENDA NOZIPHO NKABINDE

SIGNATURE--------------------------- **DATE-----------------**

DEDICATION

This dissertation is dedicated to all the caregivers whose children have suffered severe trauma due to a rape incident.

ACKNOWLEDGEMENTS

I would like to thank the following people for playing a pivotal role in making this study a success:

- My heavenly Father for the strength and wisdom to be able to complete this study.
- Prof. Steve Collings (supervisor) for his valuable guidance, knowledge and help with my dissertation.
- The Treatment Centre for permission to conduct the interviews in their centre.
- All the caregivers who participated in this study for their time and dedication and for sharing their painful stories without which this study would not be a success.
- Miss Zama Ntuli (a counseling psychologist) who conducted the interviews and helped with the translation.
- My loving and supporting family (mother, Dumazile; father, Pomzeni; aunt, Aslita; brother, Collin;three sisters & friends, Nonhlanhla, Bongokuhle, Sthembile; two nieces, Percy, Khayalethu Junior; and my nephew Zamokuhle) for their encouragement and for believing in me. You are the greatest family I am blessed to be part of, if it was not for your prayers, support, love and encouragement; I would not have made it. I love you all!
- My late & best friend, Sebenzile Zamangwane Zikhali, who was always there for me through thick and thin. Her support, prayers and true friendship sustained me throughout my academic years.
- My other friends for their support, encouragement, and prayers throughout my studies.
- South African Police Service for the opportunity they gave me to further my studies.

Abstract

The purpose of this research was to examine what the caregivers of raped children experience in the aftermath of child rape disclosure. Nineteen caregivers were drawn from a Treatment Centre, for child rape victims, using purposive sampling. Information was gathered from them by means of focused in-depth interviews that were conducted by a qualified psychologist and the data collected from these interviews were analysed using thematic analysis. According to the findings of this study, caregivers reacted emotionally, physically, and psychologically to rape discovery. What was feared by most caregivers was that their children might have contracted HIV during the rape incident. Most caregivers also complained of the service rendered by the police and considered it to be the worst as compared to that provided by medical staff. When it comes to coping strategies, most caregivers seemed to have been assisted by the Treatment Centre in dealing with rape disclosure. This suggests a need for the development of more such Treatment Centres which are readily accessible by the public.

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CHAPTER ONE

INTRODUCTION

1.1 Background to the study

"When you leave your child alone in the home, he/she is not safe. And in the street, he/she is not safe. And in the school, he/she is not safe. There is no where she can walk and be safe." (Russell, 1991: 6) These are not only the concerns of Mary Mabaso (quoted in Russell, 1991), from Soweto, but of all South Africans, as rape in South Africa has reached epidemic proportions.

According to Richter (2005), a report by the Child Protection Unit of the South African Police Services notes that 21 000 cases of rape and attempted rape of children under the age of 17 were reported in the year 2000. When South Africa became a democracy in 1994, there were already 18,801 cases of rape per year, but by 2001 there were 24,892 (Dempster, 2002; cited in Meier, 2002). And in May 2002, the following statistics were reported in Parliament for the period of January to September 2001; 15 650 cases of child rape were reported to the South African Police Services (SAPS); of these, 5 859 (37,4%) children were under 12 years of age and the rest (62.6%) were 12 to 17 years of age (van Niekerk, 2004, cited in Burton 2005). According to South African Police Service statistics (SAPS, 2003-2004), child abuse is on the increase in South Africa. Dawes, Kafaar, De Sas Kropiwnicki, Pather and Richter (2004; cited in van Zyl & Sinclaire, 2006) reveal that, from April 2002 to March 2003, there were 52 425 rapes reported in South Africa, of which a significant number were of children under the age of 18 years (van Zyl & Sinclaire, 2006). In KwaZulu-Natal alone, justice officials and AIDS workers say that at least five rape cases involving girls under eight

are being dealt with daily in every magistrate's court in the province (Govender, 1999).

These statistics are extremely troubling. It is also worth noting that these statistics only represent the tip of the iceberg, as there are children who are silent about rape due to fear of criticism, stigma, and shame that is attached to rape/sexual abuse (Halonen & Santrock,1996). Personal discussions with social workers and other child protection personnel from the South African Police Service strongly suggest that these official records are woefully short of the actual percentage, since investigators are reluctant to classify a case as rape unless case evidence is decisive.

With the rising numbers of people infected with HIV, one may wonder how many of these young rape victims get infected during the incident. South Africa, a country with the highest incidence of rape and child rape in the world, has approximately one in nine of its 41 million population infected with HIV/AIDS and nearly 60 children are raped every day in South Africa (HIV/AIDS Statistics: National Institute of Allergy and Infectious Diseases, Fact Sheet cited in Earl-Taylor, 2002). Questions arise as to what exactly contributes to the escalating numbers of child rape victims and what renders children vulnerable to rape (Richter, Dawes & Higson-Smith, 2004).

According to the University of KwaZulu Natal anthropology lecturer and researcher Leclerc-Madlala, a popular myth that sex with a virgin is a cure for AIDS could be the basic reason why HIV carriers target children in a belief that it will cure them of this dreadful disease (Govender, 1999). Experts have agreed to disagree about the causes of rape (Earl-Taylor, 2002). Whether the false belief in the "Virgin Cure" preventing/curing HIV/AIDS is responsible for the rising numbers of child rapes is a

question that needs to be answered.

Despite the wide-spread prevalence of child rape in South Africa not much is known about how the caregivers of raped children experience or cope with the rape of their children. According to Bernard (2001), the discovery of rape can be a very painful and difficult experience for all the caregivers involved, it can further evoke conflicting emotions.

1.2 Motivation of the study

According to Walters (1975) and Carter (1990), rape is considered a family problem. It has been noted that raped children turn to their caregivers for support and security after the incident (McCahill, Meyer & Fischman, 1979). It is the sense of involvement and closeness the caregiver exhibits that makes the child victim feel safe and supported because, as expected by society, it is the responsibility of caregivers to nurture and guard, instruct, and protect their children from the time they are young (Umeh, 2001, p. 70). This sense of moral responsibility can result in caregivers experiencing feelings of blame for not protecting their children from the rape. In a study by Carter (1990), all 24 women who participated blamed themselves for the rape of their children.

Given the important role caregivers play in the recovery of child victims, it is imperative to understand how caregivers are affected by child rape disclosure, especially in the context of the HIV pandemic. This will assist in the development of intervention strategies that will assist caregivers to effectively respond to the needs of their children in the aftermath of disclosure, and enable them to participate fully in the procedures that need to be undertaken for child victims to recover and for perpetrators

to be put behind bars. The paucity of research on these issues has resulted in this study being conducted.

1.3 Purpose of the study

While child rape primarily affects child victims, it must be understood that these children are members of a larger organization, a family. And in families, caregivers who normally take care of children and meet their needs (financial, emotional, social, and intellectual) can be affected as well. It must also be noted that rape disclosure involves lengthy and difficult procedures that children cannot attend to or cope with by themselves.

Thus the objectives of this study are the following:

- To investigate the unexplored experiences of caregivers
- To deepen our understanding about the difficulties the caregivers experience in making sense of child rape.
- To explore the ways in which caregivers have reacted and responded to the disclosure.
- To explore the ways in which caregivers have dealt/coped with the disclosure.
- To assist in developing policies that will help caregivers survive the experience and learn ways to support their raped children.
- To explore how the disclosure has impacted on the functioning of the family as a system.

1.4 Definition of terms

According to Robertson (1989), in order to communicate effectively it is important that terms be commonly understood by everyone. And therefore for this study caregiver, disclosure, and rape definitions will be provided.

1.4.1 Caregiver

A caregiver is any person who is responsible for a child. Such a person caters for the physical, emotional, and psychological needs of the child and the child looks up to this person for support. It can be anyone from a grandparent, to a parent or next-of-kin. A caregiver in this study can be considered as a child's source of trust and support.

According to the South African Children's Act, a caregiver is someone who voluntarily cares for a child either indefinitely, temporarily or partially. Even though this person does not have any parental responsibility and rights in respect of a child, he/she must, whilst the child is in that person's care:

- safeguard the child's health, well-being, and development; and
- protect the child from maltreatment, abuse, neglect, degradation, discrimination, exploitation, and any other physical or mental harm or hazards.

This person is also expected to exercise any parental responsibilities and rights necessary, including the right to consent to any medical examination or treatment of the child, if such consent cannot reasonably be obtained from the parent or primary caregiver of the child. The child therefore deserves to be supported by his/her caregiver if, for example, he/she has been raped.

It can be concluded that the caregiver, as someone who looks after the child, has a responsibility to protect the child from maltreatment, abuse, physical, and mental harm. This includes protecting the child from rape. And if the child has been raped, the caregiver is expected to safeguard the child's health, well-being and development, by making sure that he/she receives professional assistance.

1.4.2 Rape

Lewis (1994) defines rape as a traumatic and violent sexual assault involving intercourse with a woman without her consent. According to the traditional common law offence, rape is defined as "carnal knowledge of a female forcibly and against her will" (Bienen, 1981, p.174, cited in Koss & Harvey, 1991). Carnal knowledge, according to Koss and Harvey (1991) means penile-vaginal penetration (Koss & Harvey, 1991).

These definitions pose an assumption that only females can be raped (Wade, 2001) and that rape involves violent acts by the perpetrator and non-consent by the victim.

Within the last few years some progressive countries have passed laws which acknowledge that men can be raped, hence the following definitions of rape:

"any assault which culminates in an act or acts of unwelcome penetration of the mouth, anus, or vagina of either gender by either gender." (Wade, 2001, p. 4)

A representative definition of rape is the following: "Vaginal intercourse between male and female and anal intercourse, fellatio, and cunnilingus between persons regardless of sex. Penetration, though slight, is sufficient to complete vaginal or

anal intercourse" (Koss & Harvey, 1991, p.4).

In these definitions, rape has been expanded from penile-vaginal intercourse to include oral and anal penetration. According to Koss and Harvey (1991), the definition of rape can be expanded to include non-violent methods of obtaining compliance.

In this study, rape will be defined as unlawful sexual intercourse (anal or vaginal penetration) which can occur under many different circumstances, including the following:

- when force, or threat of force, is used to overpower or control the victim;
- when a non-violent method is used to manipulate the victim to comply and
- when the victim is too young to give legal consent (agreement) for sex.

There are two major categories of rape. Firstly, there is within-family (intrafamilial) rape. This is rape, according to Jehu (1988) and Robertson (1989), that occurs within the family or extended family where the perpetrator will be a relative of the victim, perhaps a father or the mother, or a grandfather, an uncle or maybe a cousin.

The second category of rape is where the perpetrator is outside the family (extrafamilial rape). The perpetrator may be the next-door neighbour, the after-school care centre worker, the sports coach or the 'man in the car', to name a few (Jehu, 1988; Robertson, 1989).

1.5 Overview of the present research

This study will commence with a review of relevant literature concerning raped children in the aftermath of disclosure, commencing with the current situation in South Africa (Chapter 2). A detailed research methodology will be explicated including a

focus on ethical issues pertaining to researching sensitive issues (Chapter 3). Chapter 4 will present the results of the present study, incorporating a discussion in terms of relevant literature. Finally, chapter 5 will focus on the implications, recommendations, and conclusions of the study.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

Children are considered a blessing from the Creator; they are precious, innocent, and fragile at the same time. They are esteemed as the future of the nation by society. Children should feel safe and protected within society, but this is not always the case. Often, the very society which esteems children as its future jeorpadises their future in a number of ways, one of which is rape. Once raped, these children become victims and have to undergo a lot of changes. According to Koss and Harvey (1991, p.1), "once one is victimized one will never again feel quiet invulnerable".

The changes that child rape victims have to undergo affect not just them but, as Koss and Harvey (1991) argue, their families as well. Caregivers who are responsible for taking care of children, providing their needs, protecting, guarding, and guiding children are especially affected as rape might raise doubts regarding their care-taking skills. International and local literature will be reviewed in this chapter in order to explore the impact of rape disclosure on the victim, family, and most significantly caregivers. This review will commence with factors contributing to child rape, followed by the effects of rape disclosure on the families and caregivers, care-giving in the aftermath of disclosure, and finally how caregivers cope following disclosure.

2.2 Factors contributing to child rape.

There are many factors contributing to child rape but for the purpose of this study six will be discussed as they are related to the study's objectives.

2.2.1 Virgin cure myth

One reason, reported by Richter (2004) and Lobaido (2001), why child rape cases are on the rise is the myth that having sexual intercourse with a virgin cures HIV/AIDS. Children, instead of adults, are thus targeted as they are most likely to be virgins. According to Sharon (1994, cited in Mukamana, 2004), a rape myth is a false idea about what rape is and it offers rapists permission to rape by giving them an excuse for their behaviour. This myth can be traced back to the 19th century European belief that sexual intercourse with a virgin was a cure for syphilis, gonorrhoea and other Sexually Transmitted Infections (STIs) (Earl-Taylor, 2002). Earl-Taylor (2002) further stated that when soldiers from the World War II spread STIs, the virgin cure became famous in South Africa.

Even in this era of HIV and AIDS this myth is still popular as evidenced by an article written by Prega Govender . In this article a 62 year old man raped a seven-year-old girl who was his neighbour and on enquiry by the child's mother he initially

[1] Sunday Times Newspaper of the 4th of April 1999 (Child rape: A taboo within the AIDS taboo; more and more girls are being raped by men who believe this will 'cleanse' them of the disease, but people don't want to confront the issue.

denied involvement in rape but he later confessed that he was HIV positive and had wanted to 'cleanse' himself by having sex with a virgin.

It is, however, important to note that research has not been conducted to support or refute this popular myth believed to be a contributing factor in the escalating number of child rapes (Richter, Dawes, & Higson-Smith, 2004).

2.2.2 Power issues

Coppin (2000) believes that rape is not about sex but about power and violence. The rapist believes that he or she has a right over the victim's body, irrespective of the victim's needs and feelings. He further states that irrespective of the circumstance, rape should not be viewed as the victim's fault but that the rapist must always be held accountable for his/her own actions. However, the blame might shift to the caregiver as the protector and the one who is supposed to take care of the child victim.

On the one hand you find fathers who rape their children because they have absolute control of the victim (Wade, 2001). These kinds of rapists have been noted by several authors (Finkelor, 1984; Herman, 1981; Russell, 1983, 1984; Summit & Kryso, 1978) as autocratic and dictatorial father figures in the families of raped children (Porter, 1984). Furthermore, these fathers maintain control through the use of force, threats and intimidation in such a way that, according to Robertson (1989), women and children in such households have no choice but to comply with the demands of the father figure irrespective of whether they agree with his demands or not. Jehu (1988) and Magwaza (1997, cited in Richter et al., 2004) view the power imbalance in such

households as increasing the children's vulnerability to rape because, according to Tang (2002, cited in Richter et al., 2004), children are compelled to obey. On the other hand, according to Jehu (1988), there are fathers whose power is manifested in a form of control over their children's social contacts, by keeping them in the house. These children tend to trust family and be wary of society. Jehu (1988) notes that this kind of family life can encourage intra-familial rape as these children view the demands placed on them by their fathers as harmless.

There are also those adults who were raped while they were children, who according to Mufson and Kranz (1991), feel insecure and powerless; this results in them feeling comfortable with children to an extent that what they consider as love for these children is manifested in a sexual form.

2.2.3 Parental skills

Children who are raised by parents who lack parental skills might put their children at risk of being raped. Children whose parents or caregivers lack assertive skills, for instance, are also unlikely to acquire such skills (Jehu, 1988). This might therefore put them at risk of being raped as they will be unable to voice their concerns to perpetrators. According to Richter et al. (2004), this problem can be addressed by equipping parents or caregivers with parenting skills and thereby assisting children.

Caregivers who are emotionally disturbed are not in a position to guide and raise their children or to avoid exposing them to such risks as rape; furthermore, these caregivers are unable to show affection to their children (Jehu, 1988; Richter et al.,

2004). This may drive their children to look for affection outside of the home where they may be placed in a situation where they are vulnerable to rape. Furthermore, according to Richter et al. (2004), these children may even be reluctant to disclose rape incidents.

2.2.4 Ineffective adult figures

Children are taught to respect and trust adult figures including parents, teachers, and pastors from the time they are young (Mufson & Kranz, 1991). Unfortunately some of these adult figures tend to take advantage of the children who respect and trust them. They betray this trust by making sexual advances to children. An analysis of data from the dockets of crimes committed in Gauteng in the years 1996 and 1997 suggests that people who live near the child, who are acquainted with the child, or the child's family pose a particular risk (Burton, 2005). Furthermore, an analysis of the child-perpetrator relationship conducted by Collings and Wiles (2004) revealed that in 26% of the cases, the perpetrators were family members, 12% of the cases involved people well acquainted with the child victim, while in 21% of the cases the perpetrator was a neighbour.

Because children are most likely to be raped by people they know and trust (Koss & Harvey, 1991) it is assumed that these rapes must have been planned and premeditated (Volgeman, 1993). This in turn might result in caregivers blaming themselves for being so ignorant that they were unable to read the cues of premeditated or planned rape of their children.

2.2.5 Stepfathers as risk factors

Increasing number of children in this day and age are born out of wedlock while others are faced with a challenge to choose which parent they would prefer to live with after divorce. And the fact that these parents are likely to get new partners places their children at risk of being raped by their partners. Previous studies provide evidence suggesting that many children are raped by their stepfathers (see for example Walters, 1975; Bernard, 2001; Miller, 1990, Mufson & Kranz, 1991). The reason for this, according to Robertson (1989), might be that these stepfathers spend a lot of time in close proximity to stepchildren and thus have access to them. Another reason might be that these children are not their natural children and it is likely that the stepfathers have not grown fond of them, as they were not involved in nurturing these children when they were at a tender age (Jehu, 1988).

2.2.6 Spousal tribulations

In a study conducted by Jehu (1988), marital conflict and /or disruption was reported by 72% of victims, with 68% living in constant fear of being deserted by significant others. Half of the father figures were physically abusing the child's mother, and poor social skills were reported for three-quarters of both parental figures. Children from such families tend to lack love, support, and attention which may result in them being exploited by any adult who seems to meet these needs.

Another contributing factor to intra-familial rape, as reported by Gregory-Bills and Rhodeback, (1995; cited in Burton, 2005), is apparent in families where there are

vague role boundaries and where one parent is absent. In such cases children end up adopting parental roles (including sexual roles). According to Robertson (1989), sexual relationship problems occurring between husband and wife can also contribute to intra-familial rape because children are targeted as sexual substitutes for mothers or fathers. Walters (1975) also reported sexual involvement between children and their parents as resulting from the anger one parent has towards another.

From the foregoing, it is evident that family members are affected by any breakdown in family life and, sadly, the most affected are children.

2.3 The effects of rape disclosure

Rape disclosure not only affects the child victim but also the family, and more so the caregivers.

2.3.1 Family

The discovery of child rape not only affects the child but the family concerned as well. According to Johnson (1993), rape pulls family apart, especially when the perpetrator is a family member, as he/she is viewed as bad and is also blamed for the tragedy the family is facing. Furthermore, the child victims become angry, first and foremost, at the perpetrators because they once trusted them and also at other family members for having not protected them (Stark & Holly, 1998). The father (as a perpetrator) also blames the mother and the daughter for betraying him by reporting the rape incident to the police (Walters, 1975).

However, there are also families who are drawn together by child rape disclosure. Because of fear of humiliation or stigmatisation and maintaining the good name of the family; caregivers in such families decide to unite with other family members in keeping the incident a family secret (Robertson, 1989; Richter et al., 2004).

2.3.2 Caregiver

Previous studies have shown that caregivers are affected by child rape disclosure and thus react in a number of ways. Emotional reactions that are manifested by some caregivers include; feelings of denial, shock, numbness, fear, silence, sadness, shame, guilt, powerlessness, and hostility (Walters, 1975; Bernard, 2001; Jehu, 1988 & Robertson, 1989). Caregivers are thus challenged by the disclosure, as they have to deal with their own emotional reactions to the incident while dealing with their children's feelings of pain and anger at the same time (Bernard, 2001).

Confusion is the first reaction to rape disclosure manifested by caregivers and it only lasts for a short period of time (Robertson, 1989). During the time caregivers are still confused, the support they are supposed to provide to the child victims is compromised as they are unable to think logically and rationally. Robertson (1989) therefore suggests that caregivers first need to get over a state of confusion in order to effectively provide support for their child victims.

There are cases where rape disclosure seriously affects the caregivers to the extent that some even lose their lives. An example of such a case is that of Mr. Aimes

who died of heart problems after his daughter was raped and killed in 1974 (Holmes, 1991).

When a child victim decides to disclose rape to someone other than the caregiver, feelings of inadequacy as a parent are evoked from the caregiver (Johnson, 1993). According to Robertson (1989), these caregivers or parents would then view themselves as failures and start to question the quality of the relationship between themselves and their children. Other caregivers experience feelings of remorse after disclosure because they did not recognise signs of rape and because they were unable to protect their children (Johnson, 1991; Collins, 1997, cited in Bernard 2001). Feelings related to betrayal may also be manifested after disclosure by caregivers whose children were raped by people known to the family. In such cases caregivers experience mixed feelings of loyalty to the perpetrator and faithfulness to the child victim (Bernard, 2001).

According to Hooper (1992, cited in Bernard, 2001), there are mothers who need to preserve their relationship with men who rape their children because they are financially and emotionally dependent on these men. This is achieved through ignoring the signs of rape when the caregivers/mothers notice them. In such cases caregivers/mothers often weigh the financial and emotional benefits from the perpetrators against the consequences of protecting child victims (one of which might be that of losing the perpetrator or wage-earner) and this evokes ambivalent feelings in caregivers/mothers (Bernard, 2001). Furthermore, if it happens that the perpetrator is

jailed and there is no income in the house, the child victim is blamed for disclosing rape (Porter, 1984).

Similarly, the husband may not want to end the relationship if the wife is a perpetrator but instead blame the child victim for disclosing rape instead of the rape perpetrator (Muffson & Kranz, 1991). According to Muffson and Kranz, blaming child victims for disclosure might give children an impression that they asked for what happened to them.

Caregivers are also faced with the challenge of acting as a conduit for communication between the police and child victims after rape disclosure. According to section 4 of the Prevention of Family Violence Act, 133 of 1993, it is a statutory duty for crimes against children to be reported (Conradie & Tanfa, 2005). But it is unfortunate that when caregivers go to the police to report the rape, and to ask for assistance, they at times fail to get the support they deserve and, instead, experience secondary traumatisation at the hands of the police (van Zyl & Sinclaire, 2006). This is evidenced by a statement (regarding the treatment received in the police station) that was uttered by one of the participants in the study by van Zyl and Sinclaire (2006); 'I was not happy about it, but did not complain I was too worried about my child that was raped' (p.3). According to Meier (2002), caregivers experience psychological trauma in the first place when they have to wait for hours in the police stations and then listen to their children relating their rape stories. This trauma is further exacerbated by the fact that the investigation takes a long time and that during the process of investigation caregivers are not updated about the case proceedings. Thus, caregivers become

reluctant to continue with the prosecution because of delays and the frustration involved (Meier, 2002). However, a Parliamentary Task Group that was established in order to improve child protection, and services to abused children, acknowledged that the overload of cases and scarcity of resources within SAPS could be a reason affecting service delivery (Richter et al., 2004).

Medical practitioners, like the police, can also be sources of secondary traumatisation for caregivers and their children after disclosure. Meier (2002) reports that medical examinations are delayed for hours or even days resulting in evidence being lost. This means that child victims accompanied by their caregivers have to go through the process of medical examination again. As a solution to this problem van Zyl and Sinclaire (2006) suggest that medical practitioners responsible for forensic investigations of child victims should be properly trained to prevent the secondary traumatisation of child-victims and their caregivers.

Even when it comes to court proceedings, which are long and emotionally taxing for both the child victim of rape and his/her caregiver (Conradie & Tanfa, 2005), caregivers are expected to be there. In the court setting the child victims and their caregivers re-experience the incident. According to Muller and van der Merwe (2002), in cases where child victims are unable to testify because of fear or incompetence, caregivers are expected to testify in the trial. An example quoted from Muller and van der Merwe (2002) is that of a five year old child victim who was not willing to speak at a trial but when the mother was called in, progress was made as the mother was able to give the court answers that her child whispered to her. And while waiting for the

prosecution, caregivers also experience pressure from perpetrators, especially if these perpetrators are family members, to drop the charge (Conradie & Tanfa, 2005).

To deal with the effects of rape, the child victims together with their caregivers or even the whole family need therapeutic intervention to allow ventilation of feelings (Walters, 1975). According to Richter et al. (2004), caregivers are sometimes blamed for rape incidents during family therapy because it is believed that, consciously or unconsciously, they permitted rape.

Though the family is affected by child rape disclosure, caregivers can be considered secondary victims as they have to go through all the things their children are going through: from reporting the incident to the police, accompanying their children to medical examiners, to attending case trials. Just as all of this affects child victims, caregivers are affected as well.

2.4 Care-giving in the aftermath of disclosure.

McCahill , Meyer and Fischman (1979) state that after a rape incident, child victims need a supportive environment which can be provided by close family members and friends, in order to make sense of the rape. As evidenced by research, the most effective form of support is provided by non-abusing family members (Spacarelli & Kim, 1995, cited in Bernard, 2001). However, it must also be noted that the very people (the caregivers) who are expected to be a shoulder for child victims to cry on are themselves distressed by the disclosure (McCahill et al., 1979). And the fact that caregivers are not

coping with disclosure could affect a caregiver-child victim relationship (Bernard, 2001).

In the first place, child victims expect caregivers to have protected them from rape. To a child, caregivers are all-knowing and therefore child victims expect them to know about what they are going through without having verbalised their pain and hurt (Sanderson, 1995).

In the midst of such difficulties there are, however, caregivers who are encouraging, and accepting, and who are able to show empathy, and understanding of their children's experiences (Robertson, 1989). Caregivers can also be supportive by monitoring the sleeping and eating patterns of the child victims (McCahill et al., 1979). And according to Stark and Holly (1998), such caregivers convey to child victims that their needs do matter.

On the other hand there are caregivers who react in ways that exacerbate the damage that has already been done by the rape of these children. For example, as opposed to being empathic, some caregivers become emotionally distanced after disclosure which hinders their effective caring (Bernard, 2001). More specifically Koss and Harvey (1991) state that it is contempt and rejection caregivers have towards their children that cause psychological damage to child victims and thus effect caregivers' affective caring. Bernard (2001) further states that the caregivers' ability to facilitate the recovery process of child victims can be affected by the ambivalence that caregivers have about their relationship with both their partners and the child victim. It is therefore

imperative that caregivers deal with these feelings in order for them to remain open and responsive to their children.

2.5 Caregivers'coping strategies

According to Robertson (1989), rape disclosure devastates caregivers who are at the same time expected to take care of the child victim. The guilt, confusion, and shock they experience when they find out about the rape renders them unable to cope with the situation (Robertson, 1989) and thus, just like child victims, Burton (2005) feels that caregivers require therapeutic intervention to deal with the situation. However, it must be noted that often caregivers are not counselled to alleviate their own reactions to rape disclosure but, according to Meier (2002), they are counselled on psychological effects and the safety of child victims. To affirm this view, Richter et al. (2004) reports that the reason caregivers are involved in therapy is to form a therapeutic coalition with the therapist in order to decrease the effects of rape on child victims.

The family can serve as a source of support for caregivers, especially when the perpetrator is not a blood relative. This can happen when the family does not put pressure on the caregiver to report the incident; instead caregivers are given the support they need (Bernard, 2001). And the support caregivers receive from their families enables them to understand children's needs after the rape incident (van Zyl & Sinclaire, 2006).

However, coping with rape becomes complex when the perpetrator is the caregiver's partner. In such cases families often exert pressure on caregivers not to

involve anyone outside the family (including the police and therapists) and this exacerbates their feelings of isolation which in turn affects their care-giving strategies (Bernard, 2001). According to Johnson (1993), support groups can also assist caregivers to realise that they are not the only ones facing a crisis, develop friendships that can act as support systems, and learn effective parenting skills for their child victims.

2.6 Theoretical framework

The theoretical framework which will be utilized in this research is ecological systems theory. According to this theory, an individual's behavior can only be understood by taking into account his/her complex system of relationships affected by multiple levels of the surrounding environment. These levels can be conceptualized as a series of concentric rings (Berk, 2003).

At the **centre** is the individual's biological and psychological make up as well as emotional tendencies and inclinations such as his/her temperament and personality for responding to and acting on the environment (Bukatko & Daehler, 1998).

The **microsystem** is the innermost level of the environment which refers to activities and interactional patterns of an individual's immediate surroundings. These would include family members, neighbours, friends, and relatives; social and educational circumstances. The individual's biological and psychological make up influences, and is influenced by, the microsystem (Berk, 2003). The **mesosystem** encompasses connections between microsystems, such as home and school (Berk,

2003). That is, it relates to the relationships and channels of communication between the different microsystems responsible for raising the child.

The **macrosystem** consist of cultural values, laws, customs, and resources (Berk, 2003). The priority that the macrosystem gives to an individual's needs affects the support they receive at the inner levels of the environment (Berk, 2003; Bukatko & Daehler, 1998). External environmental settings which only indirectly affect development fall under the **exosystem**. These may include the caregiver's workplace and government institutions (Berk, 2003). In a nutshell, the ecological systems approach is interested in investigating whether a particular phenomenon might be understandable in terms of the contexts within which they occur (Terre Blanche & Durrheim, 1999). The following is a schematic diagram of the levels of the environment in Bronfenbrenner's (1979) Ecological Systems Theory.

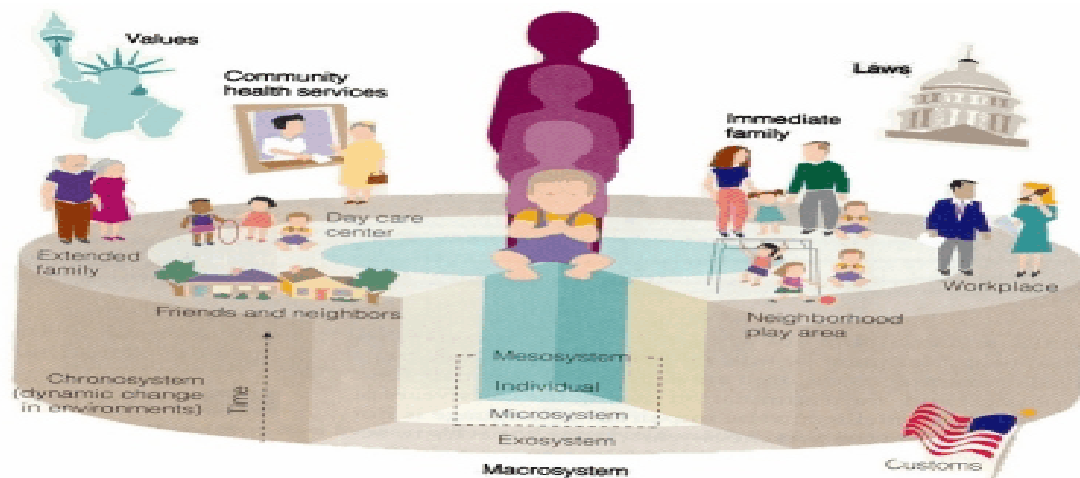

Figure 2.1: Bronfenbrenner's Ecological Systems Theory, retrieved from http://www.education.umd.edu/Depts/EDHD/geron/lifespan/6.html on 15 July 2007

The various contexts described by ecological systems theory need to be considered when attempting to understand the experiences of caregivers whose children disclose child rape. That is, the experiences of caregivers in the aftermath of child rape disclosure are determined by multiple interacting factors. These factors not only include the caregiver's personal traits and history but also contextual factors related to family features and characteristics, community supports and accessibility, cultural issues related to values and belief systems, and larger societal attitudes.

2.7 CONCLUSION

Child rape, which results from a number of factors, has reached epidemic proportions. Following rape disclosure, families, and more especially caregivers, are also affected by the rape incident. As children rely on caregivers for support and assistance through the recovery process, it is imperative that the wellbeing of caregivers be taken care of as well.

Though there is literature on the experiences of caregivers in the aftermath of disclosure it is evident that available evidence is insufficient. This study attempts to fill the gap in available literature and provide a South African perspective on the experiences of caregivers in the aftermath of disclosure.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

The aim of this chapter is to describe the research procedures of the present study. It presents the research questions and the research design (the study site, population, sampling technique, and research participants). This is followed by the methods used to collect and analyse data. Finally, ethical considerations are discussed.

3.2 Research Questions

The research aimed to examine the experiences of caregivers of child rape victims in the aftermath of disclosure. To achieve this aim, the following questions were explored:

- What was the nature of the relationship between the child and caregiver before disclosure?
- What was the nature of the relationship between the caregiver and the child rape victim after the disclosure?
- How are the child victim and the caregiver related?
- How did the caregiver find out about the rape?
- How do caregivers feel after they have discovered that the child has been raped?
- How do caregivers feel about the disclosure?
- What affected the caregiver most about the disclosure?
- What affected the caregiver most about the rape incident?

- What did the caregiver do after finding out about the rape?
- Who accompanied the child to the police, hospital, helping professions, and court and how was the child treated?
- How is the caregiver coping with the disclosure?
- How does the caregiver experience taking care of the child victim?
- What are the steps the caregiver took to protect the child from being raped again?

3.3 Research Design

The present research employed a qualitative research design because the research required detailed accounts relating to the subjective experiences of caregivers in their real world situations. That is, this research was concerned with eliciting caregivers' meanings, or spoken words, in order to explore reality from their own perspective (De Vos, 2005). Furthermore, it attempted to understand caregivers in terms of their own definition of the world (Mouton, 2001).

In qualitative research designs, explanations tend to be rich in detail, sensitive to context, and capable of showing the complex processes or sequences of social life (Neuman, 2000). According to Terre Blanche and Durrheim (2002), qualitative methods also allow the researcher to study selected issues in depth, openness, and detail as they identify and attempt to understand the categories of information that emerge from the data.

3.3.1 Description of the study site

The sample of caregivers was drawn from an NGO which treats children who have been raped or sexually abused. The centre functions as a drop-in centre, a counselling facility, and a community help desk for children raped or sexually abused.

This Treatment centre is a Non Profit Organisation whose purpose is to rescue and uphold the rights of raped or sexually abused children, minimize their risk of HIV infection, and bring them towards wholeness.

To achieve this, the Treatment Centre trains Child Safety Officers to assist in crisis intervention of child victims of rape/sexual abuse and to also work in conjunction with the local police and legal services to assist child victims from the point of rescue and throughout the entire legal process.

There are 10 Child Safety officers who have been trained and they work with 20 new cases of rape or sexual abuse every month. The support and assistance provided by the Child Safety Officers is not only limited to child victims but also extends to the child victims' caregivers.

3.3.2 Study population

Caregivers whose children have disclosed that they have been raped constituted the population of the study. This population was characterised by attendance at the Treatment Centre for children who were raped or sexually abused.

3.3.3. Sampling Technique

As this research required a detailed account of the subjective experiences of participants, a sample group was required which had the potential to provide rich material (Burton, 2005). It is for this

reason that non-probability sampling, more specifically, purposive sampling was used to draw a sample. The purposive sampling technique is used to select members of a difficult to reach, exceptional population with specific characteristics (Kvale, 1996). It is used when the researcher has a specific purpose in mind (Neuman, 2000). For this research, caregivers whose children had disclosed that they have been raped were sourced from the Treatment Centre.

3.3.4 Description of research participants

According to De Vos, Strydom, Fouche and Delport (2000), a complete coverage of a total population is seldom possible, and all members of a population of interest cannot possibly be reached. De Vos et al. (2000) further note that the research problem in which one is interested does not always permit access to the entire population. This is especially true for research problems such as the experiences of caregivers of childhood rape victims to be investigated in this research.

Because of the qualitative nature of the present study, the selected sample aimed at providing a richness of data required to reveal valuable information. To that end, 19 caregivers of child victims of rape were sourced from the Treatment Centre. The following is a description of the relationship between the caregiver and the child victim of rape.

3.3.4.1 Caregiver's relationship to the victim

Relationship to the victim	Number
Mother	13
Aunt	4
Father	1
Grandfather	1
TOTAL	**19**

Table 1 Relationship of the caregiver to the victim (n=19)

The participants interviewed constituted family members who were the caregivers of the child victims. Mothers, aunts, a father, and a grandfather were interviewed. Out of 19 caregivers, 13 were mothers to the child rape victims, four were aunts and there was only one father and one grandfather.

3.3.4.2 Caregiver's relationship to the perpetrator

Relationship to the perpetrator	Number
Husband	1
Brother	2
Husband's brother in-law	1
Landlord's son	1
Stranger	5
Neighbour	9
TOTAL	**19**

Table 2 Relationship of caregivers to the perpetrator (n=19)

Contrary to the misconception about rape that “only strangers rape children” (Mufson & Kranz, 1991; Lewis, 1997) Koss and Harvey (1991) report that children are most likely to be raped by people they know and trust. Out of 19 perpetrators, four were family members (one biological father of the child, one brother of the caregiver, and one caregiver’s brother-in-law). Ten perpetrators were known to the child (nine neighbours and one landlord’s son), and five perpetrators were unknown to the child.

3.4 Methods of Data Collection

Focused in-depth interviews were conducted with caregivers of children who had disclosed child rape. Because of the subjectivity of the respondents’ experiences, and the fact that they do most of the talking, this method of data collection (focused interviews) yields rich information (Bobbie, 1999).

These interviews were conducted by a qualified psychologist for the purpose of dealing with the emotions that may arise during the interviews. The qualified psychologist had been working at the Treatment Centre for sexually abused or raped children for the last two years and the interviews were conducted as part of the intake interviews for that Treatment Centre.

The researcher was not involved in collecting data due to the sensitivity of the study; however, she only transcribed and translated the data tape recorded during the interviews. With the consent of the caregiver all interviews, which were conducted in the caregivers’ own language, were tape recorded.

3.5 Methods of Data Analysis

Data gathered for this research was analysed using thematic analysis. According to Leininger (1985), thematic analysis focuses on analyzing common themes by bringing together ideas and experiences that are meaningless when viewed alone. It involves identifying particular themes

which occur in the material which is being studied. Those themes may emerge from the attributions or assumptions which people make (Hayes, 2000).

Because the data are qualitative the information can vary a great deal. The same theme may emerge in different contexts, or may be raised by different people. Therefore thematic analysis involves the researcher searching diligently through the data in order to identify these themes (Hayes, 2000). During this process, contradictions, differences, and echoes were noted. Furthermore, connections between emerging themes were listed and ordered in order to make sense of the connections between emerging themes (Leininger, 1985). The following are the stages of data analyses adapted from (Terre Blanche & Durrheim, 1999; Hayes, 2000):

- Read through each interview, noting items of interest.

  - The researcher starts the process of close and multiple reading to familiarize herself with the text.

- Sort items of interest into proto-themes.

  - The initial notes are transformed into concise phrases that aim to capture essential quality of what was found in the text.

- Examine proto-themes and attempt an initial definition.

  - Themes are examined for any connections between them.

- Take each theme separately and re-examine each transcript carefully for relevant material for that theme.
- Using all the material relating to each theme, construct each theme's final form: definition and supporting data.
- Select the relevant illustrative data for the reporting of the theme.

3.6 Ethical Considerations

According to Terre Blanche and Durrheim (1999), a research design should consider ethical issues. This should be done with the aim of protecting the welfare of research participants.

Permission to conduct the research was obtained from the Treatment Centre where the caregivers of children were sourced.

Kidder and Judd (1986) note the importance of researchers considering the possibility of mistreatment of human participants in research. This means that research may become damaging to the research participants' sense of self if sensitive topics are pursued without consideration (Bobbie, 1999). According to De Vos (2005), participants need to be protected from any emotional, physical, and psychological harm, distress or danger that may result from the sensitive topics discussed in the research. Therefore, informed consent, which involves the researcher explaining clearly what the research will entail and what is expected of the participants, is important (Terre Blanche & Durrheim, 1999). That is, the participants should be allowed to voluntarily participate in the study out of their own free will and be informed that they can withdraw from the process at any stage if they so feel. Furthermore, participants need to know about tape recording the interview and give consent to it. In this study the aforementioned issues surrounding informed consent were dealt with by the researcher at the beginning of the interview and the data were collected via an intake interview (at the Treatment Centre) by a qualified psychologist who dealt with any emotional issues anticipated through ongoing psychotherapy sessions.

Participants were also informed that the information they shared during the interview would be treated confidentially and that anonymity was assured. That is, according to Neuman (2000), information is not released in a way that permits linking specific individuals to responses. Interviews were recorded and the digital recordings stored on a computer in a locked office. Access to the digital recordings on the computer required an access code which was only known by the researcher and supervisor. The transcribed material could only be accessed by the

researcher or her supervisor. Analysed data were kept in a cupboard which is locked. Furthermore, disguised names were used to protect the identity of participants from public disclosure (anonymity).

CHAPTER FOUR

RESULTS AND DISCUSSION OF FINDINGS

4.1 Introduction

The purpose of this chapter is to provide an analysis and discussion of data collected. The data, through the processes of thematic analysis, provided insights into the experiences of caregivers of child rape victims after disclosure.

This chapter will commence by explaining the codes which were used in the analysis, followed by a discussion of the major themes and sub-themes that emerged from the data. These themes are divided into two parts, the first part is based on the process of rape discovery and the second part outlines the themes according to the ecological systems theory.

4.2 Discussion of the findings

The following codes were used to identify transcripts:

- The transcripts from a caregiver were represented by the letter "C".
- This will be followed by the order the caregiver was interviewed, e.g. if the caregiver was interviewed first, "1" will come after C forming "C1".
- The caregiver's relationship to the child is then indicated. Then it will reflect the relationship of the caregiver to the child rape victim, e.g. if the caregiver is a mother to the child, "C1" will then be followed by "M" resulting in "C1/M".
- Mother will be represented by "M", Father by "F", Aunt by "A" and Grandfather by "GF".

All interviews were conducted in IsiZulu and were then translated into English.

4.3 Major themes and sub-themes

From the multiple readings of the translated data, themes and sub-themes emerged. Tables 3 & 4 illustrate these themes and sub-themes.

Major Theme	Sub-theme(s)
Process of discovery	Hindrances: - Threats against disclosure - Cultural Barriers Means of Discovery: - Discovery through observation - Child disclosed to caregiver/other family member - Child victim's voice heard through someone else.

Table 3 Description of major themes and sub-themes.

Systemic levels	Major Theme	Sub-theme(s)
Individual/ Caregiver	Caregiver's reaction to discovery	Psychological/Emotional/Behavioral Reactions
Individual/ Caregiver	Caregiver's fears	HIV infection Adopting the same behaviour Safety Mental Disturbance
Microsystem	Family Reactions	Division Unity
Microsystem	Caring for the victim	Emotional effects Psychological/ Cognitive effects Behavioural effects
Mesosystem	Coping strategies	Counselling/Therapeutic services: -Religion -Family -Friends -Neighbours
Mesosystem	Involvement with formal systems.	Police Officials Justice Officials Medical staff
Exosystem	Difficulties hindering help-seeking	Financial difficulties
Macrosystem	Cultural issues	Traditional "umuthi"

Table 4 Description of major themes and sub-themes - ecological systems theory

4.3.1. Process of discovery / disclosure

4.3.1.1 Hindrances

The process of discovery differed from one caregiver to another and there were a number of factors that hindered this process in the present study.

Threats against disclosure

One of the factors affecting the process of disclosure is when the child is threatened by the perpetrator not to disclose to anyone. According to Richter et al. (2004), threats to victims by perpetrators affect the disclosure or reporting process as the child would not want anything bad to happen to him/her (child) and his/her family. For example, one of the children in this study was hesitant to disclose to her mother that her father raped her because of her father's threats against disclosure:

"She (child) begged me (caregiver) not to tell her daddy…because he was going to hurt me (caregiver)" **C16/M**

Cultural barriers

Another factor that was detrimental to the disclosure process is the child's culture. Cultural issues may inhibit children from disclosure especially in the presence of their parents (Guma & Henda, 2004). In the Nguni culture for example, children do not often receive sex education from their parents before the puberty stage. Therefore children brought up in this culture find it difficult to talk about sex issues in front of their parents. One caregiver in this study heard rumors that her son was raped and to confirm this she had to ask a neighbour to find out from her child:

***"I asked my neighbour to be the one who ask him because I thought he will feel uncomfortable talking to me about it."* (C2/M)**

4.3.1.2 Means of discovery

Discovery through observation

According to Higson-Smith, Lamprecht and Jacklin (cited in Richter et al., 2004), caregivers became aware of child rape through disclosure. However, six caregivers who participated in this study reported that they found out about the rape through noticing signs of physical damage on their children (Lewis, 1997):

***"My mother asked my sister to phone me because they noticed that the child could not walk properly; they thought that maybe she had a boil underneath. ...when we examined her I saw that she has sores in her private part and there was also some dirt that came out of her vagina…"* C1/A**

***"…I am the one who saw her and asked… I usually look at their legs, the way they walk all the time."* C9/M**

In the following excerpt, where a child was observed by her mother to be wetting herself, disclosure came with the price of keeping the information discussed confidential. According to Higson-Smith (in Richter et al., 2004), for children to trust adults with rape disclosure, adults need to comply with children's needs:

"*I said to her if you could please tell me if there is anybody that touches 'mommy's cake', by then I was sitting on the chair and I pulled her up and carried her on my lap. I promised her that I would give her something that I have been hiding in the house.*

She said 'yes mommy there is somebody that is interfering with mommy's cake' (SHE CRIED). She then said 'mommy please don't say it because the person said that I should not tell anyone.'" **C16/M**

There were other symptoms that the caregivers noted that were not related to rape but lead to discovery, as illustrated by the following excerpt:

"I noticed the symptoms, like oversleeping and yet she is the kind of a person who is a light sleeper. …secondly she ran away from her bedroom and slept in another bedroom." **C18/GF**

Child disclosed to the caregiver/family member

Contrary to the findings by Higson-Smith, Lamprecht and Jacklin (cited in Richter, 2004) that the majority of children disclosed to members of their families (commonly their mothers), in this study only two children disclosed to their mothers. In one case, the child did not give a detailed explanation of the incident (the neighbour, the children went to after the incident, confirmed the rape):

"My child told me that there is a person who took them but there was no further explanation. My neighbour said the children came to her crying saying they were stopped by another person, they came holding their pants and underpants in their hands… I asked my neighbour how sure is she that the children were raped. She responded saying she saw their dirty bums. When I asked the children they said he took his penis and put it in them." **C11/M**

According to Higson-Smith, Lamprecht and Jacklin (cited in Richter et al., 2004), children disclose the least shameful incidents first in order to test how their caregivers will react, as indicated in this excerpt:

"'Ma…, do you know that these boys took my books out of my bag and threw them away'. I could see that she was still talking about something that happened on that incident, she was not responding to what I was saying; she was talking about something that happened on Friday. I took her and started to focus on her speech, talking to her. She talked and talked, she finished and slept." **C15/M**

The present findings are consistent with those of Lovett (cited in Lewis, 1997) in indicating that less than one-third of children disclose to their mothers, even though most of the children viewed the mother-child relationship as warm. According to Lovett, the reason for this might be the fact that threats from the perpetrator supersede the warmth from the caregiver.

Child victim's voice heard through someone else.

Consistent with findings from other studies, caregivers in this study learnt of the child rape from different sources such as other children, neighbours, child's siblings

In the studies conducted by Brooks and Higson-Smith (cited in Richter et al., 2004) it was discovered that children often disclose to other children. Similarly in this study there was a caregiver who discovered about the rape of her son through her neighbour's son:

***"…neighbour came to me when I was at home sewing, she said, 'There is something I want to tell you but please stay calm.' I heard …* (neighbour's son) *saying … raped …*(caregiver's son)*…"* C2/M**

A thirteen-year-old sister had the burden of telling her mother of the rape of her younger sister as the younger sister disclosed to her:

***"…my child told her sister what a boy from the neighbourhood did to her. …she then told me what the child told her."* C14/ M**

In another case, the father of the child discovered through the neighbour who witnessed the rapist letting the child out of his house after raping him. The father then informed the mother of the child:

***"The father of the child heard from the neighbour who tried to knock and found the door locked. The brother-in-law of my husband responded. He was asked what he was doing there; he refused to open the door. The brother-in-law thought the neighbour had left but the neighbour was waiting, hiding. When he opened the door my child came out of the house. It was this neighbour who told the father of the child. The father of the child denied this at first because he could not believe that his brother-in-law could do something like that. The child also said he did so."* C12/M**

In two cases the mothers thought that their children were hurt and when they took them to the doctor they were shocked to discover that their child had been raped. For example:

"What came to my mind, I thought it may happen that maybe when the child was playing and got hurt. … the doctors and he told me that the child was sexually abused…" **C6/M**

"…the child would complain every time I bathe her, that it is sore here **(pointing at her vaginal area)** ***for a long time she would complain that it is sore here and I would not take it seriously, I thought she had sores that would heal… the doctor from … told me that someone is abusing the child sexually."*** **C8/M**

There was also a caregiver who discovered over the phone that her daughter had been raped:

"…the police called… They said they wanted to inform me that my daughter is with them at the police station, she wanted to open a case; that she was caught by somebody and he raped her." **C10/M**

4.3.2. Caregiver's reaction to discovery

According to Wade (2001, p.31), people are "complex creatures" and thus react to situations in different ways. The reaction of the caregivers after rape disclosure has an effect on the future well-being of the child victims of rape (Robertson, 1989). Caregivers are identified as important mediators of trauma in their children and the response of the caregivers towards their victimized children affects the child's perception of the rape experience and the recovery process (Anthony, 1986; DeFrancis, 1969; Elwell, 1979; Maclean, cited in Lewis, 1997). Supportive, understanding, warm, and accepting caregivers help child victims of rape through their problems and increase their

competency (Robertson, 1989; Lovett cited in Lewis, 1997). How the caregiver reacts to child rape disclosure depends on their emotional tendencies, and their psychological, and or biological make-up (Bukatko & Daehler, 1998). However, it needs to be noted that it is during the rape discovery that caregivers are usually not able to react in a rational and logical manner, and the best interests of children are not always served. On discovery of the rape of their children, caregivers in this study evidenced different reactions.

4.3.2.1 Psychological/Emotional /Physical Reactions

As raped children suffer some psychological damage, there is a great need for these children to be supported closely (Robertson, 1989). According to Spacarelli and Kim (cited in Bernard, 2001), emotional support from a significant carer can facilitate a child's recovery process. However, with the emotional and psychological reactions caregivers experience, it is sometimes difficult for them to offer this support.

According to Udwin (1993) and Vanderkolk, Perry and Herman (cited in Lewis, 1997), caregivers' reactions on discovery of rape are similar to those of people who have post-traumatic stress disorder. These researchers report that caregivers feel angry at themselves because they were unable to protect their children from rape, and according to Robertson (1989), they also feel guilty in some way for not having figured out that something was wrong. There are also intrusive thoughts and generalized fears that caregivers experience on discovery of rape (Udwin, 1993; Vanderkolk, Perry & Herman cited in Lewis, 1997). These reactions render caregivers emotionally unable to take care

of their children as a result of their own distress. This in turn perpetuates the negative consequences of rape for the children (Robertson, 1989).

Similarly, caregivers in this study also reported having experienced anxiety, disbelief, shame, silence, shock, sadness, confusion, guilt, and somatic reactions such as sleep, and eating disturbances, tension headaches or fatigue on rape discovery:

"I started sweating, I wanted to sit down, I was shaking, I could not control my tears, and my mind was all over the place … I was shivering, shocked thinking how can this happen …" **C2/M**

"From the first time I heard, my mind was disturbed; I was confused, if this happened how it happened. I was absent minded the whole week, thinking of nothing basically, I was always crying…" **C3/M**

"I was very hurt; it was as if it is the end of the world…" **C4/M**

"…I felt pain that I have never felt ever since I was born, pain I have never experienced before. The pain that was in my heart and soul was very deep." **C5/M**

"…I was confused. I could not trust myself the whole of December, I do not want to lie, I did not have even the smallest courage in my life. I was thinking that it would have been better if it happened to me or for him to kill me the way I felt pain." **C6/M**

"…I was a fool and allowed my child to be raped?" **C8/M**

According to Bernard (2001), while in the state of shock and confusion, caregivers are unable to be alert and tend to be incapable of dealing with the situation logically and rationally resulting in the best interests of the child being compromised and the whole family suffering. Robertson (1989) asserts that in order for caregivers to

effectively support their raped children they should find ways of getting over this state of confusion as soon as possible. At least one caregiver from this study tried to do that:

"I was distressed, I cried, I tried to think how I was going to help my child." C9/M

Though caregivers in this study were negatively affected by rape disclosure, they managed to be supportive on rape discovery. According to Elliott and Briere (1994); Berliner and Conte, 1995; Gomes-Schwarts, Horowitz and Cardarelli (cited in Collings, 2005), non-supportive disclosure is when the caregiver/significant carer does not believe the child or blames him or her for the rape. None of the caregivers who participated in this study disbelieved their children and they did not blame them for being raped.

4.3.3. Caregivers' greatest fears

There were four things feared by the caregivers in this study after disclosure, the first one is that their children might have contracted HIV during the rape, the second is that their child (in cases of boys) might do the same to other young boys when they grow up, thirdly that they (caregivers) and their children are not safe from the perpetrator after they have reported the case, and lastly that their children might be affected mentally by the rape incident. These fears can be informed by the caregiver's biological and psychological make-up together with his or her emotional tendencies (Bukatko & Daehler, 1998).

4.3.3.1 HIV infection

Nearly 60 children are raped every day in South Africa (Earl-Taylor, 2002) and the possible reason for such numbers of rape cases, according to Richter (2005), could be the myth that having sex with a virgin cures HIV/AIDS.

With high prevalence rates for child rape, one has a valid reason to worry about the safety of those one dearly cares for. According to van Zyl and Sinclaire (2006), the greatest fear of caregivers of child victims of rape is the HIV/AIDS pandemic. This was evident in the responses of more than half the caregivers in this study when asked what their deepest fears were:

***"… is HIV positive, there is no telling if these children have contracted the virus."* C2/M**

***"What really scared me was that she will contract HIV and some infections"* C9/M**

***"When I heard about this incident I thought that maybe the child has contracted the virus (HIV)."* C14/A**

However, most caregivers in this study were relieved to find out that their children did not contract HI V during the rape incident:

***"They told us that it was negative…"* C/3/M**

***Another thing that helped is knowing that HIV is not in the child's blood because they have done two blood tests."* C6/M**

***"…they said that the child did not get the disease"* C7/M**

There were also those caregivers who were frustrated because they were still waiting for the HIV results of their children:

"They said the child has nothing, but they said after three months she should come back because it happens that the virus hides when it is still new in the body. This troubles me a lot emotionally". **C5/M**

"Even now at the end of the month we have to fetch the final test results and find out what the status is. So it hurts to even think about it." **C2/M**

Thus, besides dealing with the fact that their child have been raped these caregivers were also dealing with the fact that the lives of their children could be changed forever or rather shortened as illustrated by the following excerpt:

"I had that shame that my son is going to die for something he does not know. Ey, it felt so painful!" C2/M

4.3.3.2 The cycle of abuse

There was only one caregiver in this study who was worried that her son, who was raped by a neighbour, would grow up and do the same to other children:

"When I look at my son I wondered if he would grow up and do the same thing to other young boys…" **C2/M**

4.3.3.3 Safety

In cases where perpetrators were not incarcerated, caregivers reported feeling unsafe as they believed that these perpetrators would want to kill them and the child victims in order for evidence to be destroyed or threaten them to withdraw the case. This can be illustrated by the following excerpt:

" I would sleep sometimes in other people's houses, running away from my husband's family who was threatening us, sometimes I would sleep in the bushes, and yet I was sick" **C16/M**

4.3.3.4 Mental Disturbance

The findings from the study conducted by Bernard (2001) reveal that mothers were concerned for the mental and emotional health of their children after they were raped. Similarly, caregivers in this study had the same worries and concerns;

"…mentally she will be disturbed…" **C9/M**

"… I'm not sure whether my child's mind will ever be okay…" **C16/M**

4.3.4. Family Reactions

Rape disclosure not only affects caregivers but the whole family is likely to experience secondary traumatisation as well (McFarlane, 1994). According to Walters (1975), the strain that is experienced by the family of the child victim of rape may affect the family's reaction towards the child victim of rape and his or her caregiver and eventually the recovery process of both the child and his or her caregiver (Pelletier & Handy, 1986,

cited in Lewis, 1997). Ecological systems theory (microsystem level) also acknowledges that the immediate surrounding (such as family) of the caregiver may have a significant impact on how he/she (caregiver) experiences and react to child rape.

According to a study conducted by McCahill, et al. (1979), the mere presence of family members has a positive effect on adjustment of caregivers and, as a result, their children. Robertson (1989) reported that quite often the family is drawn together by the disclosure. Similarly most families in this study were united by child rape disclosure:

"My family helped me a lot. I was not expecting my uncle to be empathetic but he was, he has a very unkind heart, and he is stubborn." C13/M

"My family has no problem; they are on my side at all times, because my sister calls me often to find out if I am doing alright." **C2/M**

"My family has no problem… They were very upset such that the grandmother suggested that we should move from that place, and go live elsewhere." **C4/M**

"…mean my older sister. She was also troubled by this because she would often ask about the case, how everything is going…" **C10/M**

"We decided to call a family meeting, me and my children. We all agreed that we should support the child, so that when the child is at school there would be no problems and the child will not be hurt. Now we are a happy family, the child is alright there is no problem." **C11/M**

"My family also has no problem; they also give me constructive advice." **C11/M**

"The family was supportive, they even took the child. The child was taken by my mother's sister." **C13/M**

According to Bernard (2001), when the rape is intrafamilial the family is struck at the heart and therefore destabilized. Similarly, in this study those caregivers whose children were raped by family members or relatives were disturbed in their functioning as a united system as a result of the intrafamilial rape:

"My family did not say anything, I was the only one attending the court case, and my parents did not care." **C/8M.**

"They are the people I cannot relate to, my sisters-in-law, my brother-in-law and my husband. What we are fighting about is that my brother-in-law was arrested." **C12/M**

"…my husband's family was threatening us (caregiver and her family)…" **C17/M**

"As time went on his (perpetrator's) aunt said all nasty things to us and said that we are no longer related, there is no more a relationship between us. I must no longer come there and they will no longer come into our house." **C19/F**

It should, therefore, be noted that family reactions to rape disclosure, in this study, differed depending on whether the rape was intrafamilial or extrafamilial.

4.3.5. Caring for the victim

According to Jehu (1988), child rape victims are affected by rape in a number of ways and the caregivers observe and are sensitive to these changes these children are going through (Lewis, 1997). As stipulated in the ecological systems theory (microsystem), child rape victims form the caregiver's immediate surrounding. The interaction between the effects of rape on the child victims and the caregiver's biological and psychological make-up will inform how the caregiver takes care of the child victim of rape.

4.3.5.1Emotional effects

Burgess and Holmstrom (1974, cited in Lewis, 1997) state that the emotional response the child rape victims normally manifest is that of fear of being raped again. One of the caregivers in this study supported this view:

"…I would carry him and put him down, consoling him and assuring him that the perpetrator is not there, he was scared. When I asked why he was scared he would say he sees the perpetrator" **C5/M.**

Some of the other emotional reactions child victims of rape experienced, as reported by their caregivers, were that of being tearful and full of anger. These reactions were also reported by Jehu (1988) in his study where he found that two thirds of victims in his study experienced the same emotional reactions. The following excerpt from this study supports the above:

"…The child was crying… he was running around the yard, he was frightened. At night I would wake up and hold him and stay awake till the morning." **C5/M**

"She had changed she has a lot of anger, and she did not want to be sent on errands." **C9/M**

Contrary to the above report, there was a caregiver who reported that her child was laughing all the time, even for things that were not funny; which was strange for the caregiver:

"…He just laughed and laughed and slid down the wall and he fell. Hey, when we were still shocked he started to cry …" **C2/M**

These kinds of reactions seemed strange to the caregivers and thus difficult for them to provide their children with necessary care and support they needed. This resulted in one caregiver reacting in a way that exacerbated the child's problems:

"I used to think this year of the way I always used to hit him, that, maybe in his mind he would think that first he was sexually abused and now at home I hit him, that means he does not deserve to live."**C3/M**

"My younger brother beat her at some stage; she had locked him in the bathroom…" **C9/M**

With all these emotional reactions the child victims experienced one is left wondering how much pain these caregivers must have gone through after discovering what their children were going through alone and the fact that instead of lightening their children's burdens they had added more to them.

4.3.5.2 Psychological effects

Bernard (2001), in her study, found that adults and children experience similar cognitive or psychological reactions to traumatic incidents. These reactions include problems with concentration and lowering of intellectual functioning, especially in school-age children. Similarly, caregivers in this study reported that there were deteriorations in the school performance of their children:

"I have spoken to the principal of my child she complains that the child is not doing well at school… **C9/M**

This caregiver did not know that the child's deterioration in school performance was emanating from the fact that the child had been raped. Therefore, there is a possibility that the caregiver's focus in assisting the child to improve her school performance might be misdirected. And instead of being helpful the caregiver might therefore affect the child even more.

According to Pynoos (1985, cited in Lewis, 1997), the reason for a deterioration in cognitive functioning could be traced to the intrusion of memories and thoughts connected to the rape incident. This means that instead of the child focusing on his/her academic tasks he/she constantly thinks about scenes of the trauma he/she has experienced.

Deterioration in cognitive functioning of the child at school does not always signify that the child has been raped. What happens then to those children whose rape experience is never discovered by any of the teachers or family members? How are they going to receive support and counseling? And does that mean that they will never recover from the traumatic incident because they did not receive any support and counseling?

4.3.5.3Behavioral effects

"…when he played with the other children he was always rough, he used to hurt them. He acted strange when you call him as an adult … he would raise his voice and say yes mom I am here in a very happy mood which was unusual. He would laugh at anything even if it is not funny, he would just laugh. You would send him on an errand he would do it or sometimes he would not do it at all. One day I received a letter from

school inviting me to go and see him. I went. They said he has changed, he has been acting strangely, he does not know whether he is at school, outside in the play ground or in the classroom. He would play with other children whilst the teacher is teaching; he would turn and look the other way whilst the teacher is teaching in class. He would write just one line and he would hide the book and then you will find him sleeping. If I ask him why was he sleeping while the others were writing he would just look at me and laugh…when he comes back from school he does not play with other children anymore." **C2/M**

Her behavior has changed at home; she was so rude in an inexplicable way. She had changed she has a lot of anger, and she did not want to be sent on errands. She liked to stay by herself." **C9/M**

The above behavioral changes that were manifested by the children in this study are similar to the changes from children observed by Eth and Pynoos (1985, cited in Lewis, 1997. Children who were known to be quiet suddenly became rude, those that used to play with other children isolate themselves, and they also tend to be rough with other children.

According to Lewis (1997), caregivers' reactions could play an important role in the effects the rape incident has on their children. However, it should be taken into consideration that caregiver's reactions to their children also depend on rape discovery. There is a high probability that a caregiver who has discovered that his/her child has been

raped will react with support and care as compared to the caregiver who knows nothing about the experience.

4.3.6. Coping strategies

A study conducted by Punamaki and Suleiman (1990) indicates that coping responses of caregivers play an important role in the recovery process of children who have been exposed to traumatic or stressful situations. And the fact that caregivers are not coping with disclosure could affect child victims of rape (Bernard, 2001).

In this study different mesosystem factors proved to be beneficial for caregivers in dealing with rape disclosure. According to Heise (1998), the mesosystem is described as a link between the individual and the social support institutions / systems, that is; neighbours, friends, family (extended), and social services. Following are the mesosytem factors that were utilised by the caregivers in this study:

4.3.6.1 Counselling/ Therapeutic Services

The escalating number of cases of child rape highlights the need for treatment models which are responsive to the psychological effects of trauma towards the victims, their caregivers, and their families (Lewis, 1997). According to Richter et al. (2004) and Meier (2002), therapeutic/counselling assistance received by caregivers alleviates the load on the child rape victims' shoulders. Lewis (1997) provided the following reasons therapeutic intervention is significant for the caregivers:

- Counselling assists in understanding the effects of rape on caregivers.
- They are able to ventilate their feelings around rape in the absence of the child victims.
- They receive education on how to deal with the child victims' behavioural and emotional responses to rape.
- It is in counselling or therapeutic sessions that caregivers get a chance to be supported without being judged.

These coping strategies not only alleviate the effects of rape on the caregivers but also provide a platform for the child victims to receive support from their caregivers and thus recover speedily.

In this study caregivers reported that only children were invited for counselling:

"… they told me to bring the child to them for counselling." **C1/A**

"The nurses told us how to treat our children, and the social workers did the same." **C11/M**

It should, however, be noted that even though most caregivers reported that they did not receive counseling services from other support services, the Treatment centre where the interviews for this study were conducted seemed to play a huge role in assisting almost all the caregivers in this study in coping with the rape disclosure.

"It … helped …they tried to help me by talking to me. From the time I started coming here… I feel my pain is getting better. Although it is still there, but it is not the same as it was before I came to …"C3/M

4.3.6.2 Religion

Counselling or therapy was not the only coping strategy used by caregivers in this study. Most caregivers reported that they also utilised their religion in dealing with life's ordeal (including dealing with the fact that their children had been raped). Out of 19 caregivers who were interviewed, 14 believed that they were sustained by prayers and God:

"They supported me with prayers." **C1/A**

"Prayers also helped me." **C2/M**

"I was helped by my neighbours, they brought me prayers." **C11/M**

4.3.6.3 Family as a support system

The family can serve as another important source of support for the caregiver after rape disclosure (Bernard, 2001). The reason caregivers require this support according to van Zyl and Sinclaire (2006), is to allow them to have an understanding of the needs of their children. Most caregivers in this study reported that they received this kind of support from their families:

"My family…; they are on my side at all times. My sister calls often to find out how I am doing." **C2/M**

"My family also has no problem; they also give me constructive advice. My family used to assemble every evening to pray with me." **C11/M**

"The family was supportive, they even took the child. The child was taken by my mother's sister." **C13/A**

"The whole family is helping me." **C14/A**

However, in cases where the perpetrator is a family member the support becomes complicated as the family might pressurise the caregiver not to involve people from outside the family (for example, police, social workers, etc.) and this in turn affects the recovery process of both the caregiver and the child victim (Bernard, 2001). In the present study there were caregivers who reported that though the perpetrator was a relative they wanted justice to be served and thus had to involve the police and had to take the child to the treatment centre for counselling. They did not agree with dealing with their children's rape matter in the traditional way (sitting down and discussing the matter) which compromised the support they could receive from other family members:

"…they came to us and suggested that we sit down as a family and discuss this matter. …the family does not get along…" **C18/GF**

"They are the people I cannot relate to, my sisters-in-law, my brother-in-law and my husband. What we are fighting about is that my brother-in-law was arrested." **C12/M**

Even in cases where someone who is not a family member, especially a neighbour, is involved there seemed to be a division in the family when it comes to reporting the rape:

"My family ... They had a problem with me opening the case, because they hated the fact that they were going to have to go to court, they also said that this whole matter was going to create enemies between them and their neighbours." **C1/A**

Other caregivers did not receive any support from their families even when the perpetrator was not known to the family (a stranger):

"My family did not say anything, I was the only one attending the court case and my parent did not care." **C8/M**

"…my family… They do not do anything…. my family members … do not call to ask how we are doing, they do not come to visit." **C9/M**

4.3.6.4 Friends/Neighbours

Another support that sustained caregivers in the aftermath of their children's rape disclosure was the reaction of friends and neighbours:

"My friends who know about this are supportive. I did not tell all of them I told only my best friends." **C6/M**

"All my friends support me. They phone me to ask how I am doing. They come at home to check on us. My neighbours are very sympathetic." **C9/M**

It should be noted, however, that not all caregivers were supported by their friends and neighbours. In a case where the perpetrator was one of the neighbours there was a division in the neighbourhood and thus full support was not received by the caregivers from all neighbours:

"…it is neighbours who are like friends to me. There is division with the neighbours. Others are on my side and others on the perpetrator's side." **C2/M**

"The other neighbours are watching the children together with me quite well, except for this only one. All the other neighbours are on our side." **C14/A**

In other cases the caregivers preferred not to disclose to their friends/neighbours about the rape of their child (thus decreasing their support structure) with the fear that they will be ridiculed:

***"My neighbours do not know about this. I did not tell them and I did not want to take our mishap and spread it in the neighbourhood."* C10/M**

There was also a caregiver who did not receive any support from friends:

***"…my friends do not talk to me anymore except one"* C13/M**

4.3.7. Involvement with the systems

In the present study, caregivers expressed their appreciation and dissatisfaction with some of the important aspects at the mesosystem level, for example, SAPS personnel, justice system personnel, and hospital staff.

4.3.7.1 Police Officials

According to Russell (1991), the claim made by the South African Police Service that the number of raped victims is decreasing is not true. The reason the police are making such a claim is that the majority of victims are afraid to report rape incidents to the police for fear of experiencing secondary traumatisation from them (Holmes, 1991; Russell, 1991; Conradie & Tanfa, 2005). Such fears not only affect the reporting level of the victims but the incidence figures as well (van Niekerk, cited in Richter, 2005). In contrast, all caregivers in this study mentioned that they reported the rape incident to the police after the child rape disclosure. This is indicative of the trust these caregivers had on the police, rather than taking the law into their own hands.

Police Response

Even though all caregivers contacted the police for assistance, a number of them were disappointed with the service that was rendered by the police. One of the things they were dissatisfied with was the time the police took to respond to their complaint:

"The police asked where I was and asked them why they have not left the police station as yet, because the boy was going to run away." **C2/M**

"*…they said they were going to come and fetch the abuser, and they did not come."* C17/M

It should, however, be noted that there were at least two caregivers who, after reporting the case, got an immediate response from the police:

"We woke up in the morning and went to the police station at Isiphingo. The boy was taken by the police van at the same time. He was put in jail as far as we know." **C7/M**

"…we then phoned the …police station and they came to fetch him and we had already locked him inside the house." **C17/M**

Ill treatment in the police stations

According to van Zyl and Sinclaire (2006), caregivers and their children go to the police because they are in real need of assistance but instead they are not treated with dignity and the respect they deserve and thus retraumatised. There were caregivers in this study who went to the police station to report the rape and almost all of them were dissatisfied with the service that was rendered by the police. One of them was scolded instead of receiving assistance:

"…we will go to the police station and give a statement about everything… when I got there they shouted at me saying that my child is this and that." C15/M

This kind of treatment is degrading to caregivers and ruins the confidence caregivers have in the police. This in turn will discourage future assistance seeking from the police. It is therefore imperative that the police learn to treat caregivers and their children with empathy, patience, professionalism, and sensitivity if the crime of rape is to decrease (Conradie & Tanfa, 2005, p.8).

No assistance!

Most caregivers reported that they did not receive assistance from the police:

"…the police were very busy… they denied me help, they said the place where the child was raped is not their area, it is an area for … police station." **C5/M**

"Where I got upset is at the police station, because the police refused to open a case saying it is difficult if the child will not say who raped her." **C6/M**

"It was late therefore I went back home. I went back to the police station again the following day. I stayed there till it was time to go home without any help; I used to go absent from work all the time." **C6/M**

"When we went to the police they did not give us any help, they said it was at night they could not help us, we needed to come back the following day." **C13/A**

In terms of the Criminal Procedure Act 51 of 1977 (Conradie & Tanfa, 2005) the police are required to accept all complaints from the public. Thus, the police that were contacted by the above caregivers did not perform their duty.

Feedback on case proceeding

According to van Zyl and Sinclaire (2006), child victims and their caregivers are traumatized by the length of time they have to wait to see justice and this in turn can result in psychological trauma and leave them feeling powerless. Caregivers, in this study, were not only dissatisfied with the police response time and that they received no assistance from the police, but also with the fact that they were not informed of the case proceedings. In cases where the perpetrator was arrested, the police did not make any effort to inform the caregivers of the case proceedings. There were cases where the caregivers would be surprised to see the perpetrator out of jail and would wonder how he got out:

"Ever since I saw him, there has never been a policeman to tell me what happened." **C2/M**

"What hurts is that we last saw the police … at the beginning of this case. They did not give us any feedback about the case … It is this lack of information from the police that upsets me a lot." **C3/M**

"I have not heard anything from them (police) up to today." **C4/M**

"We are feeling very bad, we thought that (pause)…they will contact us when these people were applying for a bail…but they did not." **C18/D**

According to van Niekerk (2003), Childline has dealt with many cases which resulted in charges being withdrawn, where child victims are not afforded the protection of bail and bail legislation is not implemented properly.

To overcome this problem the police should stick to their role as outlined in the Criminal Procedure Act 51 of 1977 (Conradie & Tanfa, 2005) which states that police officials should make sure that the complainant is aware of the case proceedings.

One caregiver, however, reported that they received constant feedback on the case proceeding and were satisfied with the service that was rendered by the investigating officer (police official) responsible for her case. According to her, the officer was updating her of what was happening with the case:

"…the sergeant that was in charge of the case…came home…he said '…these people want this man to be bailed out…I am not going to grant it.'" **C16/M**

Bribery

In one case the caregiver suspected that the police were bribed when he saw the perpetrator out of jail without him receiving any explanation from the police.

"The police was in contact with them (perpetrator's family) only about this matter…we also suspected that they were bribed." **C18/D**

Overall rating of the police service delivery

According to van Zyl and Sinclaire (2006, p.5), "the parents/caregivers of child victims have first-hand experience of the police and are, therefore, in the best position to evaluate the effectiveness of the police in dealing with their children's cases. When the caregivers were asked how they experienced the overall service of the police they were all disappointed with their service with the exception of one:

"I felt very sad. You see in my mind I felt so much pain such that I wished I could have got hold of this guy and strangled him myself. I thought it would have been better not to inform the police and deal with it myself." **C4/M**

"I used to ask myself why the police haven't arrested this man after I had told them about the incident." C15/M

"*……police do not do their job properly … they are slow. It should be you who make the follow up and push them in order for them to perform their duty.* **C17/M**

The one caregiver who seemed to be satisfied with the police service delivery had this to say about the police during the interview:

"…they were so good, they were very good." **C16/M**

The good response this one caregiver received from the police is likely to increase the confidence in the criminal justice system and future reporting of crimes (Conradie & Tanfa, 2005).

4.3.7.2 Justice officials

In this study most caregivers did not mention anything about the service they received from the justice system. Only one caregiver reported that they attended a court case and according to her, the magistrate did not convict the perpetrator because of umuthi that was used by the perpetrator and her family:

"…he got away because they went to a certain Inyanga…when we came there…strange things were happening that were unbelievable…the magistrate was complaining about feeling extremely hot…" **C16/M**

From the interview with this caregiver the following could be the reasons why this perpetrator was not convicted:

- the child victim together with her two brothers gave contradicting statements in court, and
- there was no forensic evidence as the rape crime was reported a while after the child was raped.

Charging the perpetrators

Most caregivers in this study reported having no information on how the case ended. They mentioned that the police would put the perpetrator in jail after the caregivers have laid a charge and after a while they will see the perpetrators out of jail without receiving any explanation from the police officer in charge of the case. According to the findings of this study, only one perpetrator was convicted, the rest are in the community and therefore a danger to children.

4.3.7.3 Medical staff

In their study, Conradie and Tanfa (2005) report that children who have been raped have to go for a medical examination to gather forensic evidence and receive medical assistance. All caregivers reported that they had taken the child victims of rape for a

medical examination after the rape discovery. In one case the caregiver had to go back home because the hospital employee informed her that they were not working on the day she came to seek medical assistance for her child:

"I took her to hospital on a Saturday; they told me that they are not working on Saturdays. It took sometime before I could be able to take her back to hospital, I did not have time, I wanted to take her back on Saturday." **C1/A**

When this caregiver returned to the hospital she was told to go to the police station first for the docket /case number:

When I took her back they said I must first go to the Police Station and open the case and come back with a case number, so that she will be seen by a doctor…" **C/1/A**

However, according to the National Policy Guidelines, quoted in Conradie and Tanfa (2005, p.9); a child may go for medical examination prior to laying a charge for two reasons:

- he/she is not aware of the process to follow, and
- he/she does not want to lay a charge but wants medical treatment.

This means that every victim of rape is entitled to a medical examination irrespective of whether she/he has a case number or not. It was therefore negligence on the part of the hospital staff to chase this caregiver away. Van Zyl and Sinclaire (2006) caution doctors against such acts by advising them to be sensitive when dealing with child rape victims because of the HIV/AIDS pandemic era we live in and the fact that child victims of rape and their caregivers should not be further traumatized by people who are supposed to assist them.

Most of the caregivers in this study reported that they had made a police report first, with some of them being accompanied by the police to the doctor for medical examination. These caregivers did not experience any problems with the hospital staff (doctors). The only problem one caregiver experienced was that her child was told that he tested HIV negative but the results were not in black and white. They told her the results were somewhere in the office but they could not find them:

"They told us that it was negative, we were not shown any paper, they said the papers were here but they were not found (results were missing) but they said the test results were negative." **C3/M**

There was, however, another common problem that was experienced by most caregivers from this study – the fact that they discovered that their children were raped long after the rape incident.

"The doctor arrived and he spoke to the nurse and then he took the child. It became clear that it was going to be a problem because it had been a while since the incident took place. I tried to explain to them that I did not know about this. I just recently found out." **C2/M**

In such cases it becomes difficult for the police to gather forensic evidence that will assist the court in convicting the perpetrator and for the doctors to prevent the likelihood of the child contracting HIV by administering Post-Exposure Prophylaxis (PEP). Post-Exposure Prophylaxis (PEP) is a course of antiretroviral drugs which must be administered within 72 hours after exposure to HIV.

4.3.8. Difficulties hindering help seeking

At an exosystem level it emerged, from the interviews, that the caregiver's financial status also played an important role in the recovery process of the child rape victim.

4.3.8.1 Financial difficulties

A quarter of caregivers from this study reported that they were working, but financially unstable. Another quarter reported that they were unemployed and at least three caregivers reported to be self-employed (informal business), the rest being unemployed. This financial disadvantage impacted on caregivers' ability to respond to the rape incident:

"...I told the doctor that the treatment she is on is not working. He said I must bring the child with me...the public transport will cost more than I can afford since it is the two of us..." **C1/A**

"There was a time when I did not have money, the tablets got finished, I could not go and get some more." **C2/M**

"I used to run short of money to go and seek help. I remember this one time one of my neighbours advised me to go to the social workers but I could not because I did not have enough money…" **C4/M**

"No one works at home. There is no money to go back to the hospital." **C5/M**

"I could not go to the social worker I was referred to because I did not have money." **C9/M**

"...the police called ....I told them that I do not have money for transport and asked them to take her to Mshiyeni and bring her back home. We agreed on that. At 9:30 she was brought back by the social workers in their car." **C10/A**

"…when I had no money I could not be able to bring her." **C18/G**

Not only was seeking assistance from the helping professionals and the police hindered by finances, but in this study there was one caregiver who could not receive support from her family because she could not afford to phone or go to her family to report the incident.

"…I did not go tell them, because of financial circumstances." **C5/M**

One caregiver had to utilize all the money she had for the survival of her child who was raped:

"All the cards from various hospitals are full of my visits (appointments) to all hospitals, King Edward, Albert Luthuli and Mshiyeni. All this makes me realise that I could use the money to buy my children things that they do not have." **C2/M**

The fact that most of these caregivers reside in remote areas, where it was difficult for them to walk to the police stations or hospitals for assistance, made things even more difficult for them.

4.3.9. Traditional medicine/umuthi

Some of the caregivers in this study believed that the perpetrators were not charged because of traditional umuthi.

"It means they want to terminate the case… it means the children will fail to testify in court because of the muti." **C3/M**

"…his aunt used herbs or umuthi so that he could not be charged." **C18/D**

"*…he got away with it because they went to a certain Inyanga…"* **C16/M**

Whether umuthi was really responsible for the perpetrators not being convicted is a question that still remains unanswered.

There were also those caregivers who believed that the perpetrators wanted to harm them with the umuthi they were using:

"I was greatly disturbed by the fact that they are using muthi because in my mind I thought that umuthi does not really exist." **C4/M**

"… if they use umuthi, I trust in God that He is there and He will be there to protect them in everyway." **C3/M**

This belief placed more pressure on the caregivers and their families as, instead of dealing with the rape issue; they had to find traditional ways of protecting themselves from being harmed by umuthi.

4.4 Summary

There were 19 caregivers who were interviewed in this study and the majority of them were the children's biological mothers. However, there were also four aunts, a father and

a grandfather. During these interviews the caregivers reported that children were mostly raped by people they know, particularly their neighbours.

The analysis of interviews revealed that there were caregivers who discovered about the rape through the child's purposeful disclosure and there were cases where caregivers found out about the rape through observing or hearing about the rape from someone else.

On discovery, caregivers in this study reacted emotionally, psychologically, and physically. It also appeared that the rape discovery brought about a lot of fears on the caregivers, which include the fact that the children might have contracted HIV during rape, mental disturbance of a child, both the caregiver and the child being not safe from the perpetrator, and fears that the child might do the same to other young children when they grow older.

The fears and reactions experienced by the caregivers were either exacerbated (because of the division caused by the disclosure in the family) or alleviated (because of the unity created by the disclosure in the family) by the reactions of family members towards rape disclosure.

From the analysis of data gathered from caregivers, it appeared that the caregivers, who received support from the Treatment Centre where the interviews were conducted, played an important role in helping child victims of rape get back on their feet again.

Most caregivers had to make sure that the perpetrators were punished for their actions and their children receive necessary medical assistance. This was not easy as

most of these caregivers were living in remote areas where they had to travel long distances to reach the police and medical doctors. On coming into contact with these systems, the majority of caregivers were not satisfied with the services from the police officials. Though most perpetrators were released on bail caregivers did not express any negative feelings about the justice system. They were, however, pleased with the services of the medical staff. Because most caregivers were struggling financially they ended up not benefiting from these services as they could not reach them.

Cultural issues also appeared to be significant in some cases as most caregivers believed that the perpetrators were using traditional umuthi to escape justice and to harm the complainant and his/her family.

CHAPTER FIVE

SUMMARY OF FINDINGS, CONCLUSION, LIMITATIONS, AND RECOMMENDATIONS

5.1 Introduction

This chapter provides a summary of findings, conclusions and recommendations from the research.

It is important again to consider the aims and objectives of this study in order to establish if they have been achieved. This study's aim was to explore the experiences of caregivers whose children disclose child rape. The objectives of this study were to:

- To investigate the unexplored experiences of caregivers.
- To deepen our understanding of the difficulties caregivers experience in making sense of the rape.
- To explore the ways in which caregivers reacted and responded to the disclosure.
- To explore the ways in which caregivers dealt/coped with the disclosure.
- To assist in developing policies that will help caregivers survive the experience and learn ways to support their raped children.
- To explore how disclosure had impacted on the functioning of the family as a system.

These objectives were achieved using ecological systems theory as a conceptual framework. The researcher relied on non-probability samples using a purposive sampling technique. Nineteen caregivers were interviewed in their own language in the Treatment Centre; this means that there were no communication barriers between the interviewer and participants.

5.2 Summary of Findings

Thematic analysis was used in analyzing data from the caregivers and findings related to the following themes emerged:

5.2.1 Process of Discovery/Disclosure

The process of discovery/disclosure was affected by both the perpetrator's threats to the child victim of rape and the culture the child belongs to. However, in the present study there were a number of means whereby caregivers discovered child rape. Six caregivers noticed signs of physical damage on their children and these included for example, sores on the child's private parts. There were also behavioural changes manifested in child victims of rape, the examples of which were; child wetting himself/herself, oversleeping, child isolating himself /herself from others, and changes in a way the child was walking. On further investigation caregivers discovered that their children were raped. There were only two children who disclosed the rape to their mothers. In six cases caregivers learnt of their children's rape through other people, such as; the neighbour, the neighbour's son, the child's older sister, the doctor who was examining the child, and the police who took the statement from the child.

5.2.2 Caregiver's reaction on discovery

Even though caregivers in this study reacted psychologically, emotionally, and behaviorally to rape disclosure; they were able to be supportive to the child rape victims Reactions to disclosure reported by caregivers included shock, confusion, disbelief, guilt, anxiety, and sleeping and eating disturbances. There were other caregivers who reported that they became ill on rape discovery.

5.2.3 Caregiver's fears

More than half of the caregivers who participated in this study had fears that their children might have contracted HIV during the rape incident. Those caregivers who took their children for HIV testing reported to have been relieved when they discovered that their children tested HIV negative. One caregiver, whose son was raped, feared that he will grow up and do the same to other boys. There were other caregivers who feared for their lives and the lives of their children due to the fact that the perpetrator was not incarcerated. A fear of their children being mentally disturbed as a result of rape was also reported by most caregivers in this study.

5.2.4 Family Reactions

Family reactions to disclosure in this study differed depending on whether rape was intrafamilial or extrafamilial. In intrafamilial rape, it was found that there was division amongst family members and the functioning of the family was disturbed. However, in extrafamilial rape, families were drawn together.

5.2.5 Caring for the victim

The emotional, behavioural and psychological reactions manifested by child victims of rape rendered it difficult for most caregivers to provide the support required by their children.

5.2.6 Coping strategies

In this study almost all caregivers reported that they received counseling services from the Treatment Centre where this study was conducted. Fourteen caregivers were also sustained by prayers and God. In extrafamilial child rape cases, caregivers reported to that they coped with the child rape disclosure because of the support they received from their families; which was not the case with intrafamilial rape cases. Friends were also reported to be another source of strength by

the caregivers. Though there were also those caregivers who received support from their neighbours it was evident that in most cases this support was conditional. When the perpetrator was from the neighbourhood there were divisions amongst the neighbours. There were those neighbours who were on the caregiver's side and those on the perpetrator's side. This resulted in caregivers not receiving full support from their neighbours.

5.2.7 Involvement with the system

All caregivers in this study, except for one, complained about the service they received from the police. According to the caregivers, the police did not take their complaints urgently, they (caregivers) were not respected or treated with dignity, and when the case was opened they (caregivers) were not informed of the case proceedings. This resulted in further traumatisation of both the caregiver and the child.

Most caregivers in this study had no comments when it comes to the service rendered by the justice system personnel. It was also noted, in this study, that only one perpetrator was reported to have been convicted, with most being bailed out of jail and therefore still being a danger to the community.

All caregivers in this study reported that they took their children for medical examination. They (caregivers), however, held different views concerning the service delivered by the medical staff. There was a caregiver who complained about the fact that she was not assisted because she did not have the case number. Another caregiver had to return at a later date as she was told they were not working on that day. However, the overall rating of the medical staff, by the caregivers, was good because children received assistance.

5.2.8 Difficulties hindering help-seeking

The fact that all caregivers in this study were financially unstable and resided in remote areas (far away from the police stations and hospitals/clinics where they could receive assistance) made it difficult for them to seek assistance for their children.

5.3 Conclusion

This study highlights the experiences of caregivers in the aftermath of their children's rape disclosure. According to the findings of this study, caregivers reacted emotionally, physically, and psychologically to rape discovery. What was apparent was the caregivers' fears that their children might have contracted HIV during the rape incident. On rape discovery there were challenges faced by most caregivers in seeking assistance from the police and in taking their children for medical examination. When caregivers got a chance to take their children to the police and for medical examination most caregivers were dissatisfied with the service rendered by SAPS, and a few complained about the medical staff. Most caregivers complained about the difficulties they experienced in caring for the child victims of rape. When it comes to the coping strategies caregivers used, most caregivers seemed to have been assisted by the Treatment Centre.

5.4 Limitations

A number of limitations were identified in the present study and thus the generalisibility of the findings to the entire population is restricted:

- Most respondents lived in rural areas of KwaZulu-Natal and were isiZulu or Xhosa speaking. .Other caregivers from other Provinces, or who are of a different nationality, might provide different insights into the experiences of caregivers in the aftermath of disclosure.

- Only 19 caregivers attending sessions in the Treatment Centre were interviewed, it would have been useful to assess the experiences of more caregivers in other settings.
- The recording of the interviews could affect the natural flowing of the interview, that is; it could lead to caregivers being guarded about what they said during the interview.

5.5 Recommendations

According to Ritcher , Dawes & Higson-Smith (2004), in order for children to be able to answer questions in court they need to be prepared by support services (psychologists, and social workers). It is recommended that caregivers of these children also be prepared with the same support services to deal with the court proceedings as such proceedings may also negatively affect them.

- Most caregivers were not happy with the service rendered by the police; suggesting a need for proper training to be offered to all police officers, investigating officers and civilians who often come into contact with caregivers and their children (victims of rape). The training should focus on how to handle the child victims of rape and their caregivers.
- In the SAPS there are training programmes already existing (that is, victim empowerment and human rights) that focus on how police officials should handle victims. It is recommended that SAPS should identify the number of police officials that have been trained, the impact of these programmes, and (if the impact is positive) provide training for more police officials.
- There were caregivers in this study who were told by the medical personnel that their children (victims of rape) needed to see the police before coming for medical

examination. This is a sign of lack of knowledge on the part of medical personnel. It is therefore recommended that medical personnel be educated on how to handle these cases after rape discovery.

- The majority of caregivers in this study reported that rape was not disclosed by child victims, these caregivers found out from friends, neighbours, or family members. In this context it is recommended that caregivers/community be educated on how to recognise the signs and reactions to rape by children. Such training could usefully include educating caregivers on how to effectively support their children in the aftermath of rape disclosure.
- Caregivers also need to be equipped with parenting skills, (for example assertiveness) to instil them in their children. This will assist their children to be able to speak out for themselves when faced with criminals attempting to rape them. Furthermore, these skills will also help these children to inform their caregivers about rape they have experienced.
- According to the Victims Charter, caregivers/child victims of rape (or any other victim of crime) need to know their rights when it comes to criminal justice process to eliminate "secondary victimisation". This means that they have to access or receive information on the Victims Charter through justice or police officials
- Community members also need to be acquainted with the difference between the duties carried out by the police and justice personnel. This will assist them to know whom to confront for service should they be dissatisfied.
- The majority of caregivers in this study reported that they received assistance from the Treatment Centre and it is therefore imperative that

more of such centres be decentralised to local government levels/structures for convenience and easy access by community. The government should take a lead in the running and marketing of these centres.

- It is also recommended that research, which focuses on child victims of rape from other provinces and cultures be conducted in order to permit comparisons with the findings of this study.

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