FAMILIES IN TRAUMA

The Experiences and Perceptions of the Maternal Caregivers of Children affected by Extrafamilial Child Sexual Abuse

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Declaration

I, the undersigned, hereby declare that the work contained in this thesis, unless specifically indicated to the contrary, is my own original work, and that I have not previously submitted it in its entirety or in part at any university for a degree.

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1 NOVEMBER 2005.

Date

Thesis Supervisor's Approval for Submission

As the supervisor of this thesis, I have approved this thesis for submission.

B.J. Killian (Ph. D.)

Date

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Abstract

Child sexual abuse and its potentially traumatizing consequences, over both the short- and longer term, has been increasingly recognized in the literature as a possible pathway to the development of intra- and interpersonal maladjustment, affecting the mental well-being of those affected. There is a paucity of local research investigating the systemic impact of a child's sexual abuse upon the caregiving and family systems in which the child is integrally embedded. The current research was conducted primarily in response to this, with the intention of illuminating the experiences of caregivers and families managing their child's experience of sexual abuse.

More specifically, the research was interested in the experiences and perceptions of caregivers of children who had been sexually abused by an extrafamilial person. The phenomenological approach informed the planning, implementation, analysis and interpretation phases of the research. The sample included six mothers/ female caregivers who had discovered their child's sexual abuse no less than three months and no longer than twelve months prior to the research being conducted. Maternal caregivers were the primary source of information regarding their own experiences, as well as spokespersons for the caregiving family unit and its members. Two semi-structured interviews were planned for each respondent, the first interview aimed at eliciting their experiences and perceptions, and the second interview aimed primarily at providing debriefing and feedback. In view of the highly sensitive nature of the interview topic, the second interview was structured primarily out of ethical concerns for the respondent's well-being as a consequence of the interviewing.

Results of the interviews suggest that these caregivers were faced with a host of complex experiences related to three broad thematic areas, namely: their involvement with the criminal justice system; managing the child's and family's distress; and themes around coping and support. A number of sub-themes were identified within and across these three broad thematic areas, representing a complex interaction between dominant experiences. Caregivers were typically faced with a series of dilemmas and decisions in their interactions with their child, family, and the criminal justice system. Based upon the findings, a number of suggestions have been made in terms of policy and protocol development for intervening with such families and their children.

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* Pseudonyms have been used throughout this thesis to protect the identities and anonymity of the participants.

List of Tables and Figures

Preliminary Comments

1. Frequently used abbreviations and acronyms

Throughout the text of this study the following abbreviations and acronyms have been used for the sake of brevity:

CSA	-	Child sexual abuse
ICSA	-	Intrafamilial child sexual abuse
ECSA	-	Extrafamilial child sexual abuse
CJS	-	Criminal justice system

2. Use of pseudonyms

Pseudonyms have been used throughout the body of this thesis when referring to the identities of participants. While the pseudonyms have been used primarily to protect personal identities, they have also been chosen so as to reflect the cultural and race groupings of the participant individuals.

3. US style of spelling

The researcher has used the US style of spelling throughout this document for ease of reading.

4. Transcripts of the interviews

Page and line references have been made within this document to the interview transcripts. While not attached, these are available upon request.

CHAPTER ONE
INTRODUCTION

1.1 Child sexual abuse in context

Despite recent increases in public, media and research concern with the phenomenon of child sexual assault, social-systemic interventions aimed at preventing and managing the intra- and interpersonal consequences, and possible longer-term implications of such trauma within our communities, are proving difficult to implement and slow to follow suit. Against the background of poverty and high rates of unemployment, the rapid proliferation of HIV/AIDS, together with the increasing incidence of child sexual assault, creates a unique set of challenges for South African public health strategies. A great number of our children, families and communities are suffering from multiple sources of hardship and trauma, often with few accessible resources for coping. Furthermore, while a great number of our children are predicted to be orphaned as a consequence of HIV/AIDS over coming years, many, too, will be living with the disease as a direct result of sexual assault (Jewkes, 2004). The physical and mental well-being of our children and families is, thus, a pertinent and socially relevant area for ongoing research endeavours.

1.2 Child sexual abuse, caregiving and family systems

While there is an increasing body of research documenting the host of potential, and variable, negative consequences of sexual abuse (both immediate and long term) at the level of the individual child's development (Killian & Brakarsh, 2004), the likely impact on caregivers, family systems and broader community functioning has been somewhat overlooked (Banyard, Englund & Rozelle, 2001). Furthermore, it has also been recognized in the literature that the ramifications of child sexual assault, whether incestuous (intrafamilial) or non-incestuous (extrafamilial) in nature, typically extend beyond the individual to the systems of which they are a part, most notably, the family system (Asen, George, Piper & Stevens, 1989; Browne & Finkelhor, 1986; Davies, 1995; Figley, 1989; Finkelhor & Berliner, 1995; Finkelhor & Browne, 1985; Grosz, Kempe & Kelly, 2000; Kelley, 1990; Regehr, 1990).

Despite the paucity of research into caregiver and family responses to their child's sexual abuse, much of the literature on coping, risk and resilience has recognized the significance of parental, caregiver and family support as an important mitigating factor for negative child outcomes

following child sexual assault (Berliner, 1995; Gomes-Schwartz, Horowitz & Cardarelli, 1990; Kiser, Pugh, McColgan, Pruitt & Edwards, 1991; Rosenthal, Feiring & Taska, 2003; Shochet & Dadds, 1997). Caregiver support and higher parental functioning have been identified as protective factors to the sexually abused child, with caregiver distress being a risk factor for negative child outcomes. The larger family context in which children live and the amount of caregiver and family support received following sexual trauma, can be a powerful mediating factor between the sexual trauma and negative outcomes, with positive caregiver support serving as a protective factor (Banyard et al., 2001). Given these findings in the research, it would seem that efforts to better understand caregiver and family responses to their child's sexual abuse by a non-family member, as well as efforts towards optimizing caregiver's emotional well-being and their emotional availability to the child, would yield positive outcomes at the level of the broader family system.

While individual child counselling or therapy currently presents as one possible mode of intervention following sexual assault, it is the researcher's impression that so often, family members are denied involvement in their child's process, or, are unwilling to participate due to their own feelings of shame and stigma surrounding the abuse. As a result, the needs of such families and their members are commonly disregarded or inadequately addressed. Given the important role that caregivers can play in enhancing the recovery of the sexually abuse child, it is important to examine how the child's trauma can impact on non-offending caregivers and place them at risk for high levels of distress and decreased efficacy in their caregiving functions (Banyard et al., 2001). Using trauma theory as a basis for understanding, some of the research has suggested a process of secondary or vicarious traumatization in caregivers and family members affected by their child's sexual abuse, where their own empathic responses to the traumatized child predispose them to experience similar post-traumatic effects (Figley, 1995, in Banyard et al., 2001; Saakvitne & Pearlman, 1996, in Banyard et al., 2001). Research efforts towards better understanding the experiences of caregivers and family members dealing with their child's sexual assault, and interventions aimed at providing emotional and practical support as well as promoting caregiver and family coping, would go a long way towards appreciating the interpersonal and systemic consequences that are a common consequence following child sexual abuse (Killian & Brakarsh, 2004).

1.3 Parameters of the present research

While the dynamics and repercussions of incestuous, intrafamilial child sexual abuse (ICSA) are complex and profound, it is the phenomenon of non-incestuous, extrafamilial child sexual abuse (ECSA) with which the present study is concerned. More specifically, the present research was interested in elucidating the subjective experiences and perceptions of the caregivers and parents of children sexually abused by non-family members, with a view to exploring possible secondary trauma effects (for a comprehensive description of the research design, methodology and aims, see Chapter Three). The four primary research objectives for the present research included the following:

1. To gain greater understanding of the caregivers' and families' experiences post-disclosure
    a) To explore the meaning of the experience for caregivers and family members
    b) To explore the meaning of the experience for the family system (e.g. in relation to the extended family system; in relation to the community; in relation to prior beliefs and assumptions held by the family)

2. To gauge the traumatic impact and effects of the sexual abuse experience on caregivers and the family system
    c) To explore whether and how the experience has affected caregivers and individual family members
    d) To explore whether and how the experience has affected the functioning of the family system (e.g. in relation to pre-disclosure functioning; in relation to extended family and the community)
    e) To explore whether the caregivers and family system display symptoms of secondary traumatization

3. To explore risk and coping variables
    f) To explore how the caregivers and family have coped since the disclosure
    g) To explore what factors have helped to protect the caregivers and the family system from secondary traumatization
    h) To explore what factors have increased the caregivers' and family's vulnerability to secondary traumatization

4. To describe the implications for families, service-providers and policy-makers
    i) To describe how such caregivers and families may be optimally assisted to survive the experience with minimal traumatization
    j) To describe how such caregivers and families may be optimally assisted to provide the necessary support to their abused child

1.4 Overview of the present research

This thesis will commence with an outline of the relevant literature pertaining to child sexual abuse, starting with the current situation within the South African context. Definitional issues related to sexual abuse, as well as factors pertaining to ECSA and the traumatic impact upon the caregiving family system will then be addressed in the context of previous research (Chapter Two). Thereafter, the research design and methodology will be explicated, with particular emphasis on the ethical issues related to investigating sensitive research topics (Chapter Three). Chapter Four will present the results of the present study, incorporating a discussion in terms of relevant literature. Chapter Five will present a critique of the present research, as well as the implications of the findings for policy development and service-providers. Finally, conclusions will be drawn in Chapter Six.

CHAPTER TWO
LITERATURE REVIEW

Child sexual abuse (CSA), and its potentially traumatizing consequences at both the individual and societal level, has increasingly become a matter of public and research concern. Despite increased attention, however, the development of adequate theoretical and conceptual frameworks for understanding the complex socio-cultural and socio-political phenomenon that is "sexual abuse" has proved difficult. The impact upon the individual, family and broader society needs to be anticipated in the development of resources and services to assist those both directly and indirectly affected. The following review of both international and local research into the fields of ECSA (or non-incestuous CSA) and ICSA (or incestuous CSA) will begin with an introductory overview of child abuse within the South African context. This will be followed by a definition of terms relevant to the current research. Thereafter, a more detailed discussion will follow regarding the impact of ECSA upon the family system. Finally, various theoretical and conceptual frameworks will be presented as a means of understanding the possible secondary traumatic effects of ECSA upon the family system.

2.1 Introduction to CSA in South Africa

2.1.1 The cultural construction of sexual relations

A most significant issue in the context of and in relation to child abuse and, more specifically, CSA is the cultural construction of gender relations and children's sexuality. Sexuality and sexual abuse are profoundly cultural matters whereby norms for sexual relations and for their violation are created within specific cultural communities. Korbin (1990, as cited in Dawes, Richter & Higson-Smith, 2004a, p.3) states that "virtually all societies have proscriptions…on sexual behaviour among related individuals". Adult behaviour towards children is, as such, deeply ingrained in local beliefs about what is good, what is bad, and what is necessary for children. The collection of beliefs and behaviours associated with child sexuality and abuse are entrenched within cultural practices, and while there are a number of similarities, the meaning of sexual abuse is variable across cultures (Dawes et al., 2004a).

Cultural practices also include normative understandings of the power dynamics and relations between men and women. The term "abuse" is fundamentally linked to the notion of power – those with less power have the potential to be abused, whereas those with more power have the potential to abuse it. In patriarchal societies such as our own, where abusive power is frequently sanctioned within culturally defined male rights, abusive relationships between men and women may become so enmeshed with the exercise of power that those wielding it cease to recognize their acts as abusive (Dawes et al., 2004a). When it comes to sexuality, regardless of culture, the defining power of patriarchy and the necessarily subordinate position of women and children are evident. Campbell (1992, as cited in Dawes et al., 2004a) notes that in spite of legislation and norms that denounce sexual acts with children, it is men, with or without the involvement of women, who have the structural and physical power to define sexual relations. In cultures where the masculine identity is constructed and defined in terms of the exercise of power over women and children, the risk of abuse (whether sexual or otherwise) is likely to increase. More specifically it is in contexts such as our own, where the patriarchal ideology of masculinity is so deeply embedded in notions of the inextricable link between sexuality and power, that the subjugation of and discrimination against women and children is likely to be perpetuated.

2.1.2 The context and profile of CSA

CSA needs to be seen within the context of violence against children. Leventhal (1990, as cited in Dawes et al., 2004a) reports that CSA constitutes a limited proportion of all types of child abuse. Under-reporting aside, evidence suggests that significantly more young children experience other forms of neglect and violence than those who are subjected to sexual abuse by more powerful adults and other children. For example, many more children in the southern African region are faced with the chronic hardships caused by poverty. Despite the recent increase in media attention and public awareness campaigns concerning CSA, it is the abandonment, physical abuse, emotional abuse, prostitution, and participation in child labour and armed conflict that continues to place a vast majority of our children at risk (Dawes et al., 2004a; Guma & Henda, 2004).

In May 2002, the following statistics were reported in Parliament for the period of January to September 2001: 15650 cases of child rape were reported to the South African Police Services (SAPS); of these, 5859 (37.4%) children were under twelve years of age and the rest (62.6%)

were twelve to seventeen years of age. Such figures are likely to under-represent the incidence of CSA for reasons of under-reporting and lack of administrative efficiency in the SAPS (resulting in reported cases not being recorded) (van Niekerk, 2004).

In an overview of statistics of reported child abuse over the past ten years, Childline has noted the following trends (Childline, 1991-2002, 2001, 2002 in van Niekerk, 2004):

- A four hundred percent increase in the number of cases of CSA presenting at Childline centers nationally over the past eight to nine years.
- A decrease in the average age of the sexual assault victim. In 1991 the average age of the sexually assaulted child was between ten and twelve years of age. Presently, fifty percent of all children attending Kwazulu-Natal's therapy services after sexual abuse are under the age of seven years. In the Pietermaritzburg center, this percentage rose even further in the first third of 2003 to sixty-three percent.
- A decrease in the average age of the sexual offender. In 2003, forty-three percent of all cases of sexual assault reported to Childline nationally were committed by children under the age of eighteen years.
- An escalation of brute force. Many of the sexually abused children attending Childline therapy centers nationally are also severely beaten and physically intimidated by the person who has sexually assaulted them.
- An increase in the reported incidence of gang rape.
- An increase in the number of children who present with HIV infection after a history of sexual assault, seen across the Childline centers.

In both the international and local literature, the majority of children are reported to be sexually abused by familiar adults – those adults known to and often trusted by the child. These include parents, lodgers, neighbours and other adults responsible for the care of children. Children are sexually abused most frequently in the home and their neighbourhood by people known to them, with caregivers sometimes forming the direct link between the child and the abusing adult or adolescent (Richter & Higson-Smith, 2004).

In a police docket analysis of sexual crimes committed against children between the years 1996-1997 in the region of Gauteng (SAPS, 2001 in Dawes, Borel-Saladin & Parker, 2004b), it was found that:

- Fourteen percent of the time the crime occurred at the child victim's home. Fifty-two percent of the time the crime occurred at the offender's house or that of a person known to the child.
- The majority of offenders were found to be young (between twelve and twenty-five years of age), and ninety percent of all offenders were known to the victim.
- Fourteen percent of the offenders were classified as "parents", although it is unknown whether these included non-biological parents. Twelve percent were other family members. The intrafamilial total is therefore twenty-six percent.
- Thirty-eight percent of the offenders were unemployed. Twenty percent of offenders were school pupils or students in a higher institution.
- Most of the sexual crimes happened over the weekends. Other vulnerable times included during the week after school.
- Alcohol abuse by the perpetrator was commonly associated with the incident.

Thus, data from the docket analysis suggest that people who live near the child, who are acquainted with the child or the child's family, and who have time on their hands pose a particular risk. While the statistics for ICSA are alarmingly high, seventy-four percent of the offenders were not family, although they may have lived in the same household (Dawes et al., 2004b).

Finkelhor (1994a, as cited in Dawes et al., 2004b) notes that international research conducted on retrospective accounts of CSA in non-clinical adult populations places the prevalence of CSA in a wide range. Such diversity regarding prevalence rates also appears to exist within the local South African context. For example, Levett (1989, as cited in Dawes et al., 2004b) found that forty-four percent (44%) of mostly white female psychology students reported childhood sexual abuse. Collings (1991) found that nearly twenty-nine percent (28.9%) of a sample of two hundred and eighty four mainly white male university students reported childhood sexual abuse experiences. Both of the aforementioned studies used a broader definition of CSA that included

both contact and non-contact forms of abuse (see 2.2.1.3). Madu (2001), using a narrower definition of CSA to include only contact forms of sexual abuse (see 2.2.1.3), found a prevalence rate of nearly twenty six percent (25.6%) in a sample of six hundred and forty nine mainly black university students. Of these, nearly twenty-two percent (21.7%) were males and nearly twenty-four percent (23.7%) were females.

In the US, the figures from nationally representative samples of men and women are sixteen and twenty-seven percent respectively. In Britain, the figures for men and women are eight and twelve percent respectively (Finkelhor, 1994a in Dawes et al., 2004b). The question is, however, whether these are real cross-national differences, or a reflection of differing research instruments and research populations. Unless the research instruments are standardized and the research populations equivalent, it is not possible to make accurate comparisons. One such instrument includes the definition of what constitutes an act of child abuse and, more specifically, what constitutes an act of CSA. South Africa still only has a draft policy framework on child abuse and work needs to be done on emerging definitions included in policy documents. The matter is further complicated by the fact that different provinces and agencies use different approaches (Dawes et al., 2004b).

Typically, definitions of child abuse and CSA are overly inclusive and too unwieldy to be of practical use. Furthermore, there also appears to be a trend within definitions of CSA towards emphasis on physical acts, hence undermining the impact of non-contact forms of sexual abuse. Finally, the basis of many definitions is to be found in crime categories (such as rape and indecent assault) – such crime categories are not necessarily the most suitable for defining sexual abuse, and emphasis on serious crimes (such as rape) is likely to reduce sensitivity to less violent forms of sexual abuse. Finkelhor (1994b, as cited in Dawes et al., 2004b) supports this point, noting that comparisons across research studies and social service reporting agencies are problematic when definitions are neither standardized, nor sufficiently precise. Such confusion results in different estimates of the incidence and prevalence of CSA and, consequently, affects service planning. In light of the scope of CSA, it is the pertinent issue of definition that will be further explored in the following section.

2.1.3 The constitutional framework and legislative background

Whilst crime categories are not necessarily the most useful bases for developing comprehensive and practically useful definitions of CSA, the constitutional framework does provide the legislative foundation for ongoing policy development and, hence, more refined definitions of what constitutes an act of sexual abuse. The following section will outline the South African constitutional framework as it pertains to the protection of children and those affected by sexual abuse. Thereafter, various definitions of child abuse and CSA emerging from the non-legislative literature will be presented and discussed.

The South African Constitution affords special protection to children in terms of Sections 28, which constitutes a mini children's charter. It is stated that children have the right to be protected from maltreatment, neglect, abuse or degradation. Further, it is stated that a child's best interests are of paramount importance in every matter concerning the child and that a child means a person under the age of 18 years. In the context of sexual abuse, it is the child's rights to dignity, privacy and security of the person that need to be upheld and protected within laws and policies. In addition, every person is afforded general protections through the Constitution – every person has the right to freedom and security of the person, including the right to be free from all forms of violence from either public or private sources. Furthermore, every person is afforded the right to bodily and psychological integrity. The Constitution as a whole is, thus, geared to protect children, both as subjects of all the rights outlined in the Constitution and as a vulnerable group in need of specific care (Gallinetti, 2004).

In 1995 South Africa ratified the 1989 United Nations Convention on the Rights of the Child (CRC) and in 2000, the African Charter on the Rights and Welfare of the Child (1994). In so doing, South Africa undertakes to incorporate the provisions of these international instruments into domestic laws and to comply with monitoring requirements. Of particular importance in the CRC, is the State obligation to protect the child from all forms of sexual exploitation, sexual abuse and all other forms of exploitation detrimental to any aspects of the child's welfare. More than simply enacting laws to protect children from sexual and other kinds of abuse, the State must also ensure that a holistic, substantive and procedural system is in place to effectively prevent forms of child abuse and, when this is not possible, to support and assist children who are victims of abuse. Although not as specific, the South African Constitution echoes the sentiment contained

in the CRC and has, as such, committed itself to the protection of children who are the victims of sexual abuse (Gallinetti, 2004).

The African Charter broadly obliges State parties to take measures to protect children against all forms of torture, injury, neglect, and maltreatment, including sexual abuse, while in the care of a parent, legal guardian, school authority or any person who has responsibility for the care of the child. The addition of the school authority emphasizes the responsibility placed on schools to care for children in a manner similar to that of a parent or caregiver. In light of the sexual abuse reported to occur at schools, this is a most necessary addition. Like the CRC, The Charter thus places obligation on the State to prevent the sexual exploitation of children (Gallinetti, 2004).

By incorporating the provisions and obligations of the CRC and The Charter into the South African Constitution, domestic legislation will necessarily need to be addressed and efforts made towards ongoing review. The Common Law crimes of importance to CSA include the categories of rape, indecent assault, incest and crimen injuria. As previously noted, there are many restrictions in the legal definitions of such categories, most of which are under review. The Child Care Act No. 74 of 1983 is a piece of welfare legislation to provide for procedures to care for children who are neglected, abused, and in need of adoption or institutional care. Of importance is the section dealing with those circumstances that would result in a children's court (a civil and not criminal court) making a finding that a child is in need of care. Some of the relevant situations include the exposure of the child to circumstances that would result in the physical, sexual or mental abuse of a child, or where the child has been physically, mentally or sexually abused. Such a finding may result in the child being placed in foster or institutional care or, where appropriate, placed back with his of her parents. In addition, the Act prohibits and criminalizes the commercial sexual exploitation of children. However, this piece of legislation is very outdated and, in the context of children, is the one piece of legislation that has frequently been declared unconstitutional. In response, the South African Law Commission undertook a review of the Child Care Act. The resulting report and draft of The Children's Bill in January 2003 is essentially a codification of child law in South Africa. It covers areas such as child protection, children's courts and early childhood development, and deals with the situation of children in need of care. The law reform proposals contained in the draft are currently under review (Gallinetti, 2004).

The purpose of The Sexual Offences Act (No 23 of 1957) is to "consolidate and amend the laws relating to brothels and unlawful carnal intercourse and other acts in relation thereto" (Gallinetti, 2004, p.215). Some of the offences of particular importance to CSA include: procuration (any act by which a woman, usually a young woman or girl, is obtained to become a prostitute or have unlawful carnal intercourse with a third person) (Snyman, 1991 in Gallinetti, 2004); and, sexual offences with youth (often referred to as statutory rape) whereby perpetrators who have sexual intercourse with female children under the age of 16 years, even when the child has consented, are prosecuted. The problem with this section is that the perpetrator is not adequately identified. Furthermore, different ages are set for heterosexual and same sex relationships, resulting in much confusion and inconsistency regarding the ages of children and homosexual and heterosexual acts. Such shortcomings have been addressed in the draft Bill (Gallinetti, 2004).

2.2 Definition of terms

2.2.1 Non-legislative definitions: Child abuse and CSA

2.2.1.1 "Child abuse"

Svevo (1998, as cited in Guma & Henda, 2004) notes the continuing inconsistency and complexity in the definition of what child abuse entails, both within and between countries and in their different regions. As we consider the multitude of ways in which a child may become vulnerable it becomes evident that, despite prohibitions of cruelty and abuse as stated in the CRC, there is considerable cross-national and cross-cultural variation in standards of child rearing and approaches to what constitutes child abuse or maltreatment. Finkelhor and Korbin (1988, as cited in Guma & Henda, 2004) comment that there have been many attempts over the past ten years to set universal standards so as to prevent the various forms of child abuse.

Garbarino and Ebata (1983, as cited in Guma & Henda, 2004) acknowledge that efforts to determine the relationship between what is universal and local in human experience depend mainly on culturally validated definitions of child abuse. Knowing about the variation in interpersonal and family dynamics within and between different socio-cultural contexts may lead to a variety of different solutions to an act defined as "child abuse" – as discussed earlier, the

pattern of socio-cultural beliefs and behaviours considered to be "normal" and "traditional" may perpetuate violence and abuse in a way that is perceived to be customary.

Further, Finkelhor and Korbin (1988, as cited in Guma & Henda, 2004) draw attention to the notion of "personhood" when grappling with the complexities involved in defining child abuse in the international context. Differing norms regarding when and how a child should be endowed with personhood will, no doubt, affect that child's treatment by others in the community. Notions of child abuse thus depend upon culturally validated ideologies and definitions of what constitutes such an act and, hence, the cross-cultural variation in perceptions which we have come to observe (Garbarino & Ebata, 1983 in Guma & Henda, 2004).

Despite cross-cultural variation concerning the defining nature of and responses to child abuse, that we need to protect our children and respond to such reprehensible acts as CSA would seem to be acknowledged by most cultures.

2.2.1.2 "Child sexual abuse"

Although CSA has received increasing awareness from professionals, there is still a lack of agreement regarding its definition (Milner, 1998 in Townsend & Dawes, 2004). Furthermore, Calder (1999, as cited in Townsend & Dawes, 2004) comments that CSA tends to be thought of as a blanket term that covers a range of vaguely defined acts. We commonly think and speak about sexual abuse as if it were one thing, as if all episodes of CSA followed the same pattern, were prompted by the same motivations, and led to the same consequences. Rather, there are several distinct kinds of sexual abuse perpetrated against children. CSA varies by factors such as the features of the event, experiences of the child, duration of the abuse, age of the child, circumstances under which the abuse took place and effects of the abuse on the child and family. Aside from rape, other forms of the sexual abuse of children can involve the full range of human sexuality involving all the senses and various degrees of contact, force, and compliance (Richter & Higson-Smith, 2004). Haynesseman and Krugman (1989, as cited in Richter & Higson-Smith, 2004) note that sexualized attention, or playful sexuality, may be psychologically abusive for children. There is, thus, no one defining act or motivation for CSA.

A number of useful operational definitions of CSA have, however, been constructed in recent years. One such definition is that offered by Finkelhor & Korbin (1988, as cited in Guma & Henda., 2004, p.99) who define sexual abuse as:

> ...any sexual contact between an adult [as socially and physically defined] and a sexually immature child for purposes of the adult's sexual gratification; or any sexual contact to a child made by the use of force, threat, or deceit to secure the child's participation; or sexual contact to which a child is incapable of consenting by virtue of age or power differentials and the nature of the relationship with the adult.

Korbin (1990, as cited in Dawes et al., 2004a) notes that where the purpose of the act is the sexual stimulation of the initiator, then one is speaking of a sexual act. When a child is the object of such attention and the act is deemed as culturally inappropriate, then it is appropriate to speak of the act as sexual abuse. Korbin (1990, as cited in Dawes et al., 2004a, p.4) goes on to say that "child sexual abuse is best conceptualized as the disruption of expected roles, relationships and behaviors".

2.2.1.3 Contact and non-contact forms of CSA

Another widely used definition in the literature is that of Finkelhor, who acknowledges that CSA has two basic elements: "1. sexual activities involving a child, and 2. abusive conditions such as coercion or a large gap between the participants, indicating a lack of consensuality" (Finkelhor, 1994b in Dawes et al., 2004b, p.179). An important element of this definition is that the sexual activities referred to, as in Korbin's definition above, are intended primarily for the sexual stimulation of the perpetrator, even if it involves the sexual stimulation of the child. Because the precise intention of the perpetrator is not always clear, the meaning of the act is always open to interpretation. As mentioned elsewhere, cultural guidelines not only provide rules regarding who may touch whom, how and when, but also assist in distinguishing between behaviour involving a child's sexual organs that has a sexual meaning, and that which does not (Dawes et al., 2004a).

Another important aspect of the definition is that the sexual activities mentioned include both contact (in which the child has some form of physical contact with the perpetrator) and non-contact abuse, within abusive conditions.

Finkelhor (1994b, as cited in Dawes et al., 2004b, p.179) describes contact abuse as being of two types: penetration and non-penetration. "Penetration... includes penile, digital and object penetration of the vagina, mouth or anus, and non-penetration...includes fondling of sexual portions of the child's body, sexual kissing, or the child touching sexual parts of a partner's body". Contact sexual abuse, thus, involves any form of physical contact during the perpetration of a sexually abusive act, and ranges from non-genital and genital touching to vaginal or anal sexual intercourse (Townsend & Dawes, 2004).

Non-contact abuse "usually includes exhibitionism, voyeurism, and the involvement of the child in making pornography. Sometimes verbal sexual propositions are included as well" (Finkelhor, 1994b in Dawes et al., 2004b, p.179). Due to the lack of actual sexual contact between abuser and child in non-contact CSA, Richter and Higson-Smith (2004) note that these are perhaps the most underreported types of abuse. Seldom reported to child protection services, non-contact forms of CSA may serve as a precipitant to other forms of abuse, whereby the perpetrator may be grooming the child for other sexual acts.

According to Finkelhor (1994b in Dawes et al., 2004b), abusive conditions are said to exist when:

> ...the child's partner has a large age or maturational advantage over the child; or the child's partner is in a position of authority or is in a caretaking relationship with the child; or the activities are carried out against the child using force or trickery. (p.179)

Calder (1999, as cited in Townsend & Dawes, 2004) comments that there appears to be emerging consensus, both amongst professionals and laypersons, at the more severe end of the contact abuse continuum. The further one moves away from this extreme however, the more contentious the issue of definition becomes. Calder suggests that one school of thought argues for excluding all forms of non-contact behaviours in the definition of CSA, whilst others advocate the inclusion of the ostensibly benign act of surreptitiously watching a child in private personal situations.

In a comparison of South African studies investigating CSA, Townsend and Dawes (2004) report the variety of definitions of sexual abuse and associated prevalence figures. Two noticeable findings to emerge from this comparison included the lack of consensus around contact forms of sexual abuse, and the greater emphasis placed on contact sexual abuse rather than non-contact

forms. Calder (1999, as cited in Townsend & Dawes, 2004, p.59) comments that whether the behaviour in question includes contact and/ or non-contact acts, a generally accepted definition of CSA includes "any form of non-consenting interpersonal sexual behaviour that poses some risk of harm to the non-consenting individual".

2.2.1.4 Specification and objectification in CSA

Another possible categorization of CSA is between acts or events in which the child's nature, circumstances and features are critical to the selection of the child for sexual expression of the perpetrator, and sexual abuse in which they play little or any role in the sexual act. In the former it is the specific characteristics of the child that influences the perpetrator's selection of that child to sexually abuse. In the latter kind of sexual abuse the child is abused primarily because s/he cannot offer effective resistance to the will and strength of the perpetrator. The difference between what may be termed "specification" and "objectification" in CSA may be illustrated by the paedophile's choice of a psychologically significant child – a child of a particular gender or age, or with a particular shape or dress, at one extreme, and the rape of a baby by a drunk stranger who uses the child as a sexual object or prop at the other extreme. In between are forms of sexual abuse which may appear be based on either specification or objectification, but which mislead us because we have so few descriptive and conceptual tools with which to understand what has happened, or why (Richter & Higson-Smith, 2004).

2.2.1.5 Contemporary developments in definition

As research in the field of CSA continues and authors continue in their efforts to better conceptualize and understand the phenomenon, definitions are becoming more refined and inclusive. According to Tomison (1995, as cited in Townsend & Dawes, 2004, p.59) one definition of CSA that has been widely used is that of Kempe and Kempe (1983). They define CSA as "the involvement of dependent, developmentally immature children and adolescents in sexual activities which they do not fully comprehend, are unable to give informed consent to and that violate social taboos of family roles".

Tomison (1995, as cited in Townsend & Dawes, 2004, p.60) goes on to cite the Australian Institute of Health and Welfare's national definition: "Sexual abuse is any act which exposes a

child to, or involves a child in, sexual processes beyond his or her understanding or contrary to accepted community standards".

Another, even more inclusive definition offered by Sgroi, in Calder (1999, as cited in Townsend & Dawes, 2004, p.61) is the following:

> Child sexual abuse is a sexual act imposed on a child who lacks emotional, maturational, and cognitive development. The ability to lure a child into a sexual relationship is based upon the all-powerful and dominant position of the adult or older adolescent perpetrator, which is in sharp contrast to the child's age, dependency and subordinate position. Authority and power enable the perpetrator, implicitly or directly, to coerce the child into sexual compliance.

Each of the definitions described above progressively attempts to confront difficult issues, such as that of consent. The more inclusive definitions acknowledge that should a child consent, at some ages the child may not have the capacity to understand the implications of consenting to participate in sexual acts. This is more likely below the age of twelve years. There is also emerging recognition of social and community standards within some of the definitions. Finally, Sgroi's definition above addresses the issues of power relations between perpetrator and child (Townsend & Dawes, 2004).

2.2.2 "Family"

When one considers our South African context and what is implied by the term "family" within and across cultural groupings, one realizes that complexity exists with regards definition. Traditional conceptions of the normal, ideal "nuclear family unit" (with biological mother, father and blood-related siblings) are implicitly critical of deviations from this norm, and unhelpful in terms of understanding contemporary variations in family group structures. It is also well known that family relatedness can imply very close as well as rather distant relationships. For various socio-political, health and economic reasons the majority of South African families do not fit neatly into a "nuclear" conception of kinship. Furthermore, traditional distinctions between the "nuclear" and "extended" family have little relevance in light of how the family operates functionally in reality. Rather, it would appear that there exist a variety of possible constellations

that fulfill the role of "family" in terms of providing basic needs, economic support, nurturance, attachment relations, security and relations of trust.

Gittins (1985, as cited in Steyn, 1994, p.3) suggests that the following ideas, phenomena and definitions are common to many families: "co-residence; marriage; power relations between men and women; power relations between adults and children; domestic labour; sexuality and sexual relations; procreation; motherhood and mothering; fatherhood; sibling relationships; definitions of kinship; gender; authority, dependence, service; economic relations".

While this definition would appear to capture some of the roles and meanings associated with "family" a more comprehensive and flexible description offered by Reiss (1965, as cited in Steyn, 1994, p.5) states that the family is "...a small kinship-structured group with the key function of nurturing socialization". Steyn (1994) further highlights the significance of concepts such as "structure", "household" and "co-residence" when considering variations in family structure. It would seem noteworthy that none of the definitions consulted thus far include the concept of "love" in their descriptions of what the family structure provides.

Guma (2000, as cited in Guma & Henda, 2004) notes that from an African perspective, the notion of "family" is understood as an inclusive concept whereby parenthood is understood as a shared social responsibility. Parents are, thus, not just ones biological predecessors but also anyone who is related to one's biological parents and those of their age group and older. As such, all these authorities have rights to command age- and gender-appropriate obedience from child kin.

The proposition by Yorburg (1975, as cited in Steyn, 1994) of a continuum of family structures within the kinship network, ranging from "nuclear" to "extended", is a useful typology allowing for understanding of the variation and dynamic nature of family systems.

2.2.3 "Extrafamilial"

The fact that there is no narrow definition of the concept "family" in terms of biological or non-genetic affiliation has implications for our understanding of the terms "intrafamilial" and "extrafamilial". With regards sexual abuse, "intrafamilial" is typically synonymous with incestuous abuse, implying a biological or genetic affiliation between the perpetrator and victim.

"Extrafamilial" is typically synonymous with non-incestuous abuse, implying no biological or genetic affiliation between perpetrator and victim. The fact that biological relatedness is no longer the singular criterion for kinship or membership to a "family" has implications for understandings of "intrafamilial" and "extrafamilial" based on narrow biological conceptions. Beyond genetic affiliation it is the nature of the relationship between the child and the perpetrator that will determine whether the abuse be termed "incestuous" or "extrafamilial". In terms of the present study, a definition of "extrafamilial" based on a non-incestuous understanding of sexual abuse was adhered to. According to such a definition, the perpetrator is not in a kinship role in relation to the abused child, is not a member of the immediate caregiving family unit, or, is a distant member of the extended family who does not reside in the abused child's home.

2.2.4 "Secondary traumatization"

Traditionally, the term "secondary traumatization" has been used synonymously with "vicarious traumatization" and "compassion fatigue" in literature describing the experiences of mental health workers involved in trauma work. In the literature on sexual abuse, the term has been used to describe the potentially negative and traumatic consequences for the sexually abused child post-disclosure. As Shochet and Dadds (1997) note, systemic factors have been described as possibly providing secondary trauma to the primary trauma. The sources of such secondary trauma have typically been linked to the reactions of the family or broader systems (such as the child's movement through the criminal justice system [CJS]), which exacerbate the child's difficulties (Sadan, 2004; Shochet & Dadds, 1997). Regarding the responses of the child's caregivers or family, Shochet and Dadds (1997) draw attention to the "underresponsiveness cycle" versus the "unresolved grief" response which constitute the polarity of secondary trauma for the child, and which is influenced by and influences treatment decisions. Sedan (2004) cites a definition of secondary trauma as anything that re-evokes the initial trauma in an uncontained way, or an uncaring or unprotected way. It is mostly the child's parents, caregivers or family system that are called upon to minimize such effects by providing the necessary support at the time of disclosure.

The application of this term to understanding the experiences of families affected by a trauma to one of its members has received much support in recent research (Figley, 1989). Particularly relevant is the application of the term "secondary traumatization" to understanding the reactions

of family members affected by the sexual abuse of their child. Research findings of post-traumatic stress symptoms in family members of abused children would lend support for the use of the term in this context (Kelley, 1990; Manion et al., 1996; Manion et al., 1998; Newberger, Gremy, Waternaux & Newberger, 1993; Regehr, 1990; Timmons-Mitchell, Chandler-Holtz & Semple, 1996).

According to Horowitz et al. (1980, as cited in Kelley, 1990), posttraumatic stress disorder occurs in reaction to a major traumatic event and is characterized by intrusive ideas and feelings, ideational denial, and emotional numbing, as well as recurrent or prolonged episodes of depression, anxiety, guilt, shame, and hostility. For the purposes of this study, the term "secondary traumatization" will be used to describe the full range of potential stress and trauma reactions experienced by the family members of children victimized by extrafamilial sexual abuse.

2.3 Parental, caregiver and family responses

2.3.1 Risk and protective factors - Intrafamilial and extrafamilial CSA

It would seem that the more recent awareness of the effects of CSA upon the family system originated in two broad streams of research aimed at determining those factors affecting the short- and long-term impact of sexual victimization on the child. Firstly, in research investigating the risk variables (including family risk variables) that increase a child's vulnerability to sexual abuse and secondly, in research investigating resilience and the protective factors that promote the adaptive coping of the sexually abused child.

2.3.1.1 Family risk variables for CSA

There appears to be consensus in the research that the sequelae of sexual victimization do not form a consistent and identifiable behavioural syndrome, that there is a heterogeneity of possible consequences, and that the short- and long-term effects of sexual victimization on the child vary according to a number of factors (Bal, De Bourdeaudhuij, Crombez & Van Oost, 2004; Shochet & Dadds, 1997; Sesan, Freeark & Murphy, 1986). Some of these factors include the child's age and developmental level, the nature of the sexual abuse, the use of force or violence, and the duration of the abuse. Two further factors significant to this research study include the identity of

the offender and his/ her relationship to the child, and parental or significant other response to disclosure (Bal et al., 2004; Killian & Brakarsh, 2004; Sesan et al., 1986). Some research has shown that those children who are abused by a person external to the family are likely to have greater emotional distance from the offender and, thus, respond with less emotional trauma to a nonviolent assault (Burgess et al., 1978 and Sgroi, 1982b, in Sesan et al., 1986).

Despite the apparent consensus concerning the variable traumatic effects on the sexually abused child, and the broad risk factors identified for the development of severe emotional trauma following sexual abuse, there appears to be some controversy regarding family risk variables. Based upon the studies of Burgess et al. (1978) and Sgroi (1982b), Sesan et al. (1986) conclude that there appear to be differences in the family functioning of intrafamilial and extrafamilial victims of CSA. They state that those families experiencing CSA by an extrafamilial offender are found to be better functioning, less chaotic, and more motivated for treatment. Furthermore, they do not often show a blurring of generational boundaries, seem more able to express affect around the abuse, and are less isolated and more open to outside intervention than incestuous families. Moreover, the issue of divided loyalties is often absent from these families and, thus, there is less threat to family integrity following the process of disclosure. Such observations imply not only that incestuous families are more inherently and premorbidly dysfunctional in nature, but that children and families of ECSA may have different treatment needs from those of the incestuous family.

In their review of three studies aimed at describing the family characteristics associated with ECSA, Gregory-Bills and Rhodeback (1995) reach similar, yet more specific, conclusions. Marital conflicts, disruptions of the family unit, poor maternal relations, and the absence of a parent were characteristics found to be strongly related to ECSA. The absence of the mother was found to be a significant risk factor. In their review of a number of studies investigating the family characteristics associated with ICSA, social isolation, secrecy, and blurred generational and role boundaries are frequently reported. Furthermore, it is noted that children growing up in this type of family environment frequently witness female powerlessness and male dominance and control. These children often take on parenting roles, resulting in problems with their own emotional and social development.

Other research, however, has found the family environments of victims of ICSA and ECSA to be less different than previously thought. In a study aimed at determining whether the characteristics of incestuous families that appear to place children at risk for abuse can also be viewed as risk factors for ECSA, Chandler Ray, Jackson and Townsley (1991) found no statistically significant differences to exist between incestuous and ECSA families along the dimensions of the Family Environment Scale (FES). Both types of families were found to be equally and significantly poorly functioning in comparison to nonvictim control families in which there had been no experience of CSA whatsoever. It was found that those family characteristics associated with sexual abuse appear to reflect a lack of involvement of family members with each other in terms of emotional support, closeness, and activities that would promote children's growth and development. Such a lack of involvement, cohesion and organization could be associated with increased risk of sexual abuse, whether incestuous or extrafamilial. In line with a risk factor perspective on CSA, it is the presence of such factors and characteristics within families that may predispose children towards increased risk for sexual abuse, whether incestuous or extrafamilial. There appears to be an increasing body of research supporting the theory that some of the long-term impacts of CSA are related more to the child's family relationships than the nature and characteristics of the abuse itself (Hooper & Humphreys, 1998).

Similarly, Long and Jackson (1994, as cited in Bal et al., 2004) found that adult victims who had been sexually abused as children, compared to a group of randomly selected non-victims, reported more disorganized and less support-oriented family functioning. Compared to non-clinical groups who did not report abuse, specific types of family dysfunction – such as higher familial disorganization, less cohesion, poor delineation of family roles, lower expressiveness, more conflict, and rigid control – are more frequently reported by both intra- or extra-familial sexually abused victims.

Bal et al. (2004) state that it is not only the relationship of the abuser to the child but also the functioning of the family that can contribute to symptom variety. Considerable evidence now indicates that a cohesive, supportive family environment may not only protect against initial CSA, whether intrafamilial or extrafamilial, but may also serve as a buffer against the negative effect of sexual abuse when it does occur. Bal et al. (2004) acknowledge that while it is often taken for granted that the effect of sexual abuse on the child is more severe when the perpetrator

is a close family member, the severe effects of ECSA reported in the research cannot be discounted. Because abuse-related symptoms cannot unequivocally be related to the perpetrator's relationship with the victim, demographic family variables and the functioning of the family can further clarify the severity of child symptoms. Living with a single parent (which often causes stress due to a single income) or having a stepfather or an absent mother (as a result of work, depression, or drug abuse) are known to be potential risk factors that make families more vulnerable to abuse.

The adoption of an approach towards identifying risk and resilience factors in CSA becomes far more meaningful than any arbitrary and purely descriptive distinction between the terms "incestuous" and "extrafamilial" as indicators of the severity of abuse, likelihood of negative consequences or degree of family functioning.

2.3.1.2 Family protective factors in CSA

The second main stream of research regarding CSA has been aimed at identifying the protective and resiliency factors that aid in the adjustment of sexually abused children post-disclosure. As noted above, while many who have been sexually abused are at increased risk for the development of a number of psychosocial problems (including depressive symptoms, post-traumatic stress disorder, poor self-esteem, inappropriate sexual behaviour and substance abuse) there are variations in the presentation and duration of such symptoms, and many are resilient to the chronic negative effects of such abuse. The concept of resilience is understood as the process whereby individuals who experience traumatic events cope or adjust in ways that are better than expected (Masten, 2001; Rosenthal et al., 2003; Rutter, 1999). Much of the research investigating the variations in children's and adolescents' adjustment post-disclosure has focussed on the characteristics of the social support network as a significant mediating variable, as well as the child's perception of social support and its availability. As with the potential risk factors discussed above, there is a range of potential factors that might contribute to resilience. Nonetheless, as Kiser et al. (1991) note, the literature on CSA suggests that family functioning and support may be intervening variables that may serve to ameliorate the long-term effects of such abuse.

In a study investigating the ways in which social support from caregivers and peers promotes resilience and adjustment in children who have been sexually abused, Rosenthal et al. (2003) found that early emotional support provided by caregivers helps child victims to adjust during the first year following disclosure. Caregiver support, whether general or specific to the abuse, was related to more positive functioning and impacted upon ratings of self-esteem, depression, post-traumatic stress disorder and behaviour problems. Adolescents, however, did not perceive receiving optimal caregiver support, and adolescent girls derived more satisfaction than boys with support from same-sex friends. This appears to reflect not only normative developmental shifts from parental to peer support, but also normative gender differences in the significance of peer relationships. The study concludes that caregiver emotional support acts as an essential buffer against poor adjustment and the development of psychosocial problems following disclosure of sexual abuse, and that caregivers are key to providing effective interventions. It is also noted that clinical interventions aimed at helping parents or caregivers adjust have demonstrated success in improving child outcomes. Hence, interventions need to become aimed not only at the individual child level, but also at the systemic level of parents, caregivers and family systems. Therapeutic intervention aimed at decreasing caregiver distress, working through self- and child blame, and improving the ability to cope with negative emotions and cognitions need to be developed for the sake of family and community mental health.

The main premises derived from the above discussion in relation to caregiver and family responses to the sexual abuse of their child, will be discussed in the following sections.

2.3.2 Caregiver and family secondary trauma reactions

There is growing recognition that the family and broader system can affect both the type and extent of psychopathology and the prognosis for the sexually abused child, and that parental or caregiver support following child victimization is one of the most important variables not only in mitigating child symptoms but also as a predictor of better outcomes in term of adaptive coping and resilience (Berliner, 1995; Gomes-Schwartz et al., 1990; Kiser et al., 1991; Rosenthal et al., 2003; Shochet & Dadds, 1997).

There also appears to be consensus in recent literature that little attention has been paid to the examination of parental and family responses following the discovery of ECSA. The need to

expand our focus beyond the immediate child victims of sexual abuse to their caregivers and families is acknowledged based on findings that these families are at potential risk for experiencing adjustment difficulties and traumatization. Disclosure of ECSA has been found to be a stressful event that alters the balance of the family system, interfering with previously effective coping strategies. Findings suggest that the disclosure of ECSA has the potential to traumatize the entire family system and, hence, the need to include the systemic effects of ECSA as a variable in assessing the psychological impact of CSA (Asen et al., 1989; Berliner, 1995; Davies, 1995; Faller, 1994; Feehan, Farmer, Burnham, Harris & Jamieson, 1995; Feiring, Taska & Lewis, 1996; Figley, 1989; Finkelhor & Berliner, 1995; Green, Coupe, Fernandez & Stevens, 1995; Grosz et al., 2000; Hiebert-Murphy, 1998; Keller, Cicchinelli & Gardner, 1989; Kelley, 1990; Kiser et al., 1988; Kiser et al., 1991; Manion et al., 1996; Manion et al., 1998; Newberger et al., 1993; Oates, O'Toole, Lynch, Stern & Cooney, 1994; Regehr, 1990; Roesler, Savin & Grosz, 1993; Spaccarelli, 1994; Timmons-Mitchell et al., 1996; Tremblay, Hebert & Piche, 1999; Wagner, 1991; Winton, 1990).

2.3.3 Effects of parental or caregiver reactions

A further significant premise recognized in the literature is the association between parental psychopathology and children's mental health (Newberger et al., 1993). With regards to ECSA, research has documented the significant effects of the parental reactions to disclosure on the child's mental health (Davies, 1995). Grosz et al. (2000) describe the family's response to disclosure and their ability to support the child as crucial elements in recovery for the child victim.

Children's perceptions of parental responses are likely to have a significant impact on their coping and adjustment post-disclosure (Manion et al., 1996; Manion et al., 1998). Kelley (1990) notes that sexually abused children incorporate their parents' reactions to the abuse, and the child's perception of the victimization experience (as influenced by caregiver reactions) has been found to be a particularly important determinant of adult functioning (Kiser et al., 1991). Furthermore, Sgroi (1984, as cited in Kiser et al., 1991) found that parents' or professionals' reference to the child as a "victim" seemed to have long-term self-fulfilling effects. Friedrich and Reams (1987, as cited in Kelley, 1990) suggest that symptoms seen in sexually abused children reflect not only the trauma they have experienced directly, but also the family environment, the

child's perception of support, and the level of disruption that follows the disclosure of abuse. In a retrospective study conducted by Burgess, Holmstrom and Sgroi (1978, as cited in Gomes-Schwartz et al., 1990) it was found that many adults, in recalling childhood sexual abuse experiences, believed that the negative reactions of others to the abuse disclosure were far worse than the abuse itself. Thus, the reactions of parents to their child's victimization critically influence the child's reaction and subsequent adjustment.

Research done by Anderson, Bach and Griffith (1981, as cited in Kelley, 1990) found increased behavioural symptomatology in children who encountered negative reactions from their parents, such as blaming the child, compared with victims whose parents were responsive to their needs. Tufts (1984, as cited in Kiser et al., 1991) also found that negative parental responses to disclosure aggravated the primary trauma. In the same study it was also found that positive responses by mothers did not, however, serve to ameliorate the trauma or relate to better adjustment (Browne & Finkelhor, 1986). Similarly, Gomes-Schwartz, Horowitz and Sauzier (1984, as cited in Kelley, 1990) reported that when mothers reacted to disclosure of sexual abuse with anger and punishment, children manifested more behaviour disturbances. In a study of maternal reactions to sexual abuse, Newberger et al. (1993) also found that maternal distress may impede the child's recovery, and that mothers' emotional functioning post-disclosure has implications for the clinical comprehension of the abused child's experience. In a comprehensive analysis of studies investigating children's adjustment post-disclosure as a function of maternal response, Hooper (1992) states that mothers' responses are one of the key factors in children's recovery. She concludes that support from a non-abusing mother is one, if not the most significant factor in uncoupling abuse from both short-term and long-term effects. In agreement with other studies, Hooper acknowledges that while supportive responses from mothers aid in children's recovery, negative responses, such as anger, disbelief and blame significantly increase children's distress.

2.3.4 Common caregiver reactions

Gomes-Schwartz et al. (1990) acknowledge that the occurrence of sexual abuse, whether intra- or extrafamilial, represents a major disruption in the ongoing patterns of interaction between child, family, community and the social environment, and that the disclosure of abuse may precipitate even greater disruption as both family members and representatives of social institutions react to

the knowledge that the child has been victimized. Furthermore, parental reactions to the abuse and its disclosure may be influenced by many factors. Parents' previous experiences with the child may contribute to a supportive, protective stance or an angry rejection of the persistently "disruptive" child. Even in families that are usually able to provide for the child's emotional needs, the crisis engendered may temporarily impair the ability of caregivers to respond sensitively or empathically. Institutional involvement in family life may also evoke anger, defensiveness or blaming of the child. Ultimately, both the institutional reactions and actions, and the family response contribute to the impact of sexual abuse upon the child.

In a review of studies assessing the systemic impact of ECSA, Manion et al. (1996) highlight the persistent psychological distress endured by parents as well as frequent displays of post-traumatic stress disorder and grief symptomatology. Regehr (1990) describes common parental reactions as including post-traumatic stress responses or even a rape trauma syndrome, manifesting in an array of psychological and somatic effects. In a study of parental responses to the sexual abuse of children in a daycare setting, Kelley (1990) found the parents to be highly symptomatic and presenting strongly with evidence of both acute and chronic post-traumatic stress disorder.

In descriptions of parents' initial reactions to the crisis of ECSA, the following emerge frequently in the literature: anger directed at the offender or displaced onto a family member; a desire for revenge towards the offender; guilt regarding the impact on the offender's career and family; feelings of guilt, self-blame and personal responsibility; feelings of ambivalence or anger towards the child; helplessness; vulnerability; feeling a lack of control; depression; panic and anxiety; shock; denial; embarrassment; powerlessness; a desire for secrecy; a shattered sense of safety and trust; fear regarding the impact of investigation and court processes on the child; and fear regarding the future for the child and that they may be harmed for life. Furthermore, the potential for the exacerbation of marital problems has also been recognized, as has the potential for negative effects on parent-child interactions (Grosz et al., 2000; Manion et al., 1996; Manion et al., 1998; Regehr, 1990). Davies (1995) describes the wide variety of reactions from parents of ECSA victims ranging from excessive protectiveness (whether of self, the child, or the family unit) to hostility and rejection of the victim. Results of these studies are based on a combination of self-report measures, interview and observation procedures. The finding by Kelley (1990) that parental stress levels decrease somewhat over time underscores the importance of reassuring

parents that the intense psychological distress they initially experience will decrease with time, adequate support and possibly therapeutic intervention.

Gomes-Schwartz et al. (1990) and Grosz et al. (2000) note the similarity of the parental reaction to typical themes of grief and loss. The likening of the evolution of parental responses to the grieving process is observed with parents typically mourning the loss of innocence of the child. Many caregivers of sexually abused children are observed to move through the various phases of the grief response, including initial shock, denial, guilt and self-recrimination, anger, bargaining and depression before the traumatizing reality can be accepted. Helping caregivers to deal with their own feelings about the abuse is, thus, essential if they are to become allies in comforting and protecting the child. A sensitive attunement to the varying needs of caregivers, whether supportive, educational or both, is therefore required. More specifically, Kiser et al. (1991) recognize the essential elements of family treatment of ECSA to include returning control to the families; increasing cohesion in the family, marriage, and community; normalizing behaviour; building on competencies; and identifying and supporting coping strategies.

2.3.5 Differential caregiver reactions - Acute and chronic

While the above studies speak uniformly of parental or caregiver responses as including the typical reactions of both the maternal and paternal caregivers, researchers have also explored the differential reactions.

2.3.5.1 Maternal reactions

The legacy of the "mother-blaming" myth, and the ethic of blame that has historically been apportioned to women and mothers in the field of CSA (Carter, 1993; Gomes-Schwartz et al., 1990; Hooper, 1992; Hooper & Humphreys, 1998) has resulted in a disproportionate amount of research attention being paid to women's and mothers' responses and subsequent adjustment to the knowledge of their child's sexual abuse (Hiebert-Murphy, 1998; Newberger et al., 1993; Timmons-Mitchell et al., 1996; Wagner, 1991). Earlier notions of mothers' secret complicity and collusion, particularly within the area of ICSA, has been the source of much debate over the years between a traditional systemic understanding of CSA, and the feminist perspective emphasizing the socio-cultural and socio-political factors that enable women and mothers to be held accountable by a dominant patriarchy (Hooper & Humphreys, 1998). While some have attempted

to show that a poor mother-daughter relationship may increase a child's vulnerability to all types of sexual abuse (Finkelhor, 1979 in Gomes-Schwartz et al., 1990), others have argued that laying the blame on mothers is merely an outgrowth of misogynistic cultural attitudes (McIntyre, 1981 in Gomes-Schwartz, 1990). Debate aside, there appears to be not only a relative lack of literature regarding the role and responses of the mothers of ECSA victims, but also the noticeable exclusion of men and fathers in the research on CSA. There is a paucity of data on paternal reactions and adjustment to the ECSA of a child.

Rationale for the continued and exclusive contemporary focus on maternal reactions and subsequent adjustment to CSA typically emphasizes the primary responsibility for parenting that the mother often has, as well as for providing emotional support to the child (Hiebert-Murphy, 1998; Newberger et al., 1993; Timmons-Mitchell et al., 1996; Wagner, 1991). While these studies succeed in highlighting the extensive psychological distress and clinical pathology experienced by these mothers, they do not specify whether the effects found are a result of ECSA, ICSA, or a combination of confounded results. One significant finding in these and other studies (Carter, 1993; Gomes-Schwartz et al., 1990; Hooper, 1992; Kelley, 1990; Kiser et al., 1991) is the increased psychological distress found in mothers with childhood histories of sexual victimization. For those mothers abused as children, the sexual abuse of their child may precipitate a twofold crisis in which they must deal simultaneously with their own unresolved trauma as well as the knowledge that their child has been victimized. Overall, findings suggest that while all mothers of a sexually abused child are at risk for developing clinical symptoms of post-traumatic stress disorder, it is those abused as children themselves who present the greatest risk for experiencing psychological trauma. Social support, however, was found to be a significant moderator of the traumatic effects for all mothers (Carter, 1993; Hiebert-Murphy, 1998; Kelley, 1990; Newberger et al., 1993; Timmons-Mitchell et al., 1996; Wagner, 1991).

In a study of parental reactions to a disclosure of ECSA, Manion et al. (1996) found that the mothers of ECSA victims displayed significantly higher overall levels of emotional distress (relative to fathers and comparison groups) that presented in the clinical range for secondary traumatization. As mentioned in previous studies, explanation of these results emphasizes the mother's role as primary supporter of the child and, hence, the likelihood that her self-esteem is directly related to the parenting role. It is stated that "because mothers' locus of control and sense

of self-worth are more likely to be tied to their child-rearing role, they are more vulnerable to feelings of self-blame, loss, helplessness, and futility to prevent or change what happened" (p.1105). Furthermore, mothers' satisfaction in the parenting role and perceived environmental support were found to be significant predictors of initial maternal functioning following disclosure (Manion et al., 1996).

A useful categorization of the scope of possible effects and consequences experienced by mothers of CSA victims (whether intrafamilial of extrafamilial) is offered by Carter (1993). She recognizes that negative psychological consequences, social consequences and economic consequences following a disclosure of sexual abuse impact in different and significant ways. Psychological consequences include the full range of shock and trauma reactions to disclosure. Many of the women in her study reported impairments in their daily functioning following an initial period of shock and disbelief. Two months post-disclosure many of the mothers reported alternating symptoms of rage and depression, with suicidal and homicidal ideation fairly common. Isolation and a lack of social and emotional support were reported by a majority of the women, with female friends and sisters featuring as the most reliable sources of emotional support. For many, the knowledge that the offender was still at large in the community instilled fears and extreme anxieties for the safety of their children, themselves and their families. For some, these fears were exacerbated by genuine threats on the part of the perpetrators. A further source of psychological distress experienced by most of the mothers was feeling helpless in the face of their child's manifestations of distress and trauma. Many expressed feeling unable (or unsure how) to respond appropriately to, or to console and ease their child's distress. A final source of psychological distress reported by many mothers was their experience of the institutional and judicial response. Many reported feelings of persecution and, hence, strong needs to defend and justify themselves as innocent parties. Finally, it was found that those mothers who had experienced sexual abuse as children reported feelings of re-traumatization and re-victimization upon the news of their child's sexual abuse. This significantly affected their ability to comfort and respond to the child's distress.

The social consequences experienced by many of the women in Carter's (1993) study centered around feelings of shame and guilt, and their feelings of being ostracized in and by their communities. Experiences of isolation and social stigmatization were frequently reported,

together with the expected symptoms of depression. Those who attended support groups, however, reported much benefit from their involvement and decreased feelings of isolation.

Finally, the economic consequences for mothers affected by the sexual abuse of their child were often extreme. While issues of economic dependence affected those (especially unemployed) mothers of ICSA to a greater extent, most of the women did not have viable economic choices after their children disclosed the abuse.

Leaving their place of work was not a viable economic choice for most, especially in single-parent and single-income homes. For many, the work patterns changed as a result of the disclosure, with movement between full-, to part-time, to no work. Those employed mothers who decided to share the information of sexual abuse with employers or colleagues reported receiving little or no emotional support or consideration. A further economic burden expressed by many was the obligation to take the child for professional counselling or therapy. Aside from the direct costs for professional services, transport costs and the costs to their work schedule were expressed as further stresses.

Hooper (1992) refers to the process of "secondary victimization" that many mothers of sexually abused children experience. She defines this process as revolving primarily around the ongoing relationship with the primarily victimized child. Both the actual and the anticipated effects of sexual abuse on the child (as well as the broader disruption of family relationships involved) mean that there are long-term implications for mothers. Most of the women in Hooper's study made comments indicating a sense that sexual abuse was an irrevocable event that would likely affect the child (and consequently themselves) for life. Remer and Elliott (1988a, as cited in Hooper, 1992) note that there are similarities with the accounts of others secondarily victimized in relation to rape and sexual abuse – the adjustment process is painful, long-term and nonlinear, and anger, guilt, frustration and a sense of being trapped are common feelings. In Hooper's study the concept of "secondary victimization" was, however, found to be necessary but not sufficient to represent the meaning of mothers' experiences. Their own experiences of victimization (primary victimization), whether psychological, sexual or physical, were also an important part of the context in which the meaning of the child's abuse for them was constructed. In focusing on victimization it is not intended to attach to mothers a whole identity or status as victim. Rather, as

noted by Kelly (1988a, as cited in Hooper, 1992), victimization is a process which many women and mothers can and do resist. It is also, however, a process which may inhibit their ability to protect their children.

A significant issue raised in the literature (Carter, 1993; Hooper, 1992; Hooper & Humphreys; 1998) is that commonly referred to by professionals as "disclosure". Contrary to the notion of a singular, time-limited event implied by the term "disclosure", the mothers interviewed in the study conducted by Hooper and Humphreys (1998) referred to the process of "finding out" - a complex process that could take place over varying time spans, and an interpretive process involving others both within and outside of the family in which information was often ambiguous, limited and/ or conflicting. The ability to believe that CSA had occurred was found to be inextricably linked with this complex process of "finding out". Discovery, thus, is an active and interactive process that develops over time, often with no clearly definable beginning or end. Hooper (1992) reports that the terms used by mothers to describe the process of "finding out" include "not knowing", "suspecting", and "knowing", all of which indicate the dynamic interactions and negotiations that occur at each level of awareness and the process of change. The phase of "knowing" may still not signify the end of the discovery process as events must still be ascribed meaning, and meanings change over time, influenced by later family interactions, public responses and information as well the mother's own experience. The process of discovery, thus, involves issues of definition - defining what is acceptable and what constitutes abuse along a continuum of behaviour and relationships. As reported in Hooper and Humphreys (1998), the subjective experience of a fragmented, multi-layered state in which contradictory positions could be held simultaneously gives insight into the fluctuation and change experienced by many mothers in this position. The analysis of mothers' process of discovery suggests that assessments that attempt to categorize mothers' experiences around dichotomies – knowing or not knowing, believing or disbelieving, supportive or unsupportive – are inappropriate. Rather, these mothers experience fluctuations in their responses to their children, as they cope with their own emotional distress and the disruption brought to their lives by the discovery of abuse (Hooper, 1992).

While these research findings regarding the reactions and consequences for adjustment are reported specifically regarding mothers and maternal caregivers, one might assume that many of these findings may be generalized to understanding the responses of fathers and paternal

caregivers to "finding out" about the ECSA of their child. This would appear to be an area for further research.

2.3.5.2 Paternal reactions

The scarce literature on paternal functioning following a disclosure of ECSA suggests that fathers are just as likely to experience significant levels of distress. Manion et al. (1996) found that while the fathers in the study did report experiencing significantly more distress, there were no significant differences between case and comparison fathers. Similar results were found in a study by Manion et al. (1998).

Kelley (1990) found somewhat contradictory results, with higher levels of distress found in fathers relative to mothers of ECSA and comparison groups. A distinction is made, however, between the acute and chronic phases of a parent's reaction to the stressor of ECSA. During the acute phase, parents typically deal with feelings of shock, anger, denial and guilt, as well as with their involvement in complex legal, mental health and social service systems. The chronic phase is typically characterized by prolonged, persistent stress symptomatology clinically recognized as a form of post-traumatic stress disorder. The sexual abuse of a child may be experienced by caregivers as chronic due to the long-term impact on the child, the need for extended therapy, and in many cases, lengthy legal proceedings that may prevent the family from achieving closure on the event.

In comparison to mothers who reported immediate stress reactions, it was noted that fathers in the study (Kelley, 1990) may have been experiencing a delayed stress response and, hence, increased levels of distress found at the time of the study (on average, one year post-disclosure). This gender difference in the onset of parental stress reaction is explained in terms of the greater difficulty fathers may have in expressing and discussing their thoughts and feelings related to their child's victimization and/or because of a tendency to put their reactions aside in an effort to better protect their family. Manion et al. (1996) lend support for this theory as an explanation of results in their study. Grosz et al. (2000) also note that some fathers in their study appeared to experience a delayed emotional response and dealt with their feelings only after the mother had made progress in recovery.

Overall, the research on ECSA highlights the acute and chronic stress endured by many parents or caregivers in such crisis, and the real potential for the development of secondary traumatic stress responses.

2.3.5.3 Reactions of non-abused siblings

While it is frequently stated in the literature that ECSA has the potential to traumatize the entire family system, it is interesting that only one study (Grosz et al., 2000) examines the impact on non-abused siblings in cases of ECSA. In this study it was found that siblings often felt much guilt about the sexual abuse, with many feeling responsible for not protecting a younger sibling. For those siblings who knew the abuser, ambivalent feelings of anger, sadness, loss or confusion about this person frequently emerged.

Kiser et al. (1991) note that despite the very little specific research conducted on how siblings cope with their siblings' alleged ECSA, inferences can be drawn from studies of chronically ill children. Among siblings of the handicapped, one more frequently finds negative self-image, high anxiety levels, academic difficulties, somatic complaints, and behaviour problems. McKeever (1983, as cited in Kiser et al., 1991) comments that these adjustment problems are related to global family depression and anxiety, social isolation by the family, efforts to decrease the parents' demoralization, preoccupation, and emotional distance, and efforts to protect the family's image by pretending as if all is normal. In such families, some siblings may move into caretaker roles, moving from sibling rivalry and moving toward sibling rescue and even parent rescue (Penn, 1983, in Kiser et al., 1991).

It would seem that more attention needs to be paid to sibling reactions as well as parent reactions if the full familial impact of ECSA is to be examined.

2.4 Theoretical orientations

It is frequently acknowledged in the literature that one of the main shortcomings of research in the area of CSA, whether intra- or extrafamilial in nature, is the lack of a comprehensive theoretical and conceptual framework to guide understanding of child, caregiver and family reactions following disclosure (Feiring et al., 1996; Ligezinska et al., 1996; Manion et al., 1996; Manion et al., 1998; Regehr, 1990; Spaccarelli, 1994; Veitch Wolfe, Gentile & Wolfe, 1989;

Winton, 1990). The tradition of research into CSA and its effects upon the family system has its roots in a systemic approach, with a more exclusive focus on intrafamilial dynamics and effects. Very little research has examined the familial effects of ECSA and, hence, more specific theoretical frameworks for understanding the experiences of these caregivers and families are scarce. In the following section, an overview of some of the more popular theoretical frameworks for understanding and conceptualizing the etiology and consequences of CSA will be discussed. This will be followed by a more specific discussion of the concepts and theoretical frameworks pertaining to ECSA.

2.4.1 The etiology and impact of CSA

2.4.1.1 <u>The family systems tradition</u>

Finkelhor (1986) notes that family systems thinking, together with the ensuing feminist perspective, has done much to aid the recognition of the problem of CSA – an area which had been apparently neglected and undetected for years. From its inception, the family systems approach has considered symptomatic children and realized that they might be expressing more fundamental problems originating with parents or other individuals in the family system. Within the field of CSA, this realization paved the way for more specific attention to those families affected by ICSA. Furthermore, family systems theory served as an important alternative to the traditional psychoanalytic views, which long obscured the problem of sexual abuse by its exclusive intrapsychic focus on the child. The family systems approach focuses on patterns of interaction within families, with a particular emphasis on communication and the psychological roles adopted by family members. The view of causality as circular, involving all family members is central. In this model sexual abuse easily becomes seen as an individual response, and hence secondary to shared problems such as poor communication. With the aid of concepts concerning the dynamics of secrecy, blame, enmeshment and blurred boundaries, family systems theory provided a model of the "classical" incestuous family which aided many therapists and child welfare officials at the time in the identification of such families. Such family systems concepts have also had a great influence on the process of therapy with and the rehabilitation of sexual abuse victims and their families (Finkelhor, 1986; Hooper, 1992; Hooper & Humphreys, 1998; White & Klein, 2002).

Despite its many important contributions, however, the family systems approach (also referred to as the "family dysfunction model") has come under increasing criticism. As mentioned earlier, the feminist perspective emerged in the 1980s with the aim of disaggregating the family, and conceptualized CSA within the framework of the abuse of power by the (usually male) offender, supported by a conductive socio-cultural context (Hooper & Humphreys, 1998). Criticisms of the limitations of the family systems approach have focused on a number of areas and assumptions. Firstly, one limitation concerns the scope of family systems analysis. While the family systems approach has focused almost exclusively on the problem of father-daughter incest, this has been found to constitute a surprisingly small proportion of sexual abuse cases. Research has consistently found the largest amount of sexual abuse to be committed by persons known to the child, but not related, such as neighbours, family friends, teachers, ministers and babysitters. The traditional family systems approach has not often addressed these other types of abuse. Furthermore, the sexual abuse of male children is not consistently addressed within the scope of the family systems approach (Finkelhor, 1986; Hooper & Humphreys, 1998).

A second premise of the family systems approach that has come under reconsideration includes the strict distinction it has encouraged between ICSA and ECSA. The distinction is based on a presumption that dynamics in ICSA will be very different as they involve more intense betrayal of the child and more serious conflicts of loyalty among family members. This division of the field has some justification but can be overdrawn. As discussed earlier, some ECSA has dynamics similar to ICSA, and visa versa. For example, a child's molestation by the family doctor or trusted family friend can provoke the same crisis of loyalty in parents and family that occurs when a child reports abuse by an uncle or cousin. In many cases, the position of trust of such extrafamilial offenders towards the child and family can be closer than in the case of the uncle or cousin (Finkelhor, 1986).

Another question that has been raised is whether the family systems approach gives an adequate account of the sources of offender behaviour. The implication of much family systems analysis is that sexually abusive behaviour grows out of a matrix of family dynamics, and that it is an adaptation to some type of whole family dysfunction, rather than any deviant tendency in the father. Some available findings suggest that such explanations may not be sufficient, however, and that there are broader sources to even father-daughter incest, including the possibility that

many incestuous abusers would be inclined to abuse independent of family dynamics. Research findings suggest that a simple family systems analysis of incestuous behaviour may be too narrow in many cases, and need to be supplemented with individual analysis of the offender (such as whether a pattern of emotional or personality disturbance exists, or whether there is an extensive criminal history which may contribute to the incest behaviour) (Finkelhor, 1986).

Finally, the family systems approach to sexual abuse has been examined for its implicit value judgements. Some critics, such as the feminist movement, have maintained that the analysis not only exaggerates the role of the mothers, but often places moral responsibility for the abuse on them (Finkelhor, 1986; Hooper & Humphreys, 1998). As Zaphiris (1978, as cited in Finkelhor, 1986) notes, the behaviour of mothers in incest situations can be just as easily accounted for by viewing the mother herself as a victim – trapped in an oppressive role to start with, and then faced with an impossible dilemma which may be easier to deal with via denial.

Hooper (1992) notes that there are now theorists who attempt to combine family systems thinking with feminism, recognizing the different experiences of individuals within families, the significance of gender and power in family/ household relations, the plurality of family/ household forms, and the interconnectedness of conflict and inequity within the family/ household with structural inequalities in the wider societal context.

2.4.1.2 The four pre-conditions model of sexual abuse

One such theory, developed to explain both ICSA and ECSA, which has become widely accepted by many professionals, is that suggested by Finkelhor (1984, as cited in Finkelhor, 1986). In an attempt to expand the analysis of sexual abuse beyond the limitations of the family systems approach while still maintaining some of its insights, Finkelhor developed the Four Pre-Conditions Model in an attempt to consolidate the variety of factors that have been found to contribute to the occurrence of sexual abuse both within and outside the family (Finkelhor, 1986; Hooper, 1992).

The model proposes four pre-conditions that must be fulfilled for CSA to occur. A potential abuser first needs to have some motivation to abuse a child sexually. Finkelhor (1986) states that there are three components involved in this motivation: a) emotional congruence, whereby

relating sexually to the child is motivated by the satisfaction of some more important emotional need. This may include the desire to feel powerful and in control in sexual relationships, or the need to remediate some early childhood abuse by re-enacting it in the role of the abuser; b) sexual arousal, whereby the potential offender finds children to be unusually sexually arousing; and c) blockage, which implies that alternative sources of sexual gratification are not available to the potential offender, either because of internal conflicts or the absence of a partner. Finkelhor (1986) notes that while not all of these components are necessarily present in the motivational systems of all abusers, there is some combination found in all.

The second pre-condition to be fulfilled is that the potential offender has to overcome internal inhibitions against acting on that motivation. Finkelhor (1986) mentions such things as alcohol, stress, learned rationalizations, culturally weakened taboos and personality factors such as impulsivity that may explain the overcoming of internal inhibitions in some individuals.

Thirdly, the potential offender has to overcome external impediments to committing CSA. Such environmental restraints are undermined when, for example, children are poorly supervised by parents, are isolated, or when offenders have unusual opportunities for access to a child because the child is alone or housing conditions are crowded (Finkelhor, 1986).

Lastly, the potential offender or some other factor has to undermine or overcome the child's possible resistance to sexual abuse. Finkelhor (1986) states that while some children simply have personalities or demeanours that discourage abusers, others may actively resist the abuse by declining ploys, fighting back or running away. Those factors that may undermine a child's ability to resist may include emotional insecurity, lack of knowledge about sex, or a relationship of great trust with the abuser.

Explanation of the occurrence of sexual abuse requires addressing, first, all four pre-conditions and second, the interaction between individual, familial and societal factors at each stage. Advantages of the model include its adaptability to all types of sexual abuse, its incorporation and expansion of many of the insights of the family systems approach, and the possibility for greater focus on dynamics within the offender. The model places greater emphasis on the emotional meaning of the sexual activity for the offender and on the possibility that a deviant

pattern of sexual arousal plays a role. Furthermore, it places some focus on the important issue of inhibitions, and offers helpful perspective on the issue of "responsibility" (Finkelhor, 1986; Hooper, 1992). Regarding the position of mothers, Hooper (1992) notes that because offending behaviour can commonly be traced back to adolescence (before the marital relationship was formed), the part mothers play if this model is adopted is at the third and fourth stage, via the child's supervision and vulnerability. Any contribution women's relationships with their children make to the child's vulnerability is, thus, significant only after the abuser is motivated to abuse and has overcome his own internal inhibitions.

MacLeod and Saraga (1991, as cited in Hooper, 1992) have questioned this model, arguing that the third and fourth pre-conditions do not belong within the area of explanation since they are concerned with how and not why offenders abuse. To some extent this is true, but since offenders often target children they perceive to already be vulnerable, the child's prior emotional security and supervision may bear some relation to why that child at that time. A more productive way forward than altogether rejecting the question of why some children are more vulnerable than others would be to locate it in a broader context than the mother-child relationship, as well as recognizing that much greater priority should be attached to why offenders abuse. All children are vulnerable to adults to some extent, and no child is supervised all the time. While some children are less supervised and more vulnerable than others, not all of them are sexually abused, and some are sexually abused despite close supervision and close relationships with their mothers.

2.4.1.3 The impact of CSA – A conceptual framework

Extending upon models such as those presented above, Gomes-Schwartz et al. (1990) have presented a useful framework for understanding and conceptualizing the complex factors that influence the impact of sexual abuse upon the child and family. Their framework focuses on the complex relationships between factors in the child's development prior to the sexual abuse; the nature of the sexual contact; the manner in which the abuse was disclosed; the reaction of others (especially family members and community agencies such as protective services and courts); and the interventions that occurred after the abuse was disclosed.

The three major components of the framework include pre-existing conditions, the sexual abuse, and reactions to the abuse. Within each of these components, a number of variables are presented which either directly or indirectly influence the impact of the experience (Gomes-Schwartz et al., 1990).

Those pre-existing conditions of significance to understanding the impact on the child and family include: factors relating to the social environment (such as the availability of resources for aiding families in distress); factors relating to the child (such as the child's developmental stage and course of development, pre-existing psychopathology, a history of emotional deprivation, intelligence etc.); and factors related to family functioning (such as parental psychopathology, family disorganization, hostility versus warmth towards the child, the ability to provide adequate nurturance etc.). These three factors are represented to interact with each other and exert mutual influence. They are represented to influence not only the vulnerability or predisposition to sexual abuse, but also reactions to the abuse (Gomes-Schwartz et al., 1990).

Variables pertaining to the sexual abuse itself include the duration of the abuse, nature of relationship with the offender, the use and degree of violence, the type of sexual activity, the method for gaining the child's compliance, and the interval between the abuse and disclosure. Such factors are indicators not only of the severity of the abuse, but are also theorized to influence the nature of response and the ultimate impact (Gomes-Schwartz et al., 1990).

Finally, Gomes-Schwartz et al. (1990) describe the reactions to the abuse to include both institutional reactions and family responses. The significance of parental or caregiver reactions to the child's ultimate adjustment has been discussed elsewhere. Variables influencing family responses may include the presence of accusation versus support, denial versus acknowledgement, allegiance to the child versus to the offender, and the ability to protect the child. Institutional reactions refer to the actions of protective services, the actions of law enforcement agencies and court personnel, medical procedures etc. As has been suggested in the literature, many of the actions that occur post-disclosure may be more stressful than the sexual abuse itself. The removal of a child from the home may, in fact, contribute towards greater self-blame and feelings of responsibility for disrupting the family. Similarly, interventions by police

and court personnel may also have the potential for further increasing the trauma (Gomes-Schwartz et al., 1990).

It would seem that while this model incorporates a systemic understanding not only of the conditions which may contribute to a child's vulnerability to sexual abuse, but also to the consequences which affect the impact on and subsequent adjustment of the child, the model may lack applicability to understandings of family responses. Furthermore, attention to the perpetrator characteristics and motivations is not acknowledged. When considered together with Finkelhor's (1984) four pre-conditions model, however, a more comprehensive understanding of the many complex and interrelated factors at play in CSA emerges.

2.4.2 Theoretical frameworks pertaining to the familial effects of ECSA

There are a number of concepts from the literature on psychology and psychopathology that have been applied to the understanding of parent, caregiver and family reactions to ECSA. Some of these have been used and implied throughout this review. In the following section, three major frameworks will be discussed with relevance to the familial effects of ECSA.

2.4.2.1 The loss model

As mentioned elsewhere, the similarity of the progression of parental reactions to the process of bereavement and grieving has been observed in the literature on ECSA (Gomes-Schwartz et al., 1990; Grosz et al., 2000; Hooper, 1992). Based on Kubler-Ross's (1981) model of the process of bereavement and grief response following significant loss, many parents of sexually abused children have been observed to pass through similar stages of shock, denial, guilt, anger, bargaining and depression before the reality of the abuse is eventually accepted. Typical themes of grief and loss have been observed, with parents not only mourning the loss of innocence of the child, but also the loss and failure of their ability to protect their child (Kiser et al., 1991). As noted, grieving is a process and the sources of loss multiple and ongoing (Hooper, 1992). Many parents are reported to perceive and grieve multiple losses in the aftermath of disclosure, including losses of the ideal child, family, church and community (Kiser et al., 1991).

Remer and Elliott (1988b, as cited in Hooper, 1992) suggest that every child or adult who is raped or sexually abused may have on average three significant others who are affected with

grief-type responses, and who commonly include the main sources of support for the person victimized. These people may be seen as secondarily victimized, and their process of recovery does not necessarily match that of the person primarily victimized. As Remer and Elliott note, relationships are vulnerable to breakdown from the mismatch between the recovery processes of those primarily and secondarily victimized. As discussed earlier, the concept of "secondary victimization" involves the ongoing relationship between the parent/ caregiver and siblings (the family system), and the primarily victimized child. As such, it would seem to provide a useful intermediary conceptual link between the concepts of "loss" and that of "secondary traumatization".

Losses which disrupt the pattern of attachments within which people construct the meaning of their lives, disrupt the ability to experience life as meaningful and induce grief, however rational the changes may seem from the point of view of someone with other attachments (Marris, 1986 in Hooper, 1992). In her study of maternal experiences and responses post-disclosure, Hooper (1992) reports a sense that a whole world view was shattered and threatened, that the assumptions of shared understandings, trust and predictability of behaviour on which everyday life and interaction depend, had been overturned. As such, recovery from grief involves reconstructing meaning by rebuilding the continuity of life, making sense of what happened and assimilating it into the present situation in a meaningful way.

Myer (1984, as cited in Hooper, 1992) suggests that pathological grief outcomes result when the individual becomes stuck in one of the stages of bereavement, such as never overcoming the stage of denial. Marris's (1986) conceptualization, however, of grieving as a process involving the need to reconcile conflicting impulses acknowledges that "stuckness" is not necessarily experienced as a single emotional state, but may involve a combination of denial, anger, guilt and depression. The central conflict for those in the process of grieving involves the simultaneous desires to return to a time before the loss occurred, and to reach forward to a state of mind where the loss is forgotten (Marris, 1986, in Hooper, 1992). Where grief is unresolved, the conflicting claims of past and future are unreconciled, with an often idealized view of the pre-abuse past, a desire for vengeance for the future, and a sense of little or no meaning in the present (Hooper, 1992).

Marris (1986, as cited in Hooper, 1992) describes the process of working through the grief towards ultimate reintegration as a process whereby the conflicting impulses are reconciled by extracting from the past it's meaning for the present. Marris suggests four types of conditions that may affect the ability to reconstitute meaning. Firstly, the person's own experience of attachment in childhood may influence their general sense of security and resilience in the face of loss. Egeland et al. (1988, as cited in Hooper, 1992) found that women who were aware of their own past history of abuse and how it had affected them were less likely to have child care problems later than those who were not. Secondly, the more conflicted, doubtful or unresolved the meaning of what has been lost, the harder it is likely to be to reconstitute meaning in a way which successfully disengages emotion and purpose from irretrievable circumstances. Thirdly, the less opportunity people have to prepare for a loss, and the less predictable and meaningful the event itself, the more traumatically the whole structure of meaning will be disrupted and the more insecure all attachments will seem thereafter. Finally, events after the loss may either support the process of recovery, encouraging the ambivalent impulses loss induces to work themselves out, or frustrate it. In the aftermath of CSA, many caregivers are immediately faced with instructions, expectations, and often disbelief or blame.

With regards to the reconstruction of meaning and the re-establishment of the continuity of self, Breakwell's (1986) typology of coping strategies in response to threatened identity is another useful model for coming to terms with loss (Breakwell, 1986, in Hooper, 1992). As such, coping strategies are defined by their goal, as ways of preventing, avoiding or controlling distress. When identity is threatened, coping strategies are adopted which either deflect or accept the threat. This may involve a variety of responses that change the situation that causes distress, change the meaning of the situation, or control the stress once it has occurred. As Breakwell states, "Any thought or action which succeeds in eliminating or ameliorating threat can be considered a coping strategy whether it is consciously recognized as intentional or not" (Breakwell, 1986 in Hooper, 1992, p.34).

From the above discussion on significant loss, the process of bereavement and grieving, and the resolution of grief, certain implications for intervention emerge. Validation of the experiences of and responses to loss experienced by parents, caregivers and siblings would seem essential in the aftermath. It would also seem that family members need to be allowed time to work through the

conflicting impulses of resistance and adaptation that grief involves. Furthermore, Hooper (1992) notes that continuity in the areas of life not directly affected is an important factor in coming to terms with loss.

2.4.2.2 The post-traumatic stress disorder model

Post-traumatic stress disorder (PTSD) and, hence, the derivation of secondary traumatic stress effects, is a commonly used conceptual framework from which to study the effects of ECSA on the family system. According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) (American Psychiatric Association, 2000), the diagnostic criteria for diagnosis of this condition include symptoms of persistent re-experiencing, avoidance or numbing of general responsiveness, and increased arousal (see Appendix A for the full diagnostic criteria of PTSD). By comparison, Acute Stress Disorder is defined in the DSM-IV-TR (American Psychiatric Association, 2000) to include symptoms of dissociation, re-experiencing, avoidance and increased arousal or anxiety, with a potentially more immediate and acute onset (see Appendix B for the full diagnostic criteria of Acute Stress Disorder).

As discussed previously in this review, there is much evidence to support the application of a PTSD framework and, hence, the concept of secondary traumatization to the post-disclosure experiences of caregivers whose children have been the victims of ECSA. Recognition of such secondary trauma effects emerged from the literature supporting a PTSD formulation of the impact on the sexually abused child (Veitch Wolfe et al., 1989). These authors also recognize that individual differences in response to CSA (and other stressful life events) are related to three mediating variables: the severity of the abuse; the availability of social support; and attributional styles regarding the cause of cause of negative life events. While the first two variables have been acknowledged elsewhere in this review, the last variable, relating to the processes of cognitive appraisal, attribution and meaning-generation, will be developed in discussion in the following sections.

2.4.2.3 Other theoretical advances

A number of other useful theoretical frameworks have been developed over the years that serve to bridge the gap in understandings and conceptualizations of the effects (both individual and familial) of both ICSA and ECSA.

While not specifically applicable to the family system, the "traumagenic dynamics model" of CSA (Finkelhor & Browne, 1985) offers further understanding of the links between the experience of sexual abuse and the consequences. Four dynamics are presented to describe the variety of different types of symptoms. Traumatic sexualization, betrayal, powerlessness and stigmatization are the dynamics used to explain how children's cognitive, emotional and social functioning may be affected by sexual abuse. The family reaction and social responses to disclosure are described as impacting strongly on these dynamics over time. Feiring et al. (1996) use the model as a basis for developing a further model that specifies psychological mechanisms related to the traumagenic dynamics of stigmatization. Significant is the important role of cognitive attribution in the development of meaning around the abuse experience, which is said to determine longer-term adjustment.

Spaccarelli (1994) presents a "transactional model" that conceptualizes sexual abuse as a stressor consisting of a series of abuse events, abuse-related events, and disclosure-related events that each has the potential to increase maladaptive outcomes for the victim. Person-environment transactions and the bi-directional influences of cognitive appraisal, social support and coping strategies are described as determining outcome. Family variables are discussed as moderators in the prediction of how victims appraise and cope with the abuse experience.

The "lifespan-developmental model" (Newberger & De Vos, 1988) was initially proposed to guide understanding of coping and adaptation of the child victim. It has, however, been successfully modified as a model of secondary traumatization for parents (Ligezinska et al., 1996; Manion et al., 1996; Manion et al., 1998). The model recognizes that the traumatic stressful experience begins with the onset of the abuse and continues through the phase of disclosure. The two potential sources of trauma identified by the model are the objective aversive aspects of trauma, and the subjective experience of trauma. The model has the advantage of integrating individual, cognitive, and familial variables in predicting the outcome of primary and secondary victims following sexual abuse. Ligezinska et al. (1996) recognize the significance of the subjective meaning of the experience to the child and family in determining outcomes.

2.4.3 The family myth model

The psychological mechanisms of cognitive appraisal, cognitive attribution and the attachment of meaning by family members to the sexual abuse experience would seem particularly important in terms of family coping and adaptation. Van Scoyk, Gray and Jones (1988) have proposed a model for understanding child and family reactions to ECSA that incorporates not only a cognitive conceptualization of the post-disclosure effects, but also an emphasis on the concept of family myths.

2.4.3.1 Definition of "family myth"

The concept of "family myth" has been described in the works of Ferreira (1963) and Byng-Hall (1973) and based on earlier conceptualizations of family homeostasis and equilibrium (Jackson, 1957 in Ferreira, 1963). The idea of family myth was introduced within the context of systems theory by Ferreira, who considered it to be a family defense mechanism. He defined the concept of myth as the pattern of mutually agreed, but distorted, roles which family members adopt as a defensive posture and which are not challenged from within the family system. Byng-Hall (1973) reports that Ferreira considered that these roles could provide a useful blueprint for social action but at the same time reduce the family's flexibility and capacity to respond to new and unrehearsed situations. Ferreira considered that the function of such myths was to maintain homeostasis and equilibrium within the family. The survival value of the myth, thus, rests in its protection of the system against the threat of disintegration and chaos. "For the family myth is to the relationship what the defense is to the individual" (Ferreira, 1963, p.60).

The myth represents a compromise between family members so that each individual's defenses are maintained through the myth. The individual's defenses and roles are intertwined in a manner that supports the family myth. Due to this interdependence, a violation of the individual or of the family system threatens both – threats to the myth also threaten the individual's defenses, and changes in individuals threaten the family myth (Byng-Hall, 1973; Ferreira, 1963; Van Scoyk et al., 1988). Ferreira (1963) believed that all families use myths that they were adaptive in some ways, and that they provided prescribed roles. In a clinical population, however, there are multiple, markedly distorted and rigid myths that have been associated with family dysfunction and poor adaptation. Byng-Hall (1973) also focused on a clinical population, defining myths in a pathological context. The concept of family myth provides, thus, a framework which can link

individual to family psychopathology and, more specifically, acts as a bridging concept between psychoanalytic psychology and systems theory.

2.4.3.2 Common parental issues and themes

Van Scoyk et al. (1988) acknowledge that the ramifications of sexual abuse are felt throughout the family system. The intrusion of violence into a family's world shatters not only the child's sense of self and belief in a safe world in which parents can protect them, but also the parents' convictions that they can trust their own judgement and protect their children. The child's and family's usual protective, defensive adaptations often do not defend adequately against this trauma, and the very beliefs, rules, and myths by which the family has navigated its way through the world are suddenly brought into question. The findings of this study will be presented and discussed in some details as they are thought to be most relevant to the present research.

In their assessment and treatment of child victims of ECSA and their families, Van Scoyk et al. (1988) note that the issues of these families, both during the evaluation and treatment phases, were different from incestuous families. Furthermore, they found that the myths and beliefs that characterized ECSA families were not necessarily rigid or distorted, but had not been severely challenged prior to the sexual abuse. The family's attempt to maintain these myths, despite their abrupt and traumatic invalidation, was found to characterize the early stages of treatment. It was found that the theoretical and practical focus on family myths, and their re-examination in an attempt to integrate the abuse into the family's view of the world, were helpful in re-establishing family equilibrium.

Interviews with parents of children sexually abused by an extrafamilial perpetrator revealed a number common issue and themes. These have been summarized by Van Scoyk et al. (1988) as follows:

Parents' Presenting Problems

1. We don't believe this could have happened. We would never let anyone harm our child.
2. How should we respond to our child?
    (a) Why didn't the child tell us earlier?
    (b) Why can't we talk now?
    (c) It will get worse if we talk about it.
    (d) Child withdraws after parents' response.

3. Child's sexual development will be irrevocably affected.
4. Societal stigma.
5. We trusted the babysitter, neighbour etc.
6. What should I do with my anger?
7. How should we respond to the perpetrator?

Common child reactions and symptoms were also documented, but will not be reproduced here. Children were found to have specific issues, many of which were reflections of parental issues. Overall, the nature and severity of symptoms found in most of the children were conceptualized in terms of post-traumatic stress disorder.

2.4.3.3 Common parental and family myths and beliefs

While all of the families had in common the sexual abuse of their child, each family arrived with a unique set of values, beliefs, relationships and expectations. The trauma made its impact on the family system of mutually held assumptions or myths with their historical roots and future expectations. Thus, while many issues arising from the abuse were similar among these families, the pre-existent history and beliefs were different. Furthermore, it was found that within each family the same traumatic event had an impact on each individual in a unique manner and within a different time frame. Family members were often found to be out of synchrony, with children, parents and siblings dealing with different traumas at different points in time.

A number of common themes related to family myths were discovered in all of the participating families in the study. These commonly held beliefs provided the basic structure and unquestioned security that allowed the family to function without overwhelming concern or anxiety. While these myths would not normally be regarded as distorted or pathological, the trauma of sexual abuse resulted in the breakdown of this basic structure and the signs that an otherwise functional system had become overwhelmed. These myths have been summarized by Van Scoyk et al. (1988) as follows:

Parents'/ Family Beliefs and Myths

1. Our family is a safe place.
2. We can protect our children from evil.
3. We can trust our judgement about those to whom we entrust our children's care.
4. If something terrible does happen, "Justice will be done".
5. "Vengeance will be ours" – sayeth the parents.

6. We are law-abiding, ethical citizens.
7. We can live in peace in our community.
8. We can talk about things in our family and leave the problem behind.
9. It will get worse if we talk about it.
10. Children who are sexually abused are somehow ruined for life.

2.4.3.4 Towards a theoretical framework

Using the concept of "family myth", and based on their findings of a common set of parental and family myths within families affected by ECSA, Van Scoyk et al. (1988) have proposed a conceptual and theoretical framework for understanding and assessing these families and their responses post-disclosure.

There are three main concepts within their proposed framework. Firstly, the trauma of sexual abuse, being outside the usual range of human experience, creates a violation or a breach in the family's protective shield. The family becomes overwhelmed. Some components of this shield include the family's shared ideology, myths and beliefs. Ferreira's (1963) and Byng-Hall's (1973) definition of a myth as an adaptive and organizing collective defense constitutes one part of a family's protective shield. The impact on the individual varies with the nature of the breach or violation. Variables may include whether the incident was isolated or repeated; whether it was violent, seductive, or coercive; and whether the perpetrator was a friend, relative, or stranger.

The second concept is that the sexual abuse has a considerable impact on the family and the child's predictable passage through the world. The family's sense of existence, meaning, and its very continuity are suddenly shattered and called into question. The abuse essentially stops the family's continuity and projected passage in its tracks, derailing the entire family system.

The third concept is that the issues and themes that arise as a consequence of disclosure are intimately connected to pre-existing family myths and beliefs. Thus, while there may be similarities between each family's response to the trauma, there are also likely to be significant differences that may be traced back to the family's beliefs and values. In summary, Van Scoyk et al. (1988) present this theoretical structure as follows:

Theoretical Framework

1. Violation/ breach in the protective shield
    (a) Family ideology/ myths/ beliefs
    (b) Individual defenses
2. Impacts on family trajectory
3. Issues/ themes following disclosure

The implications for intervention with such families include not only the assessment and discussion around commonly held beliefs and ideals held by family members, but also the need for active reframing of the event and possibly education around child behaviour. In their treatment approach, Van Scoyk et al. (1988) focus on the identification and clarification of the set of myths active in each family, and on the impact of the abuse on the family collectively and individually. The less rigidly a family held to certain beliefs, the more readily they were able to integrate the trauma, modify their myths, and adapt. The more fluid the system, the more readily the parents were able to deal with their own issues, become more available, and respond more supportively to their child.

In sum, the literature suggests that the study of family reactions and adaptability to a disclosure of ECSA is a socially relevant and complex exercise. In light of the high incidence of sexual crimes in South Africa it is surprising that little attention has been paid to the life-worlds of so many families having to cope with this trauma. Denying the traumatic impact of sexual abuse on the most integral of social institutions in the name of under-resourcing or inadequate service-provision would seem socially irresponsible. We cannot expect this vulnerable population to carry the burdens of the socio-political crime of sexual violence. If families are to continue functioning as the primary networks of support and kinship it is imperative that family mental health be attended to.

CHAPTER THREE
RESEARCH DESIGN AND METHODOLOGY

> ...unless we attend to the social network of the victim, the victim will not recover quickly from her or his stressful experiences. Yet, as a result of the traumatic experiences, the network (most often the 'victim' is the family) can barely handle routine matters and may be unable to help members struggling to recover emotionally. (Figley, 1989, p.3)

So often the immediate family is relied upon to provide the necessary emotional and social support to the sexually abused child in the events post-disclosure, and in the wake of the family's own traumatic reactions. Furthermore, it is frequently assumed that the family is in an emotional, financial and social position to do so, and somehow inherently "knows" how best to provide the emotionally corrective environment that promotes the optimal healing of the child. Yet, how can the family system be expected to attend to and be emotionally available to the child in the face of its own trauma? It has been the researcher's experience that families affected by the sexual abuse of a child have unique needs and face unique challenges as they come into contact with various legal and social agencies. Furthermore, family members are often denied involvement in the child's counselling or therapy process, or may withdraw from participation due to their own feelings of shame surrounding the abuse. It would, thus, seem that the needs of caregivers and families affected by their child's sexual abuse are not adequately responded to.

3.1 Research questions

Based upon a thorough review of the literature (see Chapter Two), the current research aimed to explore the phenomenon of secondary traumatization in families affected by ECSA. The primary objective was to elucidate the subjective meanings of the abuse experience for caregivers faced with the sexual victimization of their child by a non-family member, or, by an extended family member not residing within the immediate household (or "nuclear") family home. Furthermore, the resultant effects on caregiver and family functioning were explored in terms of possible secondary trauma effects. While the experience of secondary trauma in caregivers and family systems affected by ECSA was an anticipated outcome, it was by no means assumed. A most significant component of the research was aimed at exploring resiliency factors and identifying

those resources that may account for the caregivers' and family's adaptive coping and adjustment post-disclosure.

Based upon the objectives outlined in Chapter One, the research questions are as follows:

1. What are the caregivers' and families' experiences and understandings of the sexual abuse post-disclosure?
    a) What is the meaning of the sexual abuse experience for caregivers?
    b) What is the meaning of the sexual abuse experience for the family system (e.g. in relation to the extended family system; in relation to the community; in relation to prior beliefs and assumptions held about self; in relation to prior beliefs and assumptions held about the family)?

2. What are the effects and traumatic impacts of the sexual abuse experience on caregivers and the family system?
    c) How has the experience affected the functioning of caregivers and individual family members?
    d) How has the experience affected the functioning of the family system (e.g. in relation to pre-disclosure functioning; in relation to the extended family; in relation to the community)?
    e) Do caregivers and the family system display symptoms of secondary traumatization?

3. What are the risk factors and coping variables in such caregivers and families?
    f) How have the caregivers and family coped since the disclosure?
    g) What factors have helped to protect caregivers and the family system from secondary trauma effects?
    h) What factors have increased the caregivers' and family's vulnerability to secondary trauma effects?

4. What are the likely implications for families, service-providers and policy-makers?
    i) How may such caregivers and families be optimally assisted to survive the experience with minimal traumatization?

j) How may such caregivers and families be optimally assisted to provide the necessary support to their abused child?

The research objectives and questions are based on the following basic assumptions:

1. That the families of children who have been sexually abused by a non-family member (ECSA) are vulnerable to experiencing secondary trauma effects.

2. That secondary trauma effects may impact and manifest in a variety of complex ways in different family members and family systems, at different times.

3. That certain factors may be present which serve to increase the vulnerability of family members and family systems to secondary traumatization following ECSA.

4. That certain factors may be present which serve to protect family members and family systems from secondary traumatization following ECSA.

3.2 Research design

In contrast to the objective and quantitative means of assessing the family atmosphere (such as the Family Environment Scale by Moos and Moos, 1981) employed by many of the studies reviewed in Chapter Two, the present research was concerned with gaining enhanced understanding of the unique meanings and subjective interpretations of the abuse experience for family members and systems, with a view to exploring secondary trauma effects. The qualitative paradigm and, more specifically, the phenomenological approach informed the research design, methodology, analysis and interpretation.

Based upon interpretive enquiry, the qualitative approach is concerned with the exploration of meaning and interpretation, with the underlying assumption that reality is subjective, only being "known" by those who experience it personally (Durrheim, 2002; Kelly, 2002; Terre Blanche & Durrheim, 2002). Mouton (2003) notes that the focus in qualitative research is on an insider-perspective rather than an outsider perspective, where the researcher attempts to understand people in terms of their own definition of their world. Understanding from the point of view of

the subjective perspectives of the individuals involved is the domain of enquiry. Furthermore, qualitative research is sensitive to the contexts in which people interact with each other, including the frame of reference of the individual.

The ontological assumption of this frame posits that people's subjective experiences are real and should be taken seriously, while the epistemological assumption holds that others' experiences can be understood by interacting with them and listening deeply to what they tell us. Methodologically, this implies a relational or interactional component, in which first-hand and detailed accounts of the phenomena under study are obtained by engaging with those who present rich descriptions of their experiences. A key methodological principle involves "staying close" to the data, and interpreting it from a position of empathic understanding (Terre Blanche & Durrheim, 2002; Terre Blanche & Kelly, 2002).

The necessity of obtaining information-rich data in qualitative research is sometimes referred to as "thick description". Geertz (1973, as cited in Terre Blanche & Kelly, 2002) notes that the purpose of interpretive inquiry is to provide "thick description", by which is meant a thorough description of the characteristics, processes, transactions and contexts that constitute the phenomenon being studied, couched in language not alien to the phenomenon, as well as an account of the researcher's role in constructing this description. Denzin (1989, as cited in Mouton, 2003, p.188) describes the term as follows:

> A 'thick description' does more than record what a person is doing. It goes beyond mere fact and surface appearances. It presents detail, context, emotion, and the webs of social relationships that join persons to one another. Thick description evokes emotionality and self-feelings. It inserts history into experience. It establishes the significance of an experience, or the sequence of events, for the person or persons in question. In thick description, the voices, feelings, actions, and meanings of interacting individuals are heard.

Within the qualitative paradigm, the phenomenological approach was used as the basis for inquiry and analysis. According to this perspective, a commitment is made to understanding human phenomena in context, as they are lived and experienced by the subjects themselves, and

using context-derived terms and categories (Dooley, 1995; Terre Blanche & Kelly, 2002). The intention of illuminating the "life-worlds" (or *lebenswelt*) of those involved also implies the necessary "suspension", or temporary bracketing, of the researcher's preconceived notions and prejudices regarding the phenomenon, and allowing it to unfold and reveal itself as we listen closely (Ashworth, 1996; Giorgi, 1994; Giorgi & Giorgi, 2003; Keen, 1975; McCall, 1983).

Kruger (1990, as cited in Terre Blanche & Kelly, 2002, p.140) states "It is necessary to give up manipulation of the phenomenon in favour of allowing this to show itself by an intimate communion with it". This conscious and continuous process of self-observation and reflection on the nature of engagement would appear similar to the concept of the "observing ego" described in much psychodynamic theory. The researcher experienced the process of "bracketing" as a fluctuation between varying levels of "awareness" – being conscious of and sensitive to the effects of preconceived ideas, expectations and personal value judgements, and endeavoring to suspend them in favour of allowing the phenomena to unfold naturally, and without leading the interviewees unduly.

3.3 Design validity and coherence

Durrheim (2002) draws attention to the four dimensions that need to be borne in mind when developing a research design, namely: the purpose of the research; the theoretical paradigm informing the research; the context or situation within which the research is carried out; and the research techniques employed to collect and analyze the data. While the former two dimensions have already been addressed, the latter two will be discussed under the sampling, data collection and data analysis sections in the remainder of this chapter. Durrheim (2002) notes that the process of linking the research questions to the execution of the research process needs to be guided by thorough reflection on relevant issues pertinent to each of the four dimensions mentioned above. To ensure that valid data are yielded (those that accurately reflect on the research questions posed), two principles of decision-making need to guide the process of reflection, namely, design validity and design coherence.

Design validity is concerned with whether the research is designed to give sound and believable conclusions, or whether the findings may be explained by some other factors not previously taken into account. Maximizing the credibility of qualitative research involves an ongoing process in

which the researcher continually searches for discrepant evidence to the research question/s posed, as a means of producing a rich and credible account (Durrheim & Wassenaar, 2002).

With regards to the present research, the researcher was aware from the outset that a number of possible variables may intervene to moderate the presence and severity of secondary trauma effects, and the course of adjustment for family members and the family system post-disclosure. While the significance of these factors was initially unknown, the researcher entered the process of data collection with some cognizance that they might be relevant, and listened accordingly. These factors, which consider issues pertaining to the context and history of the interviewees and (in a broader sense) the geographic, economic and social context of the research itself include: the availability and utilization of support systems, including social, economic and emotional support; the individual and family socio-economic groupings, and the stability or lack thereof; the degree of family cohesion and stability pre-disclosure; the presence of a history of caregiver childhood sexual victimization, particularly of the maternal figure; and the degree of marital satisfaction pre-disclosure. The degree to which these (and other) variables might serve to ameliorate or reduce the stress of the current family crisis was deemed significant from the outset in terms of the research questions aimed at identifying risk and resiliency factors.

As a broader construct than design validity, design coherence refers to the integration of the research paradigm, purpose, question/s, context and techniques such that an internal "logic" is achieved (Durrheim, 2002; Durrheim & Wassenaar, 2002). As stated previously, the present research aimed to elucidate subjective meanings and interpretations, adopting a phenomenological and qualitative approach in the collection of rich experiential data. The technique of depth-interviewing according to a semi-structured interview format was used with a relatively small number of interviewees, selected on the basis of their having directly experienced ECSA within their immediate family unit. The precise details regarding sample selection and data collection will be discussed in the remainder of this chapter.

While the above discussion has focused explicitly on elements of the research design, validity and reliability constructs will be addressed in due course. More specifically, the generalizability or transferability of the data, as well as the dependability of the findings will be discussed as they are relevant to the current research.

3.4 Ethical considerations and integrity of the research

From the conceptualization stages, the researcher was acutely aware of the sensitive and highly personal nature of the research topic. It was anticipated that not only would there likely be difficulty in gaining access to those families willing to participate, but that the interview process might re-evoke painful memories and emotions. Aside from the harmful consequences this may have for interviewees, premature drop-out from the process would yield incomplete data. Recognizing the common experiences of denial, shame, and the need for secrecy around the abuse, and anticipating the chaotic nature of many of these families' daily lives, the researcher was consciously aware not to impose, place unnecessary expectations or exacerbate stresses and anxieties. The researcher spent much time in personal reflection and in supervision contemplating how best to ensure the ethical integrity of the research while obtaining the necessary content and richness of the data. Furthermore, the researcher recognized the need for flexibility and responsivity, and the need to maximize the therapeutic or cathartic value of the interview process by responding with empathy towards interviewees when required. The underlying principle informing this research was, simply, to do no harm. It was the most earnest intention of the researcher at all times not to compromise any individual or family in any way, to respect family wishes and their intimate knowledge of what may compromise the functioning of their system, and to be sensitive to the need for preserving the dignity and rights of all involved.

Durrheim and Wassenaar (2002) note that while there are many ethical considerations that should be addressed in the planning and implementation of research, the essential purpose of ethical research is to protect the welfare and the rights of those involved. The three broad principles upon which many ethical guidelines are based include those of autonomy, nonmaleficence, and beneficence. The principle of autonomy requires the researcher to respect the autonomy of participants and to address issues such as voluntary and informed consent, the freedom to withdraw from the research at any time, confidentiality, and the participants' rights to anonymity in any publication that may arise out of the research. The principle of nonmaleficence is concerned with preventing any harm to participants as a result of the research process. Typically, this involves a risk-benefit analysis whereby the potential risks and benefits to participants need to be considered and carefully weighed up. Finally, the principle of beneficence is concerned with ensuring the benefit of the research process - if not directly to the participants, then more broadly to other researchers and society at large.

Emanuel, Wendler, Killen and Grady (2004) expand upon the above, including the principle of justice and, hence, the need to ensure fairness and that the rights of the participants are upheld at all times. They outline seven requirements that help to ensure ethical practice in the human sciences, namely: social value; scientific validity; the fair selection of participants; favourable risk/ benefit ratio; independent review; adequate informed consent; and an ongoing respect for dignity. More recently, the additional requirement for community participation and feedback has been added to the above.

In considering the above principles and guidelines, the researcher undertook a number of steps to maximize the ethical integrity of the research. The need to minimize undue risk and to enhance the potential benefits was considered key to the research. In conducting a risk-benefit analysis prior to commencement of the research, the researcher determined the primary anticipated risks to include sacrifices of finance (due to possible travel expenses) and time, and the potential to cause distress due to the recollection of painful and traumatic memories and experiences. While participation would be purely voluntary, and without material or financial benefits, the researcher was aware that other rewards may, however, be gained in the process. It was anticipated that for many participants, this would be the first opportunity to express freely their experiences, thoughts and feelings about the abuse. It was anticipated that for some, the cathartic potential of the interview process would be experienced positively. Overall, however, the researcher was aware that while the research is primarily aimed at social and research benefit and the creation of awareness, no individual or family would be compromised in the quest for social value and relevance. Furthermore, it was resolved that in order to maximally assist participants, referrals to appropriate agencies would be facilitated should participants not be receiving necessary or adequate support. Such a referral was facilitated for one interviewee and her child.

Every effort was made to conduct the research in a setting familiar to the participants, and with minimal travel requirements for the participants, but simultaneously ensuring privacy and confidentiality. Only one participant needed to travel to a suitable location to conduct the interview and was reimbursed for her travel expenses. With regards to the real potential for participants to experience additional distress during the interviews, the researcher recognized the need to remain reflexive, flexible, and sensitive throughout, and to respond accordingly so as to contain and manage distressing emotions. While some measure of distress was expected during

the interview process, the researcher resolved to cease pursuing any issue that was causing undue psychological distress. While this was not found to be necessary with any of the participants, the researcher did find it necessary to "check in" with participants at regular intervals to determine how comfortable they were with proceeding.

The issues of informed consent, confidentiality and anonymity were also addressed in detail prior to commencement of the interview process. The researcher fully informed the participants not only of the exact nature of enquiry and their involvement, but also of their right to withdraw from the process at any stage if they so felt. The aims of the research and the level of enquiry were explained, as well as potential risks and benefits that may result. The voluntary and confidential nature of the research was also explained. Participants were assured that the identities of themselves, their children and families, their personal histories, and all information given during the interviews would remain strictly confidential. The need to tape record the interviews was explained, and likely anxieties discussed. Specific permission was sought in this regard. Participants were also informed of the format in which the results would be presented and disseminated, and that this would remain the property of the supervising university. The researcher encouraged an interactive process from the start, pausing frequently during this explanation to allow for interruptions and questions, and allowing ample time at the end for discussion of anxieties, fears, or further questions. The introductory pre-amble to the research process took a standard, yet flexible, format (see Appendix C).

For those participants who were Zulu-speaking, an additional area of confidentiality needed to be addressed, namely, the presence, involvement and role of a translator. Prior to her involvement with any of the participants, the translator was engaged in a discussion concerning her role and the exact nature of her involvement. The nature, aims and parameters of the research were explained in detail. Issues around confidentiality, anonymity and trust were discussed, with special attention to the translator's participation in the community from which some of the participants originated. Thereafter, the translator signed an agreement of informed consent, pledging to protect the identities and information of all participants (see Appendix D). The translator was also instrumental in providing a full and standard translation of the introduction and interview schedule into isiZulu, and the accuracy and content thereof was verified independently.

Participants were given the opportunity to express concerns or ask further questions around the presence of the translator. After fully informing potential participants of the purpose and aims of the research, and their rights with regards to participation, and after addressing any concerns and anxieties raised, they were requested to sign a contract of informed consent. The explicit terms of consent are listed in this document (see Appendix E). For those who requested it, a copy of the signed consent form was provided.

A final area of consent that was addressed was that of agency consent. As will be discussed later, some of the participants were affiliated with a particular social agency, the consent of whom needed to be obtained not only to access particular participants, but also to use the agency name in the presentation of the research thesis. The director of the agency gave full verbal consent to use their name in the dissemination of results, and also requested a copy of the report upon completion.

3.5 Sampling

Because the researcher was interested in elucidating "thick" and detailed accounts related to subjective intrapersonal and family experiences, the sample group to be studied needed to have the potential to provide rich material. A particular population (the population of families affected by the sexual abuse of their child) with specific characteristics and experiences (the extrafamilial, non-incestuous sexual abuse of their child) needed to be sourced and approached. The method of sampling was, thus, purposive in nature – a non-random, non-probability means of selecting respondents based upon their research-relevant characteristics. This method of sampling, whereby a relatively small number of information-rich cases is selected on the basis of particular attributes, lends itself to a qualitative research design in that in-depth, detailed data are more readily obtained (Dooley, 1995; Durrheim, 2002; Durrheim & Wassenaar, 2002).

Two significant considerations when contemplating aspects of the sampling technique include that of representativeness and sample size (Durreheim, 2002). The former is concerned with the accuracy with which the sample group reflects properties of the population from which it is drawn, while the latter is concerned that the sample is large enough from which to draw inferences about the larger population it represents. While both of these aspects are easier to

control and ensure in quantitative research methodologies that are concerned with statistical accuracy, such constructs also require careful application to qualitative research methodologies.

With regards to sample size, the researcher aimed to select a small, but representative sample, able to provide the richness of data required – a convention supported by the qualitative paradigm. From the outset, it was hoped that between six and eight representative samples could be drawn. Six representative samples were ultimately obtained.

With regards to representativeness, the researcher's aim was simply to understand and represent the experiences and characteristics of those individuals interviewed and their respective family constellations. As with all qualitative research, generalizability of the findings is, consequently, somewhat limited. A further aspect of representativeness or, rather, representivity, also requires mention at this point. From the outset it was realized that gaining access to each and every member of the abused child's immediate family would not only be logistically impractical but also costly in terms of time, for both researcher and family members. While all caregivers in the abused child's family were invited to participate, it was only the primary and maternal caregiver who was anticipated to respond. This was the case. The maternal caregiver, as spokesperson and representative for the household family unit, conveyed not only personal reactions and experiences, but also relayed interpersonal and family dynamics by speaking "on behalf of" other family members.

Because the sampling technique was purposive in nature, the researcher decided to approach communities at high-risk for experiencing CSA as a means of accessing potential participants. A three-pronged approach was employed in this regard. Firstly, the researcher approached a number of private psychologists working in the Pietermaritzburg area, both telephonically and via a standard letter, requesting their assistance in accessing suitable participants. This proved to be the least successful means, as most of the psychologists were rightly concerned about the ethical implications of the research and the potential for harm, not only to their clients but also to their professional credibility should the research be conducted unethically. No participants were accessed by this means.

Secondly, the researcher approached a number of agencies in Pietermaritzburg and Durban working both directly and indirectly with sexually abused children and their families. One such agency was the Durban branch of Childline, a non-governmental organization providing a range of services to children who have been sexually abused, to child perpetrators of sexual crimes, and to the parents and caregivers of sexually abused children. The primary service offered is that of individual counselling to sexually abused children, while the other services are offered with less frequency. Three participants were accessed directly through Childline in Durban.

Thirdly, the researcher's supervisor is directly involved with the Sinani/ Kwazulu-Natal Programme for Survivors of Violence, a non-governmental organization offering a range of therapeutic services and empowerment strategies to adults, youth and children affected by violence in the region. She was able to put the researcher into contact with a psychologist involved in the Vulnerable Children's Programme (VCP). A snowball sampling technique was employed from this point forward, whereby the researcher was able to access suitable potential participants through fieldworkers both involved in the programme and living in the communities identified as high-risk for, amongst other things, CSA. Three participants were accessed through the VCP. The researcher's entry into the VCP and the process whereby potential participants were identified will be described later. An overview of the three-pronged approach to sampling employed is represented in Table 3.1 below.

<table>
<tr><td>Private psychologists in Pietermaritzburg</td><td>Social agencies in Pietermaritzburg and Durban</td><td>Vulnerable Children's Programme, Pietermaritzburg</td></tr>
<tr><td colspan="2">Step 1: Initial telephonic contact

Step 2: Written correspondence (via a standard letter)</td><td>

Step 3: Field involvement</td></tr>
<tr><td>No participants yielded</td><td>3 participants yielded, Childline, Durban</td><td>3 participants yielded, peri-urban and rural areas in Kwazulu-Natal</td></tr>
</table>

Table 3.1: The three-pronged approach to sampling

3.5.1 Criteria for inclusion

3.5.1.1 Entry level of research

For both ethical and practical reasons, the researcher initially planned to involve only those families (or spokespersons thereof) already involved in seeking therapeutic or counselling services for their abused child through a particular social agency (such as Childline). In terms of process, thus, the entry level at which the research was to be conducted was at the post-disclosure, therapeutic level of intervention, as opposed to a post-disclosure, pre-therapeutic level. This initially specified criterion is congruent with much of the reviewed literature in which case families are already affiliated with a particular social agency at the time of the research. All but one of the participants interviewed was affiliated either directly or indirectly (through their abused child) with a particular counselling agency or with a supportive programme at the time of the research. After discussing this participant's needs and experiences after the first interview, and after listening to her perception of receiving little support, either for her child or for herself, the researcher was able to successfully refer her to an appropriate counselling agency in her area.

3.5.1.2 Household family member participation

A number of criteria were decided upon as necessary for participant inclusion. As discussed in Chapter Two, difficulties around the definition of what constitutes an act of "extrafamilial" (or non-incestuous) versus "intrafamilial" (or incestuous) CSA abound. For the purposes of the present research, the definition of the immediate "family" system was based on biological relatedness as well as themes of primary caregiving, kinship, attachment, significance and trust. Similarly, the relationship of the perpetrator to the child was based on criteria of non-biological relatedness as well as non-kinship. Examples would include perpetration by an educator, babysitter, neighbour or other trusted member of the community; sexual violence by a stranger; cases of sodomy; the rape of a teenage girl by her boyfriend; and perpetration by a non-significant "extended" family member.

From the outset the researcher recognized that difficult cases to assess in terms of "extra-" or "intrafamilial" affiliation would include such cases as perpetration by the mother's boyfriend who lives in the child's home. While a determination of the precise nature of the relationship between the perpetrator and the child would help to clarify definitional issues within such

complex cases, the researcher anticipated that such "grey" areas would present themselves, and that decisions about inclusion would need to be carefully weighed up as difficult cases emerged. Some means of establishing the immediate family system and affiliations of the child were considered in advance and included: determining the child's perception of who comprises his or her "family" via collaboration with the child's primary caregiver or counsellor/ therapist; observing individual alignment of other adults towards the abused child as a means of establishing who defines themselves as "family" in relation to the child; and obtaining the child's consent (again via the primary caregiver or the counsellor/ therapist) for the participation of named family members in the research. These methods were planned as means of enhancing the accuracy in definitions of family "membership".

3.5.1.3 Non-participation criteria, age and temporal limits

For the purposes of this research, a child was defined as either male or female and no older than eighteen years of age. Furthermore, the sexually abused child was not required to participate at any point in the interview process. A child assent form (see Appendix F) was, however, constructed to allow for the child's inclusion and consent towards caregiver participation. Constructed primarily for the latency aged and older child, and with the purpose of promoting child participation and family discussion, the child assent form was to be introduced and returned by the child's counsellor/ therapist prior to confirming caregiver involvement. The child assent form was not, however, utilized – primarily due to the child's typically very young age as well as caregiver desires not to involve or burden the child with anything further related to the abuse. The latter finding correlates with some of the results of this study suggesting family polarization and shame regarding the abuse, and the consequent "silence" around the topic within the caregiving family unit.

For ethical reasons, and in line with previous research, the non-participation of minor siblings was also outlined as a further criterion regarding participation, the term "minor" applying to any sibling younger than the age of eighteen. The primary caregiver/s were, thus, anticipated to be the primary sources of information regarding family processes post-disclosure, including information regarding victim and sibling reactions. From the outset it was also anticipated that the maternal caregiver, as spokesperson for the family, would be the primary respondent, with fewer responses from paternal caregivers. This initial expectation was fully realized with all of the respondents

being female caregivers to the abused child. No paternal caregivers were available for participation in this research, and while a significant drawback in terms of representivity, is perhaps not surprising in light of the traditionally female caregiving and child-rearing role (including taking the child to counselling sessions). It must be noted, however, that one father was initially very eager to participate but was forced to withdraw from the process, along with the child's mother, due to external extended family pressures "not to talk" about the abuse. This case will be discussed in more detail in Chapter Four.

Finally, a temporal specification was also initially set according to previous research conducted in the field of ECSA and familial responses. It was decided to include only those caregivers who had discovered the extrafamilial sexual abuse of their child no less than three months prior, but no more than twelve months prior. This specification is set primarily in consideration of the high degree of family disruption and upheaval immediately following the first disclosure. The maximum length of time since disclosure was set at one year in order to capture post-disclosure events and experiences following resolution of the immediate crisis.

3.5.2 Description of the research participants

There proved to be two main difficulties with regards to accessing suitable participants. Firstly, much of the dilemma experienced in liaising with private practitioners, as well as with some agencies approached, was attempting to reconcile valid ethical concerns regarding the sensitive area of inquiry, with the potential social and research benefit offered by such research (particularly in a country affected by such high rates of sexual assault). There were rightful concerns that the interview process may interfere unnecessarily with the participant's and family's process of healing and readjustment by causing distress and the re-evocation of painful emotion. Secondly, it also proved difficult to access cases of non-incestuous, ECSA - most of the cases presenting themselves during the period of data collection involved instances of ICSA. Nonetheless, six suitable participants were accessed and interviewed over a six month period – three via the Durban branch of Childline, and three (either directly or indirectly) via the Vulnerable Children's Programme in and around Pietermaritzburg.

Information pertaining to caregiver, family and abuse-related characteristics was obtained via a standard questionnaire issued verbally after full explanation of the parameters of the research and

prior to commencement of the interviews (see Appendix G). As mentioned, all six respondents were maternal caregivers to the sexually abused child. Five of the six were biological mothers, while one respondent was the maternal grandmother and primary caregiver to the child. The sample was varied in terms of age, marital and employment status, and more or less equally divided between an urban, peri-urban and rural residence. It was significant that of the six, four women were unemployed, one a pensioner, and only one employed – a statistic that would appear concerning in light of the single status of all of these women and the financial and emotional burden of their child-rearing responsibilities. This profile was consistent with the generally high levels of unemployment presenting in our country.

The participants had the following demographic characteristics as set out in Table 3.2 below.

Name	***Age in years***	***Relationship to child***	***Ethnic group***	***Urban/ rural***	***Marital status***	***Employment status***	***Source of participation***
Thandiwe	23	Biological mother	Zulu	Peri-urban	Single	Unemployed	VCP
Busi	28	Biological mother	Zulu	Rural	Single	Unemployed	VCP
Gugu	61	Biological mother	Zulu	Rural	Widowed	Pensioner	VCP
Shamila	56	Biological mother	Indian	Urban	Widowed	Unemployed	CL, Durban
Helen	34	Biological mother	White	Urban	Divorced	Employed, full-time	CL, Durban
Joyce	57	Maternal grandmother	Zulu	Urban	Widowed	Unemployed	CL, Durban

(VCP = Vulnerable Children's Programme; CL = Childline)

Table 3.2: Demographic characteristics of participants

Characteristics related to the sexual abuse revealed that only one participant (Helen) interviewed had more than one child who had recently disclosed their sexual abuse. Six of the seven sexually abused children were female, with their ages ranging from two to eighteen years of age. Five of the seven children were under the age of ten years at the time of the interviews. The length of

time since the first disclosure ranged from three months to twelve months prior, with four of the six caregivers being interviewed within five months of the first disclosure. A significant finding, consistent with much of the literature on risk factors for sexual abuse, is that all five of the perpetrators were previously known to (and trusted by) the child and/ or family of the child. Some of these included the community pastor, the school taxi/ bus driver and the family friend. While the duration of the sexual abuse was unknown for three of the participants, the other three ranged from once to intermittently over a three-year period.

Three cases that were particularly difficult to assess in terms of their suitability for inclusion in this study included perpetration by the mother's boyfriend, in one instance, and perpetration by extended family members not residing within the household family home in two other cases. In the first case (Joyce), the child was sexually abused by the mother's short-term boyfriend. Because he was not a consistent member of the family household, did not play any role in the child-rearing or caregiving functions, and because the child did not refer to him in kinship terms (i.e. did not refer to him as her father) it was decided to include the case in this research. Two further cases that were difficult to assess in terms of their suitability included the cases of Thandiwe and Busi. In both of these cases perpetration was by a young male described by the participants in family, or kinship, terms as the child's "cousin". Upon discussion it emerged, however, that lineage was not direct and that conceptions of family membership were (as anticipated) broader within the Zulu culture. Due to the fact that neither perpetrator lived within the child's immediate household family, did not fulfill major caregiving functions, and had a history of generally limited and non-significant contact with the child, it was decided to include these cases in the research. These two cases would seem particularly noteworthy in view of the perpetrators' status as children themselves, and supports emerging local literature on the increasing incidence of child-on-child sexual abuse (Dawes et al., 2004a; Richter & Higson-Smith, 2004; Van Niekerk, 2004).

Abuse-related characteristics of the participants are represented in Table 3.3 below.

Name	*Number of children abused*	*Child's age and gender*	*Length of time since disclosure*	*Relationship of perpetrator to child/ ren*	*Duration of abuse*	*Household family composition*
Thandiwe	One	6 years, female	7 months	Second cousin, 16y	Once	4 adults 1 child
Busi	One	2 years, female	3 months	Extended family member, 12y	Unknown	5 adults 2 children
Gugu	One	18 years, female	5 months	Community pastor	Three years	1 adult 2 children
Shamila	One	17 years, female	4 months	Taxi/ bus driver	Once	3 adults 3 children
Helen	Two	9 years, male and 6 years, female	3 months	Family friend	Unknown	1 adult 2 children
Joyce	One	5 years, female	12 months	Mother's boyfriend	Unknown	3 adults 3 children

Table 3.3: Abuse-related characteristics of participants

3.6 Interviews

The use of semi-structured interviewing in qualitative research is well established as a viable tool for data collection, both maintaining the necessary structure of predetermined areas of inquiry and retaining sufficient flexibility in order to capture the subjectivity of respondent experiences (Smith & Osborn, 2003). According to this technique, the researcher had a previously constructed set of questions on an interview schedule, but the interview itself was guided by the schedule rather than dictated by it. The researcher had an idea of the area of interest and some questions to pursue, yet at the same time there was a desire to enter, as far as possible, the psychological and social world of the respondent. Hence, the phenomenological position adopted by the current, and most other, semi-structured interview projects (Smith, 1995; Smith & Osborn, 2003).

In the relationship between respondent and researcher, the respondents are perceived as the experiential experts on the subject and should, therefore, be allowed the maximum opportunity to tell their own story in their own terms. Semi-structured interviewing is, thus, advantageous in that it facilitates rapport and empathy, allows a greater flexibility of coverage, allows the interview to go into novel areas, and generally produces a richer set of data (Smith, 1995; Smith & Osborn,

2003). Furthermore, the face-to-face interaction of an interview allows the researcher to help the participant move towards non-theoretical descriptions that more accurately reflect the experience (Polkinghorne, 1989).

On the other hand, the presence of a translator needs to be considered in terms of possible effects on the developing rapport between researcher and participant, as well as the nature of information disclosed, and the accuracy and nuances of information yielded. The presence of a translator was advantageous in the current research as it allowed for a means of access into the lifeworlds of participants from another culture, race and language group to the researchers'. In light of the multiple hardships endured by all participants from the Zulu culture, it would seem essential to continue in our attempts to better understand and give a voice to their experiences. Furthermore, the presence of a translator from the same culture as the participants appeared to be important in the initial stages of the interviews, serving to facilitate a sense of shared identity and alliance. This was observed to be important in alleviating anxiety and providing a sense of comfort amidst much of the chaos in their daily lives. A final advantage of the use of a translator in the current research relates to the warmth, character and degree of empathy communicated by the translator during the interviews. The researcher was most fortunate and grateful to work with a translator who possessed all of the basic qualities essential to a humanistic approach to interviewing. Her quiet, warm and supportive nature was a most significant advantage in light of the difficult topic under study.

A number of disadvantages, however, are also inherently present in the use of a translator. The researcher was acutely aware that while much significant information was yielded, the subtle nuances that exist within language, and which often reveal much of the latent emotional content of the speaker, may not have been adequately captured in the translation. While the presence of a translator may also impede the rapport between respondent and researcher, particularly in the context of a sensitive research topic, this was not found to be the case in the present research. To the contrary, the researcher experienced the translator to be advantageous in facilitating rapport and the disclosure of sensitive information. By virtue of her culture and language group, the translator adopted, as it were, an "insider" perspective in relation to the Zulu-speaking respondents. The researcher's consequent experience as "outsider" was experienced as somewhat of a disadvantage, with concerns about the loss of potentially useful information in the process.

3.6.1 Development of the interview schedules

Two interview schedules were developed according to a semi-structured interview format. In accordance with the basic phenomenological principle of the bracketing (or suspension) of presuppositions, the researcher undertook a lengthy process of initial reflection, aimed not only at elucidating her own preconceptions around the topic, but also at identifying and developing the relevant dimensions for inquiry in the interview schedules.

Through this process the researcher became aware that some of her preconceptions or presuppositions around caregiver and family responses to CSA included the following: that sexual abuse necessarily results in some type of trauma response in those belonging to the household family group of the abused child; that all family members would be emotionally affected, and that a ripple effect would pervade through the family system, with different members displaying distress at different times; that maternal and paternal caregiver figures may respond to the trauma in different ways and at different times, in accordance with the gendered socialization of expressed emotion; that those caregivers and families more recently affected by the disclosure would display heightened levels of distress and traumatic stress; that caregiver resilience and coping is largely a function of available support (both emotional and financial) and, hence, that adaptation is largely affected by the socio-economic circumstances of the family; and finally, that there is a strong link between caregiver and child emotional well-being or ill-health.

3.6.2 Setting up the interviews

Full arrangements for the process of interviewing were made with key role-players involved in the Vulnerable Children's Programme (VCP), Pietermaritzburg, and Childline, Durban. For the sake of the participants' convenience, it was decided that the interviews be conducted in as familiar a setting to them as possible, minimizing their costs in terms of travel and time. The three participants accessed via the VCP were interviewed at central community centres in peri-urban and rural areas in Kwazulu-Natal. The three participants accessed via Childline, Durban, were interviewed at the Durban counselling offices – arrangements were made for the researcher to interview participants at a time when they normally brought their children in for counselling with a Childline counsellor. All interviews were conducted during a six-month period spanning July to December 2004.

3.6.3 The first interview

The first interview (see Appendix H) was constructed around three broad aims, with each area of inquiry designed to explore a different aspect of experience for the respondent related to the sexual abuse of their child. The first aim was to understand the context of the respondent, her family and the sexual abuse. This was facilitated by an initial open question inviting the respondent to tell the story of what had happened to her, her child and her family. All subsequent questions were used to further clarify or expand upon the phenomenon under study, and to facilitate the free description of experience and the expression of affect. The second main aim was to understand the effects of the sexual abuse at both the individual level and the level of interacting systems within and beyond the caregiving family. A number of guiding questions were constructed as pointers in this regard. The third and final aim for the first interview was to understand coping and protective factors as well as risk and vulnerability factors related to post-disclosure adjustment. This was included with a view to better understanding the unique and possibly varying needs of families and caregivers experiencing the phenomenon under study.

As initially delineated for purposes of containment, each of the first interviews took approximately ninety minutes to complete, including a short five-minute break midway. As previously mentioned, the first interview was only conducted following a comprehensive explanation of the goals and focus of inquiry of the research, and after all the areas of consent and confidentiality had been addressed and agreed to in the form of signed consent by the respondent. The brief demographic questionnaire was also issued verbally before the interview proper was conducted. Including the time taken for the afore-mentioned, the first interview took on average a total of two hours to conduct.

3.6.4 The second interview

Part of the standard explanation prior to the interview proper included recognition of the potential distress that some respondents may experience in the process of recounting their story. While the respondents were fully informed of their right to withdraw from the process at any stage, the purpose of the second (or follow-up) interview (see Appendix I) was also fully explained in terms of its de-briefing and containing potential. Overall, the aims of the second interview included: the facilitation of thoughts, feelings, ideas and questions raised during the first interview; to debrief and provide containment as required; to explore both positive and negative experiences of the

interview process for respondents; and to assess possible needs for agency referral. The length of time between the first and second interviews was not initially specified, as it was largely dependent on the schedules and availability of the respondents, researcher and other role players involved in co-ordinating the process. While it was hoped that the second interview could be done as soon as possible after the first, the length of time ranged from one week to three months due to various, unavoidable logistical problems.

Of the six respondents involved, only three were available for the second interview. Reasons for non-participation in the follow-up interview were varied. One respondent (Thandiwe) was forced to withdraw after the first interview due to extended family pressures not to further tarnish the family name by speaking openly about the abuse, revealing the immense sense of shame, and possibly fear, so often experienced in response to sexual abuse. It was disappointing that the father of the sexually abused child had also expressed an interest in participating in the research, but was forced to withdraw before having an opportunity to speak. The two other respondents who were unable to participate in the second interview (Shamila and Helen) were initially sourced from Childline in Durban, and terminated their contact with Childline before the researcher was able to follow-up with them. For reasons of confidentiality and respect for privacy, the researcher decided not to follow up on these respondents outside of their involvement with Childline. This was unfortunate, as it was the researcher's experience that the second, follow-up and debriefing interview yielded much of the richness of information hoped for as well as providing the containment and debriefing required for some respondents. It was noted, too, that because rapport had been established by the second interview, the type of information disclosed was of a far more personal nature, giving enhanced insights into the life-worlds and experiences of respondents.

Information regarding interview participation is set out in Table 3.4 below.

Name	*Interview 1 completed*	*Interview 2 completed*	*Translator required*	*Venue for interview/s*	*Reason for non-completion of interview 2*	*Length of time between interview1and 2*
Thandiwe	Yes	No	Yes	Peri-urban Kwazulu-Natal	Extended family dissatisfaction	N/A
Busi	Yes	Yes	Yes	Rural Kwazulu-Natal	N/A	3 months
Gugu	Yes	Yes	Yes	Rural Kwazulu-Natal	N/A	1 week
Shamila	Yes	No	No	Childline, Durban	Never returned to Childline	N/A
Helen	Yes	No	No	Childline, Durban	Never returned to Childline	N/A
Joyce	Yes	Yes	No	Childline, Durban	N/A	2 and a half months

Table 3.4: Interview participation

3.7 Data analysis

As Smith and Osborn (2003) reiterate, the assumption underlying the process of analysis according to the phenomenological approach is that meaning is central and the aim, thus, to try and understand the content and complexity of those meanings as expressed in the participant's story. Furthermore, the process of analysis involves the sustained engagement of the researcher with the textual data in what may be termed an interpretative relationship (Smith, 1995). While one is attempting to capture and do justice to the meanings of the respondent, to learn more about his or her mental and social world, those meanings are not transparently available but must be obtained through a sustained engagement with the text and a process of interpretation. According to Smith (1995), this dual aspect of analysis may be captured in the term "interpretative phenomenological analysis".

3.7.1 Transcribing the interviews

As Polkinghorne (1989) asserts, the process of transcription is an important facet of the data collection phase, as a written record of the interviews is developed and the raw data transformed into a data set for subsequent, more detailed analysis. It is important, however, not to reify the raw data or transcriptions thereof as it is not a complete, objective record – non-verbal behaviours and the nuances of emotional expression are not captured in the transcript, and a process of interpretation is still required from the transcriber or any other listener (Smith, 1995).

The researcher engaged in the process of transcription herself, producing a word-for-word account of each interview (full transcripts are available upon request). Although time-consuming, the researcher found this process to be enormously beneficial in terms of starting the process of analysis. Furthermore, the researcher was able to decipher some of the inaudible sections of tape based on her recollection of the interview process and material. The repeated playing of the tapes and, hence, the listening and re-listening to the data resulted in the researcher's full immersion into the texts – a state often referred to in the literature on phenomenological research as essential for the process of analysis (Giorgi & Giorgi, 2003).

3.7.2 The process of data analysis

Based upon the traditional approach to phenomenological analysis, Smith and Osborn (2003) recommend an idiographic approach to interpretative phenomenological analysis in which one begins with the particulars and slowly works up to generalizations (Giorgi, 1994; Giorgi & Giorgi, 2003; Smith, 1995). Practically, this implies the detailed analysis of one text first before moving on the others. Analysis is an iterative process in which one reads and re-reads the text in a process of uncovering that is likely to result in new insights upon each reading. The analysis is the interpretative work that the researcher does at each of the following stages suggested by Smith (1995) and Smith and Osborn (2003) for phenomenological analysis:

1. Looking for themes in the first case

(a) Following transcription of all interviews, the researcher starts the process with a close and multiple reading of one text in order to become as familiar as possible with the account. One side of the margin may be used to annotate anything striking or significant about what the respondent is saying. While some of these comments may be attempts at summarizing, others may be associations made or preliminary interpretations. As one moves through the text on a number of re-readings, the researcher is likely to comment on similarities and differences, echoes, amplifications and contradictions made by the respondent.

(b) Once this initial process has been completed for the first text, the researcher returns to the beginning of the transcript, using the other margin to document

emerging title themes. In this process, the initial notes are transformed into concise phrases that aim to capture the essential quality of what was found in the text. In this way, the themes move the response to a slightly higher level of abstraction that may invoke more psychological terminology. At the same time, however, the thread back to what the respondent actually said and one's initial response must be apparent. The challenge at this stage is to find expressions that are high enough to allow theoretical connections within and across cases, but that are still grounded in the particularity of what was actually said.

(c) Once the initial notes from the whole of the first transcript have been converted into themes, it is often useful to list the emergent themes on a separate sheet of paper and search for connections between them. In the initial list the order of emergent themes should be chronological, in other words, based on the sequence with which they came up in the transcript. The next stage involves a more analytical or theoretical ordering as one tries to make sense of the connections between emerging themes. Some themes may cluster together while others emerge as superordinate or master themes. As new clusterings of themes emerge one constantly needs to refer back to the original text to ensure that the connections also work for the primary source material. This form of analysis, thus, involves a close interaction between researcher and text in which one attempts to understand what the person is saying while simultaneously drawing on ones own interpretative resources.

(d) The next stage involves producing a table of themes, ordered coherently, that capture most strongly the respondent's concerns around a particular topic. Superordinate and sub-themes need to be clearly listed and grouped, with an identifier added to each to aid the organization of the analysis and facilitate sourcing the original source subsequently. The identifier indicates where in the text instances of each theme may be found by giving key words from the particular extract as well as page and line references. It may also help to code the instances in the transcript with an identifier.

2. Continuing the analysis with other cases

A number of options are available when moving on to the analysis of other cases – one may either use the themes generated from the first case to help orient and inform the subsequent analysis, or, one can put the table of themes generated from the first analysis aside and start the process of analysis afresh with the second transcript (in the process described above). Whichever approach is preferred, one needs to be disciplined to discern repeating patterns but also to acknowledge new issues emerging as one works through the transcripts. Thus, one is aiming to respect convergences and divergences in the data, recognizing ways in which accounts from participants are similar but also different.

Once each transcript has been analyzed by the interpretative process, a final table of superordinate themes is constructed. Again, this process is cyclical – as new themes emerge in subsequent interviews they should be tested against earlier transcripts. Deciding upon which themes to focus requires the analyst to prioritize the data and begin to reduce them. Themes are not, however, selected purely on the basis of their prevalence within the data. Other factors, such as the richness of the particular passages that highlight certain themes, as well as how certain themes help to illuminate other aspects of the account, are also taken into consideration.

Polkinghorne (1989) notes that the phenomenological researcher faces two primary challenges in the process of analysis. Firstly, s/he needs to work towards the transformation of each meaning unit (or each significant statement), given in everyday language, into statements that use psychological terms but which also adequately describe the phenomenon under investigation. Secondly, the researcher needs to reach a synthesis of those transformed meaning units by integrating them into consistent and systematic general descriptions.

The researcher consciously worked to apply all of the above recommendations for the process of phenomenological analysis to the current research. Upon reflection, the researcher recognizes that, despite the cyclical nature of analysis, she moved through six distinct phases of analysis and interpretation, namely:

- Initial read-throughs

This involved the multiple readings of the transcripts, with the intention of increasing familiarity with the texts and getting a feel for both similar and unique emerging themes and experiences.

- Note-taking

The process of making notes, reflections and commentary on emerging issues and themes was followed according to the structure outlined by Smith (1995) and Smith and Osborn (2003) described above. A two-step procedure was followed for each transcript, whereby initial reflections were gradually transformed into terminology with a more psychological understanding.

- Defining themes

The process of defining emerging themes and sub-themes was done for each transcript. Using the themes identified in the first transcript as a guide for subsequent script analyses, the researcher was aware to adopt a position of flexibility such that unique and emerging themes may present themselves without being constrained by previously defined categories. A cyclical process was adopted in this regard, whereby dominant and sub-themes were clarified only after a lengthy process of immersion in the texts. Attempts were made to couch themes in terms not foreign to the scripts from which they were derived, but to use the "local" language as far as possible so as to retain the essential underlying meanings and feelings. All scripts were coded and a detailed list of themes and sub-themes was drawn up for each participant, using page and line numbers for easy reference.

- Mapping themes

Individual scripts were visually mapped according to the dominant and sub-themes emerging. This mapping corresponds directly to the individual listing of themes mentioned above. Themes were mapped and ordered according to their prevalence within the script.

- Broader collating of themes

Once all transcripts had been individually analyzed and mapped, the process of collating themes was undertaken. After the somewhat removed process of identifying and mapping themes from individual scripts, the researcher found it necessary, once again, to immerse herself in the actual

texts so as to get a feel for the data again and its essential communications. While in many respects the central themes were readily identified, the process at times felt artificial and simplistic as all of the dominant themes appeared to be interlinked and communicating with each other at some level.

- Looking for discrepancies

Throughout the process of analysis, the researcher was aware to search not only for commonalities of experience for the respondents, but also discrepancies and unique experiences. This required an approach of flexibility and openness in allowing the data to present itself without being distorted by preconceived categories or ideas on the part of the researcher.

Appendices J-O reflect the process of analysis for each case, which, ultimately, contributed towards the synthesis of commonalities and discrepancies as presented in Chapter Four.

3.8 Reliability and validity

3.8.1 Definitional issues within qualitative research

Although conceptualized differently in qualitative research methodologies, issues of reliability and validity need to be addressed as means of ensuring optimal quality control (Peterson, 1994). As Stiles (1993) notes, both reliability and validity in qualitative research concern trustworthiness, with reliability referring to the trustworthiness of observations or data, and validity referring to the trustworthiness of interpretations or conclusions made about the data. Although qualitative research studies do not typically make a sharp distinction between observation and interpretation, it is useful to distinguish procedural trustworthiness (which contribute towards the readers' understandings of the observations) from the criteria for evaluating the trustworthiness of interpretations.

3.8.2 Safeguarding reliability

Stiles (1993) defines reliability (or procedural trustworthiness) as being concerned with whether the observations made are repeatable (after allowing for contextual differences) and whether the researcher's report conveys "what you would have seen if you had been observing" (p.602). Recognizing the difficulty and complexity of ensuring the replicability of qualitative

investigations, certain procedures appear to be evolving into standards of good practice for qualitative research. Some of these include the disclosure and explication of the researcher's personal orientation, context (both social and cultural) and internal processes during the investigation, along with an intensive engagement with the material, the iterative cycling between interpretation and observation, and the grounding of interpretations in the actual data. As Stiles (1993) comments, underlying this emerging cannon of good practice is a skepticism of the traditional concept of objectivity. Replacing objectivity is a concept that may be called permeability – "the capacity of theories or interpretations or understandings to be changed by encounters with observations" (p.602). The good practice recommendations generally aim to enhance permeability and to help readers assess the degree to which the observations have permeated the researcher's understanding.

As previously discussed, the researcher attempted to elucidate her own personal assumptions and presuppositions in a process of reflection prior to commencement of the data collection. Contextual and cultural issues were included within this process of reflection. Furthermore, the researcher kept a journal of her own experiences, observations and reactions throughout the process of data collection, as well as during the process of analysis, the purpose of which was to enhance insights. While this journal was mainly used as a personal aide in the process of data analysis, it also served as a necessary vehicle for the researcher's own debriefing in an emotionally difficult area of research. The intense process of analysis and the researcher's cyclical immersion in the data over a period of time has been discussed elsewhere, as have attempts to ensure the "groundedness" of the results in the textual data.

3.8.3 Upholding validity

Validity, as defined by Stiles (1993) concerns "whether an interpretation is internally consistent, useful, robust, generalizable, or fruitful" (p.607). Qualitative research's epistemological shift of focus, from the truth of statements to understanding by people, entails a shift in criteria for evaluating interpretations. Whether the research findings can be trusted and used as the basis for action, and whether the key ideas are well-grounded and well supported are the key concerns in assessing validity in qualitative research. Questioning the accuracy of the research findings and whether they inspire confidence is, thus, central to assessing validity claims (Silverman, 2000; Stiles, 1993).

Stiles (1993) presents a typology for assessing the different types of validity (as the basis for trusting interpretations) pertinent to qualitative research. The two factors considered in this typology include i) the locus of impact (whether the impact of interpretations is upon the reader, participants, or researcher); and ii) the type of impact resulting (whether the impact is one of simple fit or agreement with preconceptions, versus change or growth in understanding). The concept of triangulation is presented as an overriding type of validity, implying the use of multiple sources of data, multiple methods and multiple prior theories or interpretations, and assessing convergence. Convergence across several perspectives and types of impact (as outlined in the typology described above) represents a stronger validity claim than does any one alone. Guba and Lincoln (1989, in Stiles, 1993) describe triangulation as fairness – an interpretation is fair to the extent that it honours alternative constructions, including those of participants. Sullivan (1984, in Stiles, 1993) required that to be valid an interpretation must present itself as an argument in which alternatives are entertained. Misinterpretation (as the failure of empathy between researcher and participant, or between researcher and reader) is a particular danger in qualitative research and reliance upon a limited range of sources increase risk for this danger.

In terms of validity, the researcher sought independent review of her findings from both her supervisor as well as two colleagues working within the field of psychology. This process of engagement was done both jointly (with the researcher present and engaged in the review process from the start) as well as independently (with the researcher absent during review of the findings), and followed by discussion. The researcher found this interactive process to be refreshing and most beneficial in terms of clarifying themes and illuminating her oversights. While dissemination of the results to research participants had been considered, the logistics involved prevented this from occurring. The loss of three participants to follow-up after the first interview, as well as language, travel and temporal logistics prevented this type of triangulation from realizing. This would, however, be an important area to address in terms of enhancing the validity for future such studies.

CHAPTER FOUR
RESULTS AND DISCUSSION

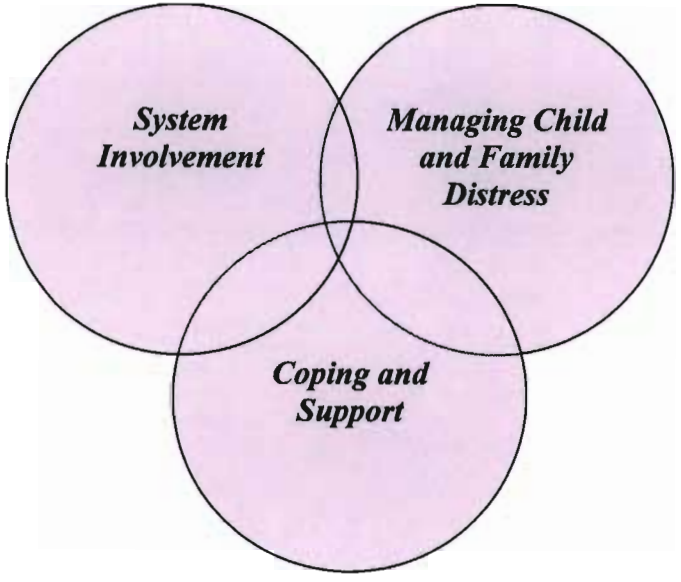
The process of analysis revealed a number of dominant as well as peripheral themes and sub-themes that, despite their usefulness in enhancing conceptual clarity and psychological understandings of the essential meanings inherent in the texts, cannot be regarded as distinct or isolated from one another. The researcher became acutely aware of the complexity of relationships existing between themes and, hence, experienced the sense of artificiality in separating out themes as distinct entities. The majority of themes identified were observed to be "talking to" one another at different levels at different times throughout the process of analysis and interpretation. As a result, the various themes may seem to be repetitive in nature, but are considered to each reflect unique aspects of the participants' experiences. While the results are presented in linear fashion, the researcher will attempt to convey this complex sense of interaction, relationship and merging between themes.

Three broad thematic areas emerged consistently throughout the textual analysis and will be used as the basis for the presentation of results. These include dialogue around involvement with the social service, legal and criminal justice systems (system involvement); issues related to managing the child's reactions and distress as well as consequent family distress and disruption (managing child and family distress); and themes related to coping, adaptation and support (coping and support). A number of further themes and sub-themes were observed to emerge from each of these broad thematic areas, and represent many of the points of intersection and communication between the broader themes. Together, these will form the basis for the presentation of results. The three dominant, intersecting thematic areas, as well as further emerging themes and sub-themes are represented in Figure 4.1 below.

The process of finding out and discovery
- The aftermath of disclosures
- Initial emotional responses
- Entry into the "system"
- Managing the child's distress
- "Not knowing" and the quest for truth

Disillusionment and frustration with the system
- Insensitivity of the system
- "Voicelessness" within the system
- Abandonment and neglect by the system
- Helplessness and powerlessness in the face of system apathy
- Waiting for justice
- Ambivalent hope
- Feeling failed by the system
- Practical consequences of system involvement

Culpability of the maternal caregiver
- Maternal failure to protect
- Caregiver isolation and burden of responsibility
- Culturally and socially defined gender roles
- The conflicted positioning of blame and guilt



The centrality of shame
- Maternal shame within the family
- Community isolation and stigmatization
- Maintaining the silence

Living with fear and loss of hope
- Ongoing threats to safety
- Changed perceptions of being in the world
- Fears for the future
- "Being a virgin" and the concept of hope
- Living in limbo
- Release and relief from perpetual fear
- Current solutions to threatened safety

Consequences to the child and family
- Initial sequelae
- The meaning of the abuse for the family
- Differential family response
  - maternal responses
  - paternal responses
  - sibling responses
- Dynamic and relational effects
- Intra-family isolation and polarization

Coping with loss
- Social support - Perceived loss of anticipated support
  - Valuable sources of support
  - Social support and resilience
  - Needs for professional support
- Faith in a higher power - Managing through God
  - Faith in the system
- Coping strategies

Experience of the interviews
- The pain of recollection
- The value of feeling heard

Figure 4.1: The dominant thematic areas yielded in the qualitative analysis

4.1 The process of finding out and discovery

4.1.1 The aftermath of disclosures

A central and consistent theme to emerge was the dialogue around the process of discovering the sexual abuse. In contrast to much of the literature, which refers to the term "disclosure" as implying a discrete, time-limited event, the caregivers interviewed referred more consistently to a process of "finding out". They spoke more readily of an unfolding process of discovery extending over a period of time, with various signs and anomalies ultimately resulting in their confronting the reality of the sexual abuse. For most, this involved a process of reflective regret and sadness as they attempted to make sense of the abuse and the events leading up to it. For all of the caregivers this process involved elements of self-recrimination and the perceived failure of their maternal duty to protect their child. These findings, whereby the process of finding out is spoken of in dynamic, evolving terms finds support in some of the literature describing maternal reactions to CSA (Carter, 1993; Hooper, 1992; Hooper & Humphreys, 1998).

The impact of this devastating reality, often preceded by a period of unconscious denial, may be captured in the use of the term "aftermath"- reactions of horror, shock, disbelief and devastation were common amongst the caregivers interviewed. In recounting the day on which she was told of her daughter's rape at the hands of the school bus driver, Shamila relayed the following (page 1, lines 19-23):

> ***"So I was actually shocked to hear about that... And uh I was very worried and very upset that I ever came across that...my small baby was raped. So I was acting a little bit fussy by the welfare, so she [social worker] told me 'no calm down' and 'the chap is locked up' ".***

Furthermore, the traumatizing impact of their finding out over a period of time was commonly exacerbated by the sequence of events, procedures and novel demands placed upon them, their child and family as they came into contact with the CJS. A sense of being overwhelmed, as well as a perceived loss of control, pervaded their descriptions of "finding out" as well as their entering and being drawn along by the "system".

4.1.2 Initial emotional responses

Of the six caregivers interviewed, four had found out of their child's sexual abuse less than five months previously, representing a period of time post the immediate crisis yet within a phase of

continued adaptation and adjustment. They all described ongoing vacillating affective states as they attempted to negotiate a host of novel situations and often conflicting emotions related to the abuse. Dominant experiences of shock, horror, disbelief, anger and guilt permeated descriptions of their reactions upon finding out, as well as in their enduring efforts at coping and their presentation during the interviews. For some, intense fear and anxiety at their child's possible HIV infection as a result of the abuse culminated in an artificial and false sense of relief upon confirmation of a negative test result. In a sense, the horror and trauma of the sexual abuse was necessarily sidelined in anticipation of having to deal with a possible sentence on their child's life, yet the relief offered by the negative test result was experienced as somewhat empty and unsatisfying in light of the child's and family's distress.

In relation to the emotional turmoil resulting from fears of her child's possible HIV infection, Joyce described her experiences as follows (Page 3, lines 20-33):

Joyce: ***"...I've been up and down to Addington [Hospital]. My mum, she lives near Addington and said I must take her to the doctor there...they were taking blood tests, but there's good news...and they said the one [blood test] that they took was the last one. So I went for the results on Monday and...thankfully now everything's ok.***

SB: ***She's not HIV positive...***

Joyce: ***Yes, she's fine...ja. And that's the thing that ...eh...made me very, very stressed as I was worried about it. I was worried about it..."***

SB: ***That must have been your biggest worry.***

Joyce: ***Yes. Yes. That she might be...[HIV positive]."***

Confusion, helplessness and frustration were also part of the experiential picture for the women as they negotiated the reality and aftermath of the abuse.

In many respects, the initial as well as ongoing emotional responses described resonate with well-known models of loss, grief and bereavement (Gomes-Schwartz et al., 1990; Grosz et al., 2000; Hooper, 1992; Kiser et al., 1991; Kubler-Ross, 1981; Payne, Horn & Relf, 2000; Worden, 1996). The process of finding out about the sexual abuse appeared to trigger a host of perceived losses for caregivers, with a variety of often conflicting emotional reactions attached. Vacillating experiences of anger and rage, denial and negotiation with a higher power such as God were frequently interspersed with experiences of depression as the reality set in and issues of

acceptance (and, for some, forgiveness) were grappled with. The tension described between simultaneous desires for vengeance and retribution on the one hand, and forgiveness according to the old adage "forgive and forget" on the other hand, represented much of the dilemma experienced in negotiating the host of losses. In their descriptions of current difficulties and coping, respondents spoke of their longing for a place in the future where all was resolved and the normality and equilibrium of daily life restored, while experiencing their current position as one of being "stuck" in the present reality of confusion and uncertainty regarding the future. Much of the tension within this dynamic may be viewed from the perspective of a process of grieving related to significant loss (Hooper, 1992).

4.1.3 Entry into the "system"

Perhaps one of the most significant and overwhelming aspects during the process of finding out was the consequent entry, for child, caregivers and family, into the CJS. For all of the respondents, the crisis of finding out about their child's sexual abuse represented their first contact with the variety of services and procedures that comprise the CJS. Contact with police, district surgeons, social workers, lawyers, etcetera was generally described in terms of a whirlwind of post-disclosure sequelae that mostly exacerbated experiences of stress, helplessness and confusion. This initial process of entry generally represented a host of novel, stressful demands and experiences for caregivers with no prior experience of the "system".

Two dominant experiences were evident in this regard. Firstly, caregivers experienced overwhelming disappointment in the impersonal nature of contact with representatives of the criminal justice procedure. Initial hopes of receiving assistance and guidance were met with apathy, inaction and multiple delays in the process, that exacerbated experiences of frustration and hopelessness. Secondly, perceptions of a "well-oiled", efficient and cohesive system were dashed during common experiences of being "passed from pillar to post" within a system that lacked coherence. Despite their eagerness to become involved in the system's procedures, caregivers routinely received directives to "back off" in favour of allowing the system to take its course. In general, initial contact with various domains of the CJS increased caregivers' experiences of helplessness, powerlessness and impotence, promoting an overall loss of faith and hope.

Gugu related her experiences (via the interpreter) of feeling passed from pillar to post during her early contact with the CJS (Page 1, lines 38-46; page 2, lines 1-11; page 7, lines13-16):

> ***"And [Gugu] came to the counsellor in the area, and she tell her 'I'm having this problem...There's this man who come break in to my house because he wanted my daughter'. And the counsellor just told her to just go and talk to the social worker about this thing. And she went to the social worker and the social worker said that because it's something that happened a long time ago 'there's nothing we can help you with. This is the rape. You have to just go to the court and put charges on the man'. And she [Gugu] went to the court and put charges on that man. And they give her some kind of a letter, and she came with that letter to the counsellor here in the area. And she said she take that letter here to the counsellor again. And the counsellor write something and take that letter back to the police. And the police take that letter and give it to the man. I don't know, like maybe a restraining order or something ... the police didn't arrest that man. "***
>
> ***"Ja, it's just that the way we find out what must I do to deal with this situation, and then that's where they told me that I must see the social worker. And the social worker just said it will just be easier to go to the police and just talk to the police..."***

Possible interpretations of such experiences would, no doubt, acknowledge the extreme burden of pressure experienced by those working in the field of sexual abuse within the CJS. The apparent mismatch between criminal justice policy and service on the ground is, however, concerning in light of the prevalence of sexual abuse in South Africa and the vast numbers of caregivers, children and families requiring both practical and emotional support. From an object-relations perspective, one could conceptualize the perception of the all-powerful system as inevitably resulting in disappointment and disillusionment (St. Clair, 2004). The power invested in the paternalistic "system" by caregivers may be unrealistic and rooted in overwhelming experiences of powerlessness in managing the widespread effects of the abuse in the family. Explanations aside, it would appear that the needs of families dealing with the sexual abuse of their child are multiple and unique, requiring a more specific, co-ordinated type of response and management.

4.1.4 Managing the child's distress

Another facet of experience described by caregivers during the initial process of finding out and discovery was the difficulty involved in managing the child's distress while simultaneously trying to manage their own. The circumstances surrounding their child's distress and symptoms, and the initial and overwhelming perception of helplessness, appeared to undermine caregivers' previous sense of competence in knowing how to manage and respond to their child. It is the researcher's impression that part of this difficulty involved reconciling the often taboo issue of children, sexuality and sex.

Typical symptoms that caregivers were faced with in their children included the following: sleep disturbance, nightmares, enuresis, loss of appetite, specific anxieties, generalized fears and anxieties (for example, of men in general), insecurity and clingy behaviours, as well as sexualized and inappropriately provocative behaviours. These are largely consistent with the symptoms reported in the literature (Killian & Brakarsh, 2004). Such symptoms of distress and trauma were reported as being both initial and persistent symptoms. Part of the difficulty experienced by caregivers in knowing how to respond to such symptoms included not knowing how to talk about, or find a language for, the abuse within the home and, hence, not knowing how to "be" with the child. It would seem that all previous patterns for interaction and communication within the family, and particularly with the abused child, were ruptured as a consequence, polarizing and isolating family members.

A further significant finding was the link between child and caregiver distress, with the child's symptoms and behaviours typically eliciting caregiver experiences of guilt, anxiety, confusion and helplessness. Experiences of loss of control, loss of hope and fears for the future, as well as the perceived loss of personal safety, were common descriptions given by caregivers in response to their child's distress. With relevance to the latter, one caregiver related her resultant and generalized fear of men in response to her child's fears. Most caregivers were acutely disturbed by their child's overt presentation of symptoms, with only one caregiver being angered and distressed by her child's apparent lack of overt distress. Such findings would seem extremely significant in terms of understanding the complex interplay between child and caregiver mental health, and providing for more specific caregiver support as a vehicle for recovery within the caregiver-child and broader family relationships.

4.1.5 "Not knowing" and the quest for truth

In light of the interplay between child and caregiver emotional well-being and the turmoil experienced by caregivers upon "finding out", one case requires special mention at this point. At the time of interviewing, Helen did not (in contrast to all other respondents) know the identity of the perpetrator. Only after the interview process was it confirmed that a case of ECSA had, in fact, occurred and the identity of the perpetrator made known to her. The essential quality of the interview with Helen revealed an intensely traumatized and distressed woman in desperate search for answers regarding not only the identity of the perpetrator, but also the nature and extent of the

sexual abuse of her son and daughter. Her dominant focus at the time of interview was on truth-seeking and an "obsessional" quest for clarity and answers, the impact of which was experienced cognitively, emotionally, physically and behaviourally, hence affecting every aspect of her well-being.

On a cognitive level, Helen's attempts to make sense of and comprehend the abuse were made harder by the fact that she had no identity for the perpetrator and, hence, no direct focus for her anger. As a result, she engaged in a perpetual and exhaustive process of retrospectively trying to comprehend others' behaviors in terms of their potential guilt or innocence. On another level, much of her anger was misplaced and directed towards her children. Furthermore, her motivation for seeking help for her son was reduced to attempts to "crack the child" in order to reveal the identity of the perpetrator and, hence, to ease the pain and turmoil of not-knowing. Perceptually, Helen's sense of personal safety and predictability in her future was severely compromised as mistrust and suspicion overwhelmed her position in relation to others. Emotionally, this position of "not knowing" was providing constant fuel to her experiences of helplessness, frustration, anger and anxiety. This case provides some insight into the emotional turmoil and shattered perceptions of self-in-the-world experienced by some caregivers of sexually abused children, which would appear to be most severe when the identity of the perpetrator is, as yet, unknown.

The following excerpt illustrates some of the difficulties experienced by Helen in coming to terms with her children's abuse by an unknown perpetrator (Page 22, lines 30-46; page 23, lines 1-9):

Helen: ***"The big questions in my life…like if I'd just listened to them, taken a separation for a three months instead of just getting divorced, then maybe this wouldn't have happened.***

SB: ***All the 'what-ifs…'***

Helen: ***Ja.***

SB: ***Do you find your thoughts at the moment, they're consumed by all of this that's been happening? Is it difficult to focus on the rest of your life, like work, because your thoughts are just racing around all this?***

Helen: ***Ja. It's hard. Um…fortunately I'm on the road and… I know I'll leave it for three days and then I'll start fighting my thoughts…that's what I'm doing this morning and, um…I'll get side-tracked, I'll have to just say to myself 'Oh golly, your boss is going to come down on you if you don't do your work now…and you know, you said you'd do so may calls and then I'll try make it up quick…***

SB: ***So there's a lot of pressure...***

Helen: ***It's pressure. Um...you get up in the morning and you think to yourself, 'Do I have to get up?' You know, 'What...what...what do I face today? I mean...What court charge? And, what's going to happen? I mean...' ".***

4.2 Disillusionment and frustration with the system

Experiences of frustration and helplessness in the face of the CJS were not, however, limited to the initial contact and point of entry, but persisted for the duration of the caregivers' involvement at various levels and with a number of different role players. This emerged as a dominant and consistent theme with all caregivers interviewed and represents one of the largest sources of their ongoing distress. While a number of their experiences have already been described, a more comprehensive explanation follows.

4.2.1 Insensitivity of the system

A number of caregivers who approached various role players in the system with the hope of receiving practical assistance and support, were disappointed at the lack of concern and the sense of indifference and apathy with which they were received. In many respects, the presenting crisis and the response were completely mismatched. This left caregivers feeling helpless, unhelped and with their needs unmet. Furthermore, the majority of caregivers reported experiences of being interrogated, bullied, blamed or patronized at various points in their involvement with the system, indicating a lack of basic respect and empathy for caregiver needs for support and practical advice. Both implicit and explicit blame of the caregivers by members of the CJS was routinely reported, placing unnecessary burden and strain upon caregivers with generally few additional resources for coping and support. Experiences of feeling unnecessarily pressured by certain role players in the system were frequently reported as additional sources of stress and strain. Shamila described her experiences of being pressurized, and her consequent thoughts of suicide, in the following excerpt (Page 7, lines 30-34):

Shamila: ***"Ja. And I told the social worker too. [I said to her] 'And if I have to overdose I'll put it in the paper through you'. [angry, blaming tone] Because she's the only one who was pushing. Too much of her pushing here, there, here, there...So I couldn't take it...***

SB: ***So you really thought about ending your own life because it got so bad for you.***

Shamila: ***Ja."***

4.2.2 "Voicelessness" within the system

A possible consequence of the above was caregivers' unanimous experience of feeling silenced, unheard and voiceless in their contact with the system. Common perceptions of being "passed from pillar to post" were cause for much frustration and helplessness as caregivers' unique set of needs were not adequately responded to.

4.2.3 Abandonment and neglect by the system

The result of the above-mentioned experiences was caregivers' overwhelming sense of being abandoned, disregarded and neglected by a justice system that was supposed to help them, their child and family adapt to the crisis of sexual abuse. In many respects, the child and perpetrator were perceived to be the focus of attention within the justice system, with little energy remaining to attend to caregiver needs. Caregivers reported feeling isolated and excluded from involvement in their child's process and progress in various areas such as court preparation and counselling. Feelings of estrangement and isolation were aggravated by minimal requests for caregiver participation and involvement within the counselling and criminal justice processes, and little feedback. Caregivers were, in a sense, expected to know how to respond to their child, manage their own (often conflicting) feelings, and to continue with life as normal. It is the researcher's impression that it is this dynamic, in which the specific needs of caregivers are denied and unattended to, which stimulates much of the helplessness and despair reported.

4.2.4 Helplessness and powerlessness in the face of system apathy

A significant consequence of caregivers' experiences of system apathy, inefficiency and indifference was the exacerbation of a perceived loss of control. In many ways, caregivers and families attempting to manage the crisis of their child's sexual abuse require a helping agency to take a measure of control initially. Helping families to restore the order and continuity of family life, by empowering members to utilize available supports and resources, would seem like an important area for early intervention. This element was absent from all caregiver experiences with the system.

4.2.5 Waiting for justice

One of the most central concepts to emerge throughout the interviews was that of "waiting" - a concept reflecting much of the ambivalence experienced by caregivers in feeling simultaneously

helpless (in the face of system apathy) and hopeful that an ultimate justice would be done on their behalf by the CJS. As Thandiwe explained via the interpreter (Page 2, lines 21-31; page 3, lines 29-33):

> ***"She said that...even the father of the child is just...is just still waiting for the police there and still waiting for them to come. And everything is still like that [the same]...They are still waiting for the police and they don't come...they don't give her any more information about what is going to happen to the one who abused the child. So, they are just waiting....They just don't know what to do. They are just waiting. She said she will be happy if the boy who raped her child will be arrested, because now nothing is happening, and she is still waiting for something...She doesn't know if it will happen, or what will happen. She said what that boy did to her child is unforgivable, so maybe if the police will arrest him...she can feel better".***

It appeared important for caregivers to defend and hold on to a position of hope and faith, despite flagging confidence in a system that wasn't perceived to be responding to their crises with any urgency. The position of waiting is also possibly reflective of the state referred to previously in the context of grief and bereavement, where an idealized future (in which all is resolved and re-stabilized) is yearned for in the present and crisis-ridden reality of being stuck and "in limbo".

Dependency upon the CJS to enforce and enact such "justice" was the common context of waiting for the caregivers. Furthermore, the concept of "justice" was generally taken to imply the due punishment and incarceration of the perpetrator. For all caregivers interviewed, the concept of justice was perceived as a necessary condition for closure, healing and moving forward with life. The fact that none of the perpetrators involved in the cases sampled had been sentenced (in one case, the perpetrator had faced no consequences whatsoever twelve months after the child's disclosure) is more than disheartening, and a serious impediment to the process perceived as necessary for recovery and healing of both caregivers and children alike. Most of the caregivers presented with at least some symptoms of major depressive disorder – a finding perhaps not surprising in light of experiences of dashed hope, helplessness, and little sense of movement towards a better, brighter or more hopeful future. The complex associations existing between child and caregiver mental health have already been mentioned. Furthermore, the incidence of re-offending amongst child sex offenders is high (Richter & Higson-Smith, 2004; Van Niekerk, 2004) and offenders out on bail pose a real and ongoing threat to the population of children in general, as well as to the children and caregivers who have already been victimized.

The pain of injustice emerged as a sub-theme in the above context. The lack of observable action on the part of the justice system, with few or no direct consequences meted out to the perpetrators, was cause for much subjective pain and suffering for caregivers interviewed. As Shamila described (Page 4, lines 39-44, page 5, lines 5-18):

> ***"No, he [perpetrator] came out because the case was dropped. Ja, because the case was dropped, because you see [name of child] wasn't returning to that court. They was waiting for her to come to the court but the welfare wasn't bringing her and coming to the court. You see now, the lawyer just dropped the charges. ... I didn't know myself what was going on...you see now whatever she [social worker] did, even my daughter she never even tell. But they don't tell me, they tell my daughter [other elder daughter] that 'see I'm taking your child from you, I'm taking your child over there'...just to be away from that man. You see, because he's staying in the same street...ja, he's staying in the street, but, uh, he's not very near...But after that we never even see him. We never see him.***
>
> ***"It was very hurted for me. Mmm, my heart was very sore, and I shouldn't sleep properly...couldn't even eat".***

In different ways and at different times during the interview process, caregivers repeated the conditionality of justice for the process of healing, the subtext revealing their present experiences of helplessness and a loss of impetus towards a desired future. One caregiver interpreted the lack of observable action and the lack of justice or punishment for the perpetrator as the justice system in fact condoning the act of her child's rape – a horrific, yet understandable conclusion to reach. While most of the caregivers revealed their fantasies for vengeance and retribution, a number of the Zulu-speaking caregivers interviewed spoke of the discord that had resulted in the home as a consequence of the lack of observable justice - male family members so enraged with the lack of justice threatened to enact a form of "street justice" that heightened anxiety for the maternal caregiver whose perceived role it was to maintain the family structure. Gugu explained, via the interpreter, the anxiety that this provoked in her as follows (Page 5, lines 23-29; page 6, lines 25-32):

> ***"She said that it's been painful to the whole family because even her two sons which are from Johannesburg, they said that the thing that's happening to the child it's just making them angry. They wanted, like, to pay revenge. And the mother [Gugu] just told them that 'no you can't do that, cos if you just do that you'll be arrested, and I will still be suffering because of it, because you'll just go to jail if you pay revenge...the reason I came here to the counsellor is that I wanted to protect them [sons], because I know how they'll take it if they see or hear what is happening to the daughter. They want to pay revenge or something. And I wanted to also protect them 'cos I know that they will be angry and then want to pay the revenge. That's one of the reasons I just take a step further to just see the counsellor instead of only just seeing what they [sons?] can do to help me".***

While this introduces some of the gendered socializations of both anger and caregiving functions, it also highlights the measures that some feel compelled to resort to in the face of injustice.

4.2.6 Ambivalent hope

The cyclical and fluctuating quality of both hope and hopelessness was linked directly to the above theme of waiting for justice in the accounts given by caregivers. On the one hand, the position of "waiting" implied a faith and belief in the efficacy of the criminal justice process to rightfully punish the perpetrator with lengthy incarceration. On the other hand, the disappointment resulting from a lack of observable action perpetuated feelings of despair, hopelessness, helplessness, frustration and anger. Feared hopelessness was another element of such disappointment, with caregivers describing their fears of not receiving due justice, and yet needing to hold on to some entity (the justice system) as their only source of hope and faith in receiving justice. The inherent tension within this position is obvious and was cause for much of the angst and disillusionment with which caregivers presented. The dilemma and ambivalence of living simultaneously with experiences of both hope and hopelessness is represented in Figure 4.2 below.

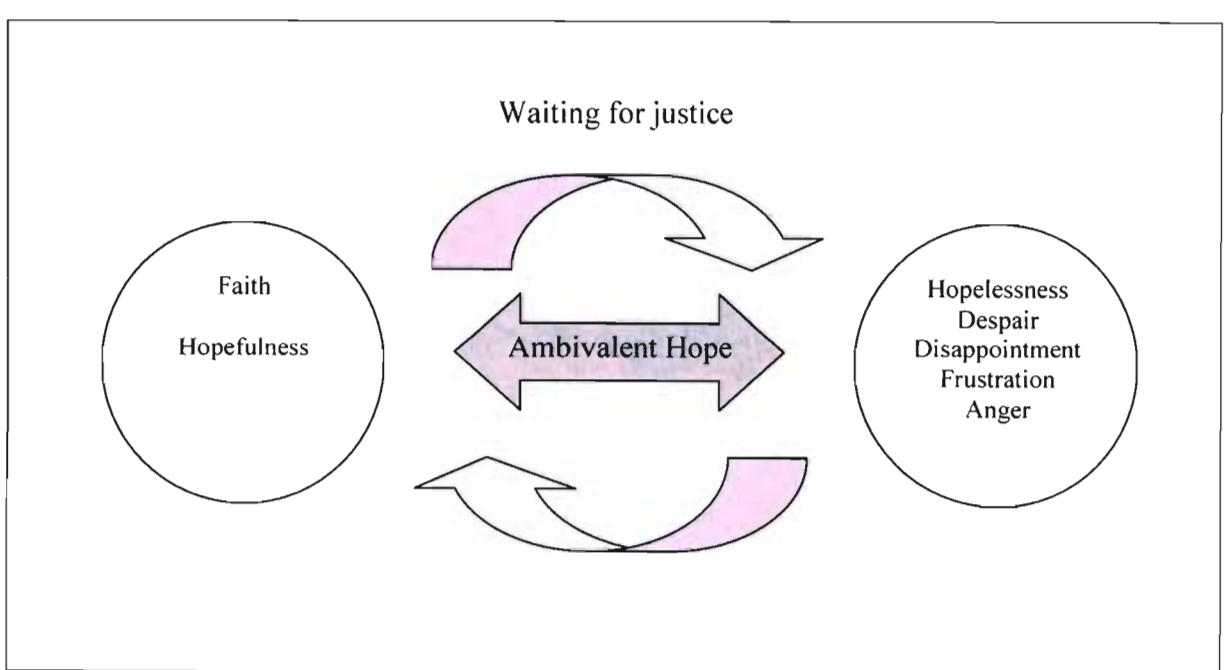


Figure 4.2: The ambivalence of living with hope and hopelessness

4.2.7 Feeling failed by the system

An overriding experience, perhaps summarizing caregivers' contact with the justice system, is that of feeling failed. Frustrations with system inefficiency, feeling harassed and unsupported, lack of adequate feedback (on, for example, the progress of the legal process), and inadequate inclusion in their child's process of counselling and court preparation, resulted in caregivers expressing a sense of being failed. Anticipations of support and practical advice-giving were not realized, compounding an overriding sense of loss. The perceived failure of the justice system to adequately protect the child, caregiver and family is, perhaps, reflective of the implications of caregiver failure to protect implied (either directly or indirectly) by some role players in the system. This emerged in the context of blameworthiness and culpability for the abuse directed towards the (particularly maternal) caregiver for failing to prevent the abuse and, hence, protect the child. Nonetheless, the theme of the "failure to protect" emerged as a consistent, yet, unnamed dialogue that will be explored in greater detail later.

4.2.8 Practical consequences of system involvement

Finally, a word on the practical implications of the caregivers' and family's involvement in the CJS. The financial burden as a result of travel expenses to court, social workers, police, doctors and counselling sessions for the child emerged as a significant concern for all caregivers. The reality is that such expenses cannot be reasonably afforded. Only one caregiver (Helen) was formally employed and earning a regular income. For this single mother, special arrangements had to be made for her time away from work to attend to her children's needs, with inevitable financial implications as well as implications for her reputation at work as a result of being frequently absent. Those caregivers living in rural areas had to make special travel arrangements, all of which come at a cost. Furthermore, all of the caregivers interviewed were either divorced or widowed, placing the burden of responsibility for all practical arrangements squarely on their shoulders. Such factors cannot be ignored when considering the host of stresses and pressures involved in coping with the sexual abuse of one's child.

4.3 Living with fear and loss of hope

Despite medical confirmation of the abuse and/or admissions of guilt on the part of the perpetrators in all of the cases sampled, none of the perpetrators involved had received formal sentencing in a court of law at the time of the interviews. Reasons for this include formal charges

not being laid (primarily out of family fears and poor education around their rights within the process of prosecution), as well as the child's not yet being ready to testify and, hence, in a process of undergoing court preparation. As a result, all of the perpetrators involved in the cases sampled were either out on bail awaiting trial, or, continued to escape legal prosecution. Perhaps the most frightening reality is that all of the perpetrators continued to reside within the same community as, and often in close proximity to, the child and family. Despite the very real fear of the child's re-victimization at the hands of the same perpetrator, caregivers also expressed generalized fears for their own sense of safety and security, with one caregiver (Gugu) having received death threats from the perpetrator should legal actions proceed. Furthermore, such a situation clearly poses the very real and ongoing threat of sexual victimization to all children within that community. Through the interpreter, Gugu described the intensity of her fears for her own victimization by her child's rapist (a community pastor who continued to reside close to the family home) following his threats to harm her and the family (Page 3, lines 1-8; page 3, lines 28-29; page 4, lines 24-35; page 8, lines 26-33):

> ***"She said most of the time she's scared...Because even during the day if she feels tired and feels like sleeping, she just locks the doors. And if someone comes, maybe like the neighbour to come and look for someone here in the house, they thought that she's not there, cos she's just scared [Gugu hides silently in house, afraid to open the door]. If she's sleeping and not locking the doors and nobody's here in the house, the man will come and maybe just even rape her".***
>
> ***"...even at night she just wakes up and hears the sound of a car, she's just scared that maybe it's him".***
>
> ***"And even after my child has run away from home, living in Stanger, the man kept coming back, threatening that he will kill me and the kids that I live with if I don't bring back my daughter, cos he still wants to ?? So there's nothing I could do to help her, or even help my kids that I'm living with, cos this man...it's like everything just keeps happening...Because what my child told me before, she told me that the man threatened that if I tell anyone he will just kill us, kill every one of us in the family. ...And even after that, he came back and threatened that I want your daughter...if you don't just bring her back, I'm going to do something bad to your family. So it's, like, very frustrating..."***
>
> ***"But the man just keep coming back. And I don't know what that man want. He keep just breaking the doors, and threatening to kill us and everything bad...So I'm just scared because I don't know what this man wants, because I'm not even that rich. But this man keeps coming back. I don't know what he wants from me or from my family".***

4.3.1 Ongoing threats to safety

The blatant lack of consequences for all perpetrators involved in the cases sampled ultimately implied that the burden of responsibility for the sexual abuse and its effects was experienced solely by the child and family. All of the caregivers expressed their sense of living in a constant state of fear and anxiety that the safety of their child, themselves and their family was

compromised on an ongoing basis. For as long as the perpetrator was still living in their community and had access to the child, the fear was prevalent. The genuine and persistent threat of re-victimization and violation extended beyond the child, however, to include caregiver perceptions of threat to their own physical and emotional integrity. Gugu had received actual death threats from the perpetrator should she proceed with legal action. The impact of such a situation was experienced by the caregivers at two levels. Firstly, an increased sense of responsibility and burden was experienced to supervise and monitor the child's whereabouts and company at all times. This increased sense of vigilance for the child's safety was made difficult for most of them who, due to their single status, generally relied upon and trusted others to assist with child-rearing responsibilities and supervision. Secondly, the impact upon the caregivers' general well-being and health was also noted. Subjective experiences of heightened levels of stress and anxiety for their own and their child's safety typically resulted in hypervigilant-like behaviours, in which caregivers were constantly "checking their backs", as it were. Sleep disturbance was reported in two cases as a result of such hypervigilance aggravating at night.

4.3.2 Changed perceptions of being in the world

A major consequence of this constant anticipation of danger and threat was the loss expressed by caregivers of their perceived safety in the world. Previous beliefs held about personal invulnerability, safety within one's community, and the trust of known others were severely challenged. In many ways, the normal "myths" that we all create in order to live functionally and adaptively in the world with others (Byng-Hall, 1973; Ferreira, 1963; Hooper, 1992; Van Scoyk et al., 1988) were severely challenged for these caregivers. In many ways this is analogous to an earthquake shattering the bedrock and foundations of one's basic belief system. The loss of perceived safety in the world and increased perceptions of personal vulnerability and susceptibility commonly had a "what if...?" quality – a sense that potential danger was now everywhere, and that one's physical and emotional integrity could be threatened at any time. Changed perceptions of self in the world, and being in the world, extended for one caregiver (Busi) to her generalized perceptions of men. Her primary positioning in relation to men had changed, as a result of her child's consequent and generalized fears, into one of fear, mistrust and suspicion. In her words (Page 5, lines 12-15; page 6, lines 30-33):

"Ja, I don't trust men because...the one who did this to my child is one...is one of the men. And, the father didn't do anything to punish him. It seems as if I cannot trust men completely for them to just be with...and make myself safe with them. They are not [safe]".

"I know that we are a big family and that I must forgive them for what happened to my child. But I cannot trust any man to live with my child. I know that we forgave eachother and talked about it, but it just ended there. But I know that if there's no-one about, I cannot leave my child with any man. Ever".

4.3.3 Fears for the future

The challenging of beliefs about being in the world, and one's perceptions of safety in the world, typically transcended to the perceived loss of a predictable future for those interviewed. The loss of predictability and increased feelings of uncertainty for the future were described in general terms, as well as relating to concerns for the child's future. Linked with this fear, was the general sense of a loss of hope for the child's future as well as a loss of hope for their own future. Feelings of despair for the child's future typically centered around perceptions of the permanency of emotional and interpersonal damage caused by such abuse, as well as fears for the child's future intimate relationships. In relation to this, most caregivers called into question their competence to manage the child's distress, anticipated behaviours and needs in the future. In many ways, the caregivers were suddenly faced with and started to anticipate the meaning and implications of the sexual abuse over the long term, for both themselves and the child.

Aside from anticipating future losses and difficulties in managing and supporting the child, those caregivers of very young children also anticipated difficulty, perhaps awkwardness, in finding a language for the abuse with their child in the future. The difficulty in knowing how to talk about the abuse or rape is perhaps most reflective of the stigma and taboo still attached to issues of sex and sexuality in general, and more specifically when it relates to children. The overwhelming sense of shame experienced by caregivers in relation to their child's abuse is another central theme to be discussed later (see 4.5). One caregiver (Busi) of a very young child believed the child to be too young to understand the full ramifications of what had happened to her, and experienced the overwhelming burden of responsibility to "explain" to the child at some point in the future what had happened. In an ironic sense, the burden of "disclosure" had become the caregiver's to carry – it had become the caregiver's "secret" to disclose to the child one day, and bore with it the dominant feelings of dread, anxiety, and shame.

4.3.4 "Being a virgin" and the concept of hope

A central concept mentioned specifically in the interviews with Zulu-speaking caregivers, and with particular relationship to the concept of hope, is the significance and meaning attached to virginity, or "being a virgin". The concept of virginity formed the central link between experiences of hope and hopelessness described by caregivers in relation to the sense of future for their child. As such, the meaning of "being a virgin" for young girls in the Zulu-speaking culture has particular implications of fellowship and belonging – of being "one of the virgin girls", as Busi put it. A sense of youthful pride, self-esteem and self-worth was also associated with preserving virginity and abstaining from sex until marriage. With an almost "sacred" element, the concept of virginity was strongly associated with hopefulness for the future.

In contrast to the youthful hope inspired by the concept of virginity, the forceful taking or loss of virginity was associated primarily with meanings to the contrary. "Lost" virginity was associated with a sense of difference, isolation and "not belonging", with consequent losses of self-esteem, pride and self-worth. An uncertain future, as well as the implied loss of choice for the future, was also described. A sense of hopelessness was attached to the premature loss of virginity.

Busi described her ideas about virginity and its relationship to future hope as follows (script 2, page 1, lines 27-37; script 2, page 2, lines 4-7; script 2, page 2, lines 20-30):

> ***"To me, being a virgin as a girl or a lady is to know that you are proud of yourself and everything, and still being a virgin. And if your virginity has just been taken by something that you couldn't even prevent...(sighs). And if you are just a virgin among other virgin girls, you just feel proud that...you can be with the other virgin girls. But for my child...that thing happened when she was too young, and she will just be told that she's still a virgin but she's not, because she was raped, when she was too young. It just felt painful to me, because at least if you broke your virginity for yourself and [someone] didn't just break it, it's...it's a little bit easier. But for me it's just different and hard..."***
> ***"Ja, being a virgin, it's about being proud of yourself that you are still clean and that you can still do everything with you life. It's not supposed to be taken from you but you're supposed to just keep it on your own..."***
>
> ***"Ja, I am still worried about her future, because my little girl will grow up knowing that she's a virgin, and if she met someone...and the others [young girls] in the community will just be proud that they are still virgins. And she will be one of those, because she will know that she never had a boyfriend or that she never slept with anyone. And she will come afterwards back to her [mother], "what is happening?" She [mother] is scared that she will need to tell her [daughter], you know, at that stage you were raped, and she will have to show her the man who raped her, who is a relative of her. So she [mother] doesn't know how she can handle that in the future...or when the time just comes...she is afraid [of what] to say".***

The complex relationships described between the meaning of the loss of virginity and hopefulness for the future, go a long way towards explaining the position of hopelessness and helplessness experienced by many of those interviewed, as well as their fears for the child's future.

4.3.5 Living in limbo

Another aspect of experience described in relation to caregivers' fears for the future and loss of hope, was the sense of "living in limbo" – a theme already explained in the context of "waiting" for the CJS to effect justice, but with unique relevance to the sense of an unpredictable future. Hopelessness and a lack of direction or clarity for the future perhaps contributed to their experiences of "waiting". Perceptions of a loss of hope for the future were evident in descriptions of feeling immobilized in the present, while ruminating over the past and longing for a desired future. Understandings of the temporal tension within loss and grieving are, thus, further complexified in light of a host of perceived losses for the future.

4.3.6 Release and relief from perpetual fear

Perhaps part of the frustration and hopelessness experienced by caregivers living in fear was their knowledge of the conditions necessary for their relief from fear, yet their powerlessness to effect such conditions due to their reliance upon the CJS. Many spoke in ideal terms of their fantasies for revenge and retribution, and their needs for the perpetrators' severe punishment. In short, the removal of the perpetrator from the community and his incarceration in prison would go a long way towards easing experiences of living in perpetual fear and danger.

4.3.7 Current solutions to threatened safety

Perhaps in contrast to the ideal and longed-for justice mentioned above, caregivers were forced to enact actual and practical measures to ensure the safety of their child, themselves and their family in the present. As previously mentioned, the child and family experienced most of the direct consequences of the sexual abuse, with few or no overt consequences being observed for the perpetrators. The perpetrators all continued to reside in the community in often close proximity to the child and family. As a result, the child and family bore the full responsibility for optimizing safety. In Joyce's case, the child was removed from the home and sent to live with the grandmother to protect her from contact with the perpetrator. In Gugu's case, the child was sent

to live with family members in another city, while Gugu continued to live in the same community as the perpetrator, fearing for her safety and life. Visits by her daughter were experienced with much ambivalence as they held the increased potential of harassment by the perpetrator. As she described through the interpreter, *"...because now her daughter's back at home that scared feeling that she had still came"* (Script 2, page 13, lines 26-27). In yet another case, the caregiver (Thandiwe) was contemplating moving her family to live in another area, away from the constant threat of her child's re-victimization at the hands of the perpetrator. In all of these cases, the disintegration of the family structure by the child's removal was the only remaining option to protect the safety needs of the child.

4.4 Culpability of the maternal caregiver

As became clear during the process of interviewing, the perpetuation of the mother-blaming myth still abounds. Although now widely rejected in the literature, the concept of "mother-blaming" was traditionally spoken of in the context of ICSA, where mothers were assumed to play some complicit and often unconscious role in permitting the abuse to occur within the family. Such notions traditionally formed the basis for the systems theory model of family dysfunction and pathology (Carter, 1993; Gomes-Schwartz et al., 1990; Hooper, 1992; Hooper & Humphreys, 1998).

Much of the dialogue around caregivers' contact with the CJS in the present study revealed that mother-blaming is not, sadly, a thing of the past and perpetuates within the context of ECSA. The implication of maternal blame, responsibility and culpability was largely reported in relation to traditional conceptions of gender role identification (see 4.4.3), with the dominant theme being the maternal failure to adequately protect the child from the abuse.

4.4.1 Maternal failure to protect

Caregivers reported experiences of both implicit and explicit blame by members of the CJS as well as the family (both the household and extended families). The implication of maternal neglect, irresponsibility and incompetence was frequently reported during caregivers' contact with the CJS, no doubt exacerbating experiences of isolation and lack of basic empathic support. Three of the caregivers reported experiences of being harshly interrogated and harassed by members of the CJS, as if haranguing for an admission of "guilt". Such experiences were

enormously distressing for caregivers who were not only reeling from the news themselves, but also attempting to support their child and family in the process.

For those who experienced blame by family members, it was generally in the cases of abuse by an extended family member (two of the cases were confirmed child-on-child sexual abuse by older, extended family children), generally by extended family members, and generally of a harsher, more punitive and explicit nature. Blame was directed specifically towards the maternal caregiver and experienced as more condemning than the implications of complicity and negligence alluded to by certain members of the CJS. When the perpetrator is "a family child", as one caregiver described, the conflicts of loyalty that emerge as a result of the abuse (i.e. loyalty to the child versus loyalty to the family) appear to result in heightened levels of overt anger all round. This conflict of loyalty will be discussed in greater depth shortly (see 4.6.4). One mother (Thandiwe) described how, in such a situation, the maternal caregiver becomes the scapegoat for and focus of the generalized family anger, hence, the blaming and shaming of the mother. According to Thandiwe (Page 7, lines 30-37):

> ***"Those who think he [perpetrator] mustn't [go to jail] they just blame the mother, saying the mother was the one at fault for the child getting raped. So, maybe if there's a way someone can be punished, then it's the mother. So some say it's the boy who must go to jail, and the others say it was the mother who was the one who was wrong, so the child was raped because of her. Maybe, if there's anyone who's supposed to be punished then it's the mother..."***

Some caregivers also reported being blamed and ostracized by the community at large, perhaps reflecting a combination of both genuine experiences of blame, as well as developing perceptions of isolation and shame. Nonetheless, caregivers generally reported experiences of blame within the three major systems of their interaction at the time, namely, the CJS, the family, and the community at large.

4.4.2 Caregiver isolation and burden of responsibility

Perhaps one of the most serious consequences of the findings reported above is the increasing sense of isolation, difference, stigmatization and shame that caregivers experienced as a result of both implicit and explicit blame. Furthermore, all were both shocked and disappointed at the "disbanding" of expected sources of support as news of the abuse spread – caregiver experiences of abandonment at the time of crisis added to perceptions of loss as well as the general sense of fragmentation and disarray reported. The absence of anticipated support from the family,

community and system was commonly reported. Furthermore, caregivers reported simultaneously having to manage a host of novel demands and responsibilities as a result of involvement in the CJS, yet with little or no practical or financial assistance. The sense of overwhelming isolation, helplessness and burden was tangible in many of the interviews conducted, and perhaps one of the largest contributors to the depressive symptomatology with which most presented.

4.4.3 Culturally and socially defined gender roles

The notion of maternal failure to protect is largely a result of dominant discourses around gender role socialization. In recounting her experiences of implied blame and incompetence, and questioning her own blameworthiness and culpability as a mother, Gugu described the multiple tensions and dilemmas she faced in coming to terms with socially constructed norms around caregiving while simultaneously attempting to defend her position of "innocence".

According to Gugu, the primary role of women and mothers in her Zulu culture is to protect and nurture the children and family, with such role fulfillment being perceived as the condition for women earning "respect" in the community. By implication, perceived role failure (i.e. the failure to protect and nurture) entails the consequent loss of respect and worth for that woman within the community. Notions of worth, respect and positioning within the larger community were strongly tied to gender role identification. Furthermore, in her self-attribution of role failure according to such norms, Gugu equated the duration of the abuse with the extent of maternal failure. Gugu also explained the process she endured of "coming clean" to her sons in anticipation of being held responsible for the child's abuse – in a sense it becoming her disclosure, with all of the elements of fear and shame attached. The female "admission" as her statement of innocence and non-complicity seems so ironic, and yet reflects so clearly not only the internal dilemma experienced by this woman, but the dominant politics of gender in relation to issues of child-rearing, sex and sexuality.

> ***"I have two reasons to tell my sons from Johannesburg [what had happened]...because one of them [reasons] is that I didn't want them to blame me for what is happening to the child. I didn't want them to see me as a failure or something, or that I didn't do something to protect the child. And the second thing is just, the reason I came here to the counsellor is that I wanted to protect them [sons], because I know how they'll take it if they see or hear what is happening to the daughter. They want to pay revenge or something. And I wanted to also protect them cos I know that they will be angry and then want to pay the revenge. That's one of the reasons I just take a step further to just see the counsellor instead of only just seeing what they [sons?] can do to help me". (page 6, lines 21-32)***

> ***"In our culture most of the time women are the ones who are looking for the safety of our children. So the reason I just thought that if maybe I just told them the whole story cos if something happens to the child, they blame you as the mother. Where were you when this terrible thing happened to this child? And when the child just told me, the reason that I thought that maybe to just prevent from them saying that I was just with the child, or the child did agree to do something and what she was doing and then maybe she just got tired of it…I thought that just to prevent all of that I have to come clean. I have to just tell everything that the child told to me and then talk to the counsellor and talk to the police to just make sure that they understand that what was happening was just a rape. No-one has agreed to just do anything with the child…or I was not involved. I was not part of what was happening to my child. I didn't just allow it to happen. So it just happened by force, because this man was just a bully to everyone in the community". (page 6, lines 38-46; page 7, lines1-8)***

> ***"I just felt like no-one in the community. I felt like…there's no need for other people to respect me because I couldn't protect my child. What happened to my daughter, I was the one who was supposed to protect, because in our culture we are the ones who're supposed to protect our children. And if these things happen…I don't know how the people are just thinking when they look at me as the mother who couldn't protect her child from what has been happening, not just once but a lot of times…it happened again and again". (page 10, lines 24-32)***

Gugu also eloquently explained the meaning of the sexual abuse to the male members of her family, with the perception of a threatened masculine identity emerging as the dominant experience as a consequence of the abuse. According to Gugu, male family members interpreted the sexual abuse of the child as a threat to their conceptions of manhood, authority and standing within and outside of the family. Furthermore, the sexual abuse represented to them a sign of disrespect, insult and shaming of the family name. Consequent desires for revenge (as an act of physical violence towards the perpetrator) were cause for much anxiety for Gugu who felt it her duty, as it were, to protect her sons from such anger in order to preserve the family structure. The gendered socialization around the expression of anger was portrayed in her conflicting desires to punish the perpetrator and enact revenge, yet simultaneously protect her sons from enacting revenge in the fear that the cohesiveness of the family unit would be compromised.

> ***"They felt like what the man is doing to the child is just maybe the way she thought she [Gugu] doesn't get respected at all, because the fact is, like, he [perpetrator] knows the kind of persons in the family [??] and he knows they [Gugu's sons] are living in Johannesburg. But the sons feel like this man is not respecting them at all, or just the other way just showing them that they are just nothing, that he can just do anything he likes to the family. And the only way they think will just put this man down is if maybe they pay revenge…fighting him, or doing something. So there's lots of argument about what should be done to this man, 'cos the police doesn't do anything to help". (page 5, lines 42-46; page 6, lines 1-6).***

4.4.4 The conflicted positioning of blame and guilt

The central dynamic and tension resulting collectively from culturally and socially defined gender roles, as well as the perpetuation of the mother-blaming myth, is the conflict experienced by caregivers of self-blame (in accordance with gendered norms for caregiving functions) versus

self-defense and justification (in realization of their non-complicity and freedom from responsibility for the occurrence of the abuse). In many ways this conflict emerged as the dominant dilemma with which all were grappling and, like the conflict of hope versus hopelessness described earlier, was experienced with much cyclical fluctuation and flux between the two states. This tension, which emerged as an attempt at coping and resolution of the crisis, may also be interpreted as the conflicted positioning of anger in response to the abuse. The constant shifting experienced was reported between the internalized versus externalized positioning of anger. The cyclical and ambivalent alignment of anger, blame and guilt is represented in Figure 4.3 below.

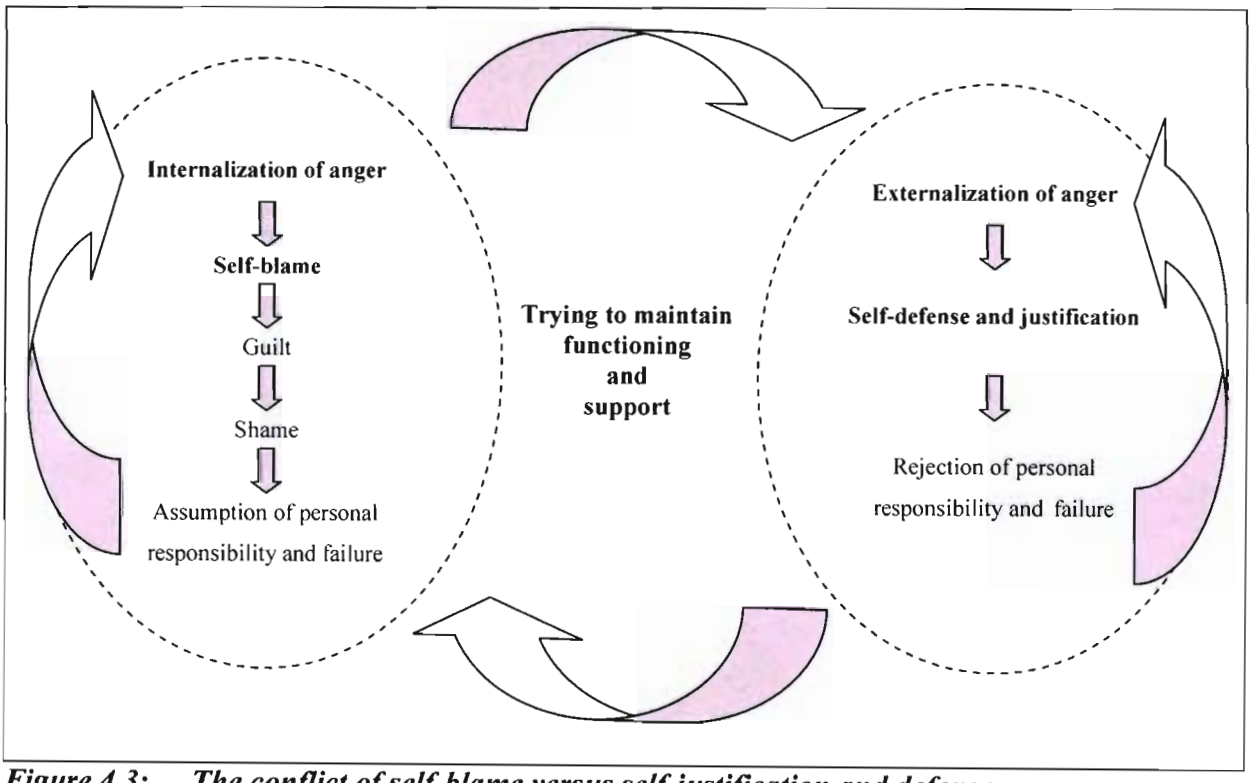


Figure 4.3: The conflict of self-blame versus self-justification and defense

4.5 The centrality of shame

Linked with the conflicted positioning of anger, guilt and blame described above was the centrality of the concept of shame throughout the interviews. This construct emerged as an overriding feature of caregivers' experiences and dilemmas in adjusting to and making sense of their child's abuse. In many ways this construct formed the central link between the inner worlds of both caregiver and child, and possibly represents the major area of experiential convergence

for mother and child. Furthermore, some caregivers described their secret and silent shame in terms that alluded not only to a sense of shared understanding with the child, but also an enhanced sense of closeness and bonding with the child as a result. Despite the obvious negative effect such experience has on self-perception and self-esteem, this dynamic may represent a major point of entry for therapeutic interventions aimed at working conjointly with caregiver and child.

4.5.1 Maternal shame within the family

Caregivers routinely described experiences of shame within both the household and extended families. The links between being either overtly or implicitly blamed, and experiences of shame were made by a few caregivers. Others, however, did not make such connections, and reported a sense of free-floating and "intrinsic" shame that resulted in much subjective experience of suffering in silence. Experiences of maternal shame and guilt were described mostly within the context of gender role socialization and the perceived failure of the maternal duty to protect the child and, hence, prevent the abuse.

One caregiver (Gugu) made the association between her child's humiliation and dehumanization as a result of the abuse, and her own experiences of humiliation and "embarrassment" as a mother within the family. Her fears of negative evaluation and judgement by family members, both male and female, were an overwhelming source of her anxiety and perceived isolation. Speaking via the interpreter, Gugu relayed the following (Page 3, lines 36-44):

> ***"...I don't know how to put it, but just the way that people look at me, looking at my problem and what is happening to me and my daughter...you know, it's like she's nobody in the family because of what this man did. So I just feel embarrassed and embarrassed for my daughter that no-one will just look at her as a person, or as a human being, just because of what has been happening to her repeatedly...that he's been abusing her, sexually abusing her. Now I just feel embarrassed to go to the neighbours or talk to the other people in the area".***

We become aware here not only of the impact upon maternal identity and conceptions of motherhood, but also of the profound effects on constructions of personal worth and "personhood" for the female members of the family. Male family members were described as exempt from such experiences of personal, intrinsic shame and humiliation. While perceived threats to conceptions of manhood and masculinity were reportedly experienced by some male family members, questions of personal worth and value were not raised. Notions of sexual abuse

and rape as the "female shame" are perhaps not as obsolete as we would like to believe, and are strongly enmeshed with social and cultural constructions around gender.

Caregiver isolation within the family (both household and extended) was also reported in association with, and possibly as a consequence of, maternal experiences of shame. Intrafamily isolation and a reported fearfulness of engaging with the subject of the abuse at any level were consistently reported. The abuse, or rape, became somewhat of the dominant, yet unspoken, truth within the family, with members being unable to talk about, or find a common language for what had happened. Issues of family denial as well as the stigma still attached to issues of sex, sexuality, children and abuse/rape, typically resulted in the topic becoming a taboo and closed one in the family. Gugu described this situation as follows (Page 9, lines 30-40):

> ***"We don't talk about it, because we just try to take it away from us. We don't even want to think about it, because we talked a lot about it the day it was happening with her brothers and everybody else who was involved then. But it's still here [motions to her head], because I still think about it. I don't know what about the others, like my sons and my daughter, if she still thinks about it or not... because we don't talk about it at all...We don't talk about it ".***

Caregivers described this situation as one in which the pain was in the silence, with many longing to break the shame and silence within the family, yet fearful to know how.

4.5.2 Community isolation and stigmatization

A further aspect of shame was experienced by caregivers in relation to their broader communities. Perceptions of difference, isolation and stigmatization abounded, together with much fearfulness around evaluation and judgement by the broader community. Caregivers' feared evaluation around issues of maternal competence and failure were the common contexts for such fearfulness and perceptions of isolation within the community. Despite having heard about sexual abuse, most caregivers reported on their sense of being the only ones in their community to face such a crisis. As Busi explained (Script 2, page 5, lines 18-28):

> ***"I'm scared and worried about if the people are saying about me behind my back...[they're saying] that maybe I'm just a careless mother who don't take care of the child...that I'm a mother who just leaves the child with anyone they see. Because I just left my child there because I thought that this was a relative, this was a friend of the family...[I thought that] I don't need to be scared of him being there with my child. So I just have this thing in my head that what if maybe they are saying that I'm a careless mother because I just left my child with some member of the family...a man in my home, and did go wherever I want to go. So I have those just pressuring my mind...which I can never ask anyone about it".***

Subjectively, many caregivers reported experiences of being ostracized in the community as a direct result of their child's sexual abuse. Thandiwe described how she had been "laughed at" by her neighbours as a result of the abuse. Joyce described how she had witnessed parents' of children at her child's school instructing their children not to play with her child as news of the abuse spread. Such public and community fears of "contamination" by the child were enormously distressing for both caregiver and child, and the possible long-term implications on the child's self-concept concerning. Experiences of stigmatization and ostracization by the community at large were clearly based upon both actual and perceived experiences.

Another facet of isolation and stigmatization within the community were concerns around the shaming of the family name, mostly referred to by the Zulu-speaking caregivers. For these caregivers and their families, the sexual abuse of their child was often interpreted as an injustice and sign of disrespect to the reputation and standing of the family within the community. Seeking active revenge upon the perpetrator and his family was mentioned as the primary means of regaining the status of the family within the broader community. The significance placed upon the family group and status, as opposed to any one individual within that group, is a defining element of kinship relations within the Zulu culture.

4.5.3 Maintaining the silence

A final aspect related to caregiver experiences of shame, isolation and stigmatization was the urgency with which they all attempted to maintain secrecy and silence around their child's abuse. This was particularly so in the contexts of the broader family, as well as community. For some this was related to the personal assumption of responsibility and much self-blame, with guilt motivating the need "not to tell". For others, it was related to their needs to protect others, especially other children and members within the family, from the horrors and reality of the abuse. It was clear from their accounts, however, that siblings and family members were, in fact, aware of at least some aspects of the sexual trauma and that the strongly maintained silence and secrecy was counter-productive to family coping. The experience of isolation in attempting to maintain the "secret" and carry the burden of responsibility alone was frequently countered by longings to break the silence in order to unburden and receive support. This dynamic reflects much of the inner conflict and tension experienced by such caregivers, and indicates the need for ongoing efforts towards "breaking the silence" of sexual abuse and rape.

4.6 Consequences to the child and family

In each of the cases sampled, the child and family appeared to bear the full and devastating consequences of the abuse (whether emotional, financial, or other), with little or no direct consequences observed for the perpetrators. In the following section, the individual as well as relational consequences experienced as a result of the sexual abuse will be presented, with particular focus on the emerging series of dilemmas described by caregivers in relation to themselves, their child, the household and extended family, and the perpetrator.

4.6.1 Initial sequelae

Perhaps one of the most distressing sequelae described by three caregivers upon finding out of the abuse, was the child's ultimate removal from the family home. A practical consequence aimed at protecting the child from the risk of further violation, one child was removed by social services to a place of safety, while the other two were removed upon the family's decision and placed in the care of extended family. In the latter two cases, the perpetrators continued to reside within the community, leaving the families with no other option for ensuring protection but to remove the child from the family home. In one case the child was removed from her siblings and mother and placed with the maternal grandmother in another suburb, while in the other case the child was sent to live with relatives in another city. On an emotional and psychological level, the impact of such events was profound for caregivers interviewed, adding to a series of losses and compounding experiences of grief, isolation, loss of control and helplessness.

Another significant aspect of experience for caregivers was helplessness and perceived loss of control around managing the child's distress and symptoms. Caregivers typically reported symptoms of enuresis, sleep disturbance and nightmares, appetite disturbance, anxiety and clinginess, sexualized and provocative behaviours, outbursts of rage and anger, as well as a host of generalized and specific fears in their children. While these emotional, psychological and behavioural sequelae remitted over the short-term for some, other caregivers reported persistent and unremitting psychological and emotional disturbances in their children for which they had no effective remedy. Caregivers' psychological and emotional sequelae in response to this situation included a variety of somatic, cognitive and behavioural reactions to be discussed shortly (see 4.6.3).

4.6.2 The meaning of the abuse for the family

For all caregivers, the sexual abuse of their child represented the single most horrifying and devastating experience for them and their families or, as Gugu explained, "the worst thing imaginable for the family". It would appear that fundamental assumptions and beliefs held about being in the world, about safety and trust, about one's ability as caregiver to protect one's children, and about a justice system that essentially acts to uphold principles of right and wrong by protecting victims and punishing criminals, were simultaneously shattered. The meaning of the abuse, thus, appeared to cut across a number of previously held "givens", impacting on multiple belief systems. As already discussed, caregivers from the Zulu culture described the additional meaning of disrespect to and tarnishing of the family status within the broader community – a personal affront, as it were. Overall, the abuse appeared to represent for caregivers and their families a serious violation of their core belief systems, with a consequent state of dis-equilibrium and destabilization that was cause for much distress.

4.6.3 Differential family response

While it was the maternal caregiver and her experiences that were the primary focus of the current study, the effects upon other members of the family system (including paternal caregivers and siblings) were also listened for. While the researcher recognizes that the maternal perspective provides some insights into the experiences of these others, and that further research aimed specifically at understanding paternal and sibling responses is called for, an attempt will be made to broadly present family experiences as disclosed during the interviews.

4.6.3.1 Maternal response

All of the caregivers reported a host of both initial and enduring psychological and emotional consequence as a direct result of their child's sexual abuse. These may be classed roughly into three categories, namely, emotional, cognitive and behavioural consequences. They all spoke of the initial shock, horror and disbelief upon finding out, with experiences of anger and rage, as well as hopelessness, despair, anxiety, fear and confusion prevalent. Many psychosomatic symptoms were also reported, with sleep disturbance, loss of appetite, headache and migraine, as well as raised blood pressure presented as the common symptoms of stress. A general decline in physical and emotional well-being was reported, with most caregivers making the association between their heightened stress levels and the onset of symptoms.

On a cognitive level, caregivers reported dominant experiences of mental confusion, experiences of "heaviness" and a sense of "losing" oneself. One caregiver (Thandiwe) reported symptoms of depersonalization as she recounted how she felt like she was "in somebody else's body" – a concerning symptom commonly associated with experiences of severe and traumatic stress, and most relevant in supporting conceptions of secondary trauma amongst the caregivers of sexually abused children. As reported via the interpreter (Page 2, lines 1-5):

> ***"She said, like, she was not in her self, her own body…She didn't know what she was thinking at that time. She felt like she was sick, but she didn't know how or where, because she didn't feel any pain or anything. She said [it was] like she was in somebody else's body".***

Another cognitive dimension that emerged as relevant in all of those interviewed, was the element of "imagining" the trauma – a process whereby caregivers were so immersed in "what it must have been like" for the child, that a process of (what can only be described as) "self-traumatization" was set in motion. This process of self-trauma had a distinctly ruminative feel for some caregivers, with one (Helen) describing elements of thought intrusion and attempts at thought avoidance in her effort towards "fighting my thoughts". Gugu reported similar experiences in her efforts to fight off and avoid persistent and intrusive imaginings of her child's trauma. Such experiences resonate strongly with diagnostic criteria for traumatic stress disorders (American Psychiatric Association, 2000) and again support conceptions of a type of trauma response in some caregivers of sexually abused children.

On a behavioural level, and likely consistent with the gendered socialization of roles, many of the caregivers attempted to fulfill a mediating and negotiating function within and beyond the household family both during the immediate crisis and afterwards. This was more so in cases where the perpetrator was previously known to and trusted by the child and family, and particularly so in the two cases of child-on-child abuse where perpetration was by an extended family child. The dilemma for these caregivers was described in terms representing divided loyalties to both their child as well as to the preservation of broader family unity. Despite overwhelming feelings of anger and desires for retribution, such caregivers found themselves in a mediating and negotiating role with the parents of the perpetrator, attempting to manage the problem "between families". As one caregiver (Busi) so aptly put it, "this is a family thing…" while another (Thandiwe) described her feelings of helplessness and despair in light of the fact that the perpetrator "is a family child…".

A further dimension pertinent to the maternal caregiver's interpretation of and coping with the news of her child's sexual abuse is the presence of a maternal history of sexual abuse or sexual trauma. In the present study, the two most overtly distressed and traumatized caregivers (Helen and Gugu) were those with a personal history of sexual abuse and trauma. None of the other caregivers reported histories of either childhood or adult sexual trauma, and the levels of overt distress generally lower for these caregivers than for either Helen or Gugu. Such findings are consistent with the literature that associates a maternal history of sexual trauma (especially childhood sexual trauma) with heightened levels of distress and generally poorer coping compared to those mothers without a history of sexual abuse or trauma, following news of their child's sexual abuse (Carter, 1993; Gomes-Schwartz et al., 1990; Hooper, 1992; Kelley, 1990; Kiser et al., 1991).

Helen reported a re-evocation of her own traumatic memories of prolonged sexual abuse by her grandfather during her childhood years, as a direct result of the current crisis. Her own feelings of shame, as well as her conflicted duties to protect versus hurt the perpetrator, were recounted. Furthermore, the current crisis had prompted a similar re-evocation of painful memory and emotion for Helen's sister, also sexually abused at the hands of the same perpetrator during childhood. The ripple effects of the child's current crisis were, thus, profound and far-reaching, eliciting a host of reactions in extended family as well. The re-evocation that Helen described appeared to result not only in a sense of over-identification with her child, but also an over-compensation for her own childhood experiences of abandonment and rejection when nobody believed her upon her own disclosure.

Gugu's re-evocation of painful memory and emotion was somewhat different in light of the fact that her experiences of sexual trauma and violation occurred during her adulthood, in the context of her marriage. Her dialogue centered mostly around her experiences of powerlessness to negotiate sex with her late husband, with issues of female sexual subordination to male sexual desires being highlighted. Rooted strongly in cultural and social mores, Gugu spoke of the female and wife's duty to respect her husband by succumbing to his sexual desires, with any self-assertion or challenge to the status quo being interpreted as a sign of deep disrespect to male authority. She spoke of her own experiences in the context of imagining the terror her child must

have endured during the rape. Such findings provide much insight into the complex processes and multiple factors potentially involved in influencing responses of the maternal caregiver to CSA.

4.6.3.2 Paternal response

Paternal caregivers, too, were reported to experience a host of both initial and enduring emotional responses to the child's sexual abuse as they attempted to make sense of and cope with the ramifications. In many respects, both maternal and paternal emotional responses and coping strategies reflect traditional gender norms around the expression of emotion, particularly anger. Initial paternal reactions appeared to center around the overt expression of anger, mostly directed towards the perpetrator, and at times directed towards the maternal caregiver and/ or child. Plans for the active seeking of revenge (as acts of physical violence and violation) towards the perpetrator were cause for much maternal distress. Reports from maternal caregivers suggest that much of this anger was directed within the household home as well, with paternal figures aggressing (mostly verbally) toward the mother and child. One caregiver (Helen) reported how her ex-husband had accused hers son of being a "liar", threatening him with imprisonment. Another caregiver (Joyce) reported that the paternal caregiver had become so angered at the child's sexualized and provocative behaviours that he'd punished her. Both such reactions likely reflect much of the shock, helplessness and confusion elicited by CSA. Furthermore, when the perpetrator was previously known to and trusted by the paternal caregiver, similar experiences of helplessness and powerlessness ensued, with conflicts of loyalty emerging strongly. Further, and more specific, research is required into paternal responses to and interpretations of their child's sexual abuse. It would seem, however, that much of the subjective confusion, anger and helplessness reported by maternal caregivers was similarly experienced by paternal caregivers, no doubt mediated by socialized norms around the expression of emotion.

4.6.3.3 Sibling responses

While none of the caregivers interviewed reported specifically on sibling responses, it did emerge that the resultant disequilibrium and sense of destabilization was cause for much conflict, polarization and a breakdown in the usual patterns of communication within the family, both household and extended (see 4.6.4 and 4.6.5). The experiences and adaptations of the abused child's sibling/s, as well as other children living within the household family, represents another significant area for future research.

4.6.4 Dynamic and relational effects

Caregivers reported on a number of central conflicts and dilemmas that emerged in the context of their relationships with others, as well as with themselves, as a direct result of the news of their child's sexual abuse. While some of these dynamic and relational conflicts have already been touched on, a discussion will now follow on the intrapersonal and systemic impacts of the abuse as reported during the interviews.

4.6.4.1 Conflicts in relation to the self

Most caregivers interviewed referred either directly or implicitly to the emerging conflict in their self-concept as a "mother", according to the traditional conceptions and role definitions already expounded. Issues related to role fulfillment and role failure were cause for much internal dilemma as all caregivers grappled, at some point or another, with the notion of their perceived failure to protect. The degree to which they were in conflict with their self-concept and role as a mother appeared largely dependent on how strongly they identified with traditional role definitions, as well as how caught up they were in the cycle of self-blame described earlier. Questions around their competence and adequacy as mothers and caregivers appeared to result in a decreased sense of confidence in their child-rearing abilities – a finding with potentially detrimental consequences to the mother-child relationship in light of both of their needs.

A different aspect of role-conflict emerged in one caregiver, Joyce, as a direct result of the initial sequelae of the sexual abuse and new arrangements made for caregiving. As the abused child's paternal grandmother, Joyce took upon the responsibility of raising the child after it was decided amongst the family that she was unsafe in the home of her mother. Joyce's primary conflict and difficulty was in reconciling the apparently divergent and conflicting role functions of "mother" and "grandmother" in her interactions with the child. Her subjective sense of "playing parts" was cause for much personal discomfort and distress, with the perceived loss of her grandmotherly role resulting not only in disappointment but also in some resentment towards her mothering duties. Her definitions of "mother" and "grandmother" were defined in opposing terms, with "mother" as disciplinarian and "grandmother" painted in all-good terms as someone who pampers and spoils the child. Joyce's proposed solution for managing her dual role functions more effectively was to legitimize and formalize her caregiving function by fostering the child – an outcome providing not only necessary financial assistance, but providing clearer definition of

her role and responsibilities towards the child in the future. This case highlights the negotiation of new rules and parameters for interaction that was a frequently reported outcome of the sexual abuse and its disclosure. Joyce described some of the tension resulting from experiences of role-conflict as follows:

> ***"She's got a mother, but she doesn't call…she calls me 'ma'. She calls me 'ma'. See the children say to her, this is not your mother it's your granny. I said to her one day, when we were sitting at home…?? So she was calling me 'ma, ma', and ??said, 'hey, this is not you mother it's your granny'. And she said 'It's my granny-ma!" [laughs]. (page 12, lines 1-6).***
>
> ***"Sometimes she hurts me when she hugs me and says 'you're my mommy, I love you granny very much'. You know it hurts me because really I am not this, I am not her mother, I'm her granny. Although I can play…I can play that part, but don't forget that her mother is her mother. I do play my part…" (Page 23, lines 32-36).***
>
> ***"Ja, mother and granny. Now she feels…really, when she's big I know she will talk about it. We'll talk to eachother. When she's big she will talk about it. She feels that the love that she's getting from me as her granny she is supposed to be getting it from her mother. From her real mother. And then she knows 'your granny and your mother brought you the same love' although I try my best, I try my best with her. I don't want her to get hurt" (Page 23, lines 40-46).***

4.6.4.2 <u>Conflicts in relation to the child</u>

The central dilemma described by caregivers as a result of the sexual abuse was not knowing how to "be" with the child, as well as manage their distress. This central predicament appeared to center around conflicted perceptions of their child's "innocence" versus "sexualization" (and, by implication, "guilt"), and seemed to be based on a number of subtle sub-themes. Most of these sub-themes were not directly, or consciously, acknowledged but presented themselves in caregivers' descriptions of the subsequent difficulties in their relationships with the child. Some of these conflicts included the following:

- Perceptions of increased, intensified emotional bonding and closeness with the child

  versus

  Perceptions of increased separation, distanciation and isolation from the child.

This dilemma was most keenly experienced by those two mothers with personal histories of sexual abuse and trauma, perhaps suggesting a process of over-identification (and, hence, perceived closeness) with the child, as well as over-compensation for their own earlier abuse experiences. The sense of enhanced closeness was, perhaps, the silent identification with and sharing of the secrecy surrounding the abuse.

- Feelings of support and affection towards the child as "normal"

  versus

  Resisting feelings of aversion towards the child as "abnormal"

In many ways this tension speaks of issues related to acceptance, rejection and blameworthiness. Notions of the child's "normality" and "abnormality" as a consequence of the sexual abuse were grappled with by all caregivers at some point, perhaps representing the strong taboos that exist around children, sex and sexuality.

- Wanting to believe and support the child's account

  versus

  Doubting and questioning the truthfulness of the child's assertions.

This dilemma perhaps reflects most keenly the difficulties accepting the reality of the child's abuse. Denial and minimization were common coping strategies observed, especially in those caregivers who had found out about the abuse more recently. These constructs and experiences perhaps fit best within a model of loss, grief and bereavement.

- Child as a source of stress and maternal distress

  versus

  Child as a source of comfort

Experiencing the child as a simultaneous source of both distress and comfort was disconcerting for some caregivers, impacting upon the nature of their interaction with the child. One caregiver in particular (Helen) described an element of caution and wariness that had developed in her relationship with her one child as a result of the abuse.

Overall, the tensions presented above should perhaps not be regarded as discrete entities, but rather as different facets, or ways of thinking about, the primary dilemma of childhood "innocence" versus the child's "sexualization". This fundamental dilemma was not one of which caregivers were consciously aware, but which permeated their descriptions of the changes in relationship with their child subsequent to finding out.

4.6.4.3 Conflicts in relation to the broader, extended family

While perceptions of family polarization and fragmentation were frequently expressed by all caregivers, it was in the two cases of child-on-child sexual abuse by an extended family child that family conflict was at its worst, causing the greatest degree of internal conflict for the caregivers. As has been described elsewhere, the central conflict that emerged in such cases was a conflict of loyalty, with caregivers feeling the tension to protect both their child and the broader family name and reputation. When the perpetrator was defined as "a family child" and the problem "a family thing", attempts were made to negotiate towards a solution and, ultimately, goodwill with the perpetrator's household family. The perceived outcome in both of these cases was, however, that despite attempts to reconcile conflicting interests, the injustice to the abused child had not been rectified, while the perpetrator received a simple scolding. The pressure experienced by caregivers to "forgive" in such cases was overwhelming. These results suggest that while broader conceptions of "family" form an essential function in terms of shared responsibilities and a broader sense of belonging within the community, the unbearable tensions arising from sexual abuse within this context create perceptions of helplessness to finding a solution.

4.6.4.4 Conflicts in relation to the perpetrator

In a similar vein to the above, when the perpetrator was previously known to and trusted by the caregivers and their families, not only was the experience of betrayal greater, but so too the conflict of loyalties emerging as a result. Joyce described the conflict of simultaneously wanting to punish and "help" the perpetrator – a man known to her family and the child's father for many years. Joyce described her ambivalence and inner conflict in terms of her difficulty reconciling the person with the act.

4.6.4.5 Conflicts in relation to the paternal caregiver

While most of the caregivers interviewed were single parents (either separated, divorced or widowed), their relationships with either the child's father or other male family members suffered as a consequence of increased family stress and disorganization upon finding out. This included the caregivers' partner, sons and, in one case, ex-husband. While the domain of discord cannot be exclusively focused on the caregivers' relationships with male family members, it was the primary caregiving dyad that appeared to suffer the greatest amount of interpersonal discord and conflict. Primarily a reflection of the general breakdown in communication and relationships

reported in the household family as a result of family stress, the sense of isolation and polarization from the paternal partner in child-rearing, support and management was experienced as an enormous source of loss and distress. As caregivers, their partners and their families struggled to find a common language for the sexual abuse, decisions about appropriate action and child management were fraught with conflict.

4.6.4.6 Conflicts in relation to the broader community

A final and most significant tension experienced by caregivers was in relation to their broader communities. Experiences of stigmatization, based often upon actual experiences of community rejection and the withdrawal of support, increased the sense of shame and perceptions of isolation and difference. Caregivers routinely reported their disappointment at the loss of anticipated supports from key members in the communities. In many ways, the tensions reported included elements of both longing for a sense of community re-integration, belonging and support, and yet simultaneously withdrawing due to experiences of shame and needs to maintain secrecy. The cyclical and reinforcing nature of this dilemma is apparent. Gugu described her feelings of difference and isolation from her greater community as a result of her child's sexual abuse as follows:

> ***"...'I feel like I could live, like, just in my own world or in my own place where nobody will see me...because I don't feel like I'm just part of the other community area who was living with me. I just felt like I can go somewhere where I can live alone with my daughter. I don't feel the same as the other people". (Page 4, lines 5-13)***
>
> ***"Ja it's very painful because I never just hear what is happening to my family and any other families around my area. It's as if I'm just the first one to just have these things happening to me...and nobody else in the area talks about it, or even heard if it ever happened in the area that I'm living in. So it's as if I'm just the first one to just have this thing happening to me and my family". (page 10, lines 37-42).***

Overall, caregivers described the series of emerging tensions and dilemmas in both the intra-personal and interpersonal spheres in ways suggesting the comprehensive impact upon their very "being in the world". Such conflicts were tangible in the often angst-ridden and anxious states in which many presented. A final area to be discussed separately is the consequences reported to the household atmosphere and family relationships.

4.6.5 Intra-family isolation and polarization

Caregivers unanimously reported a sense of intra-family polarization and fragmentation as a result of the sexual abuse disclosure. Much family pain was reported not only in the knowledge of their child's abuse, but also in the consequent isolation of members from each other at the time of crisis and afterwards. For all caregivers interviewed, reports of the abuse being a "taboo" and "closed" subject within the home were frequent, with members not knowing how to talk about it and, hence, common experiences of "suffering is silence". Breakdown in family structures for interaction and communication were reported in statements such as "we don't talk about it at home..." and "we don't talk to [the child] about it..." (Joyce), with "it" referring to the unnamed and unspoken truth. Some caregivers reported on their conscious decision to maintain "silence" in order to protect other family members (particularly siblings of the child) from the horror of the abuse. Others reported a general sense of dis-integration and polarization while yearning for normal contact with other family members, and wondering whether other members were experiencing similar isolation. The family's disbandment was yet a further source of experienced loss for caregivers. It would seem, too, that the often conflicting and divergent needs of family members resulted in common experiences of isolation, with the one not knowing how to be there for the other. Furthermore, reports from caregivers suggest that different family members responded in different ways and at different times to news of the child's abuse, providing a disjointed and un-coordinated feel to the usual flow of family life. Overall, it was caregivers' yearning for a state of family equilibrium and balance once more that was communicated most strongly. It is perhaps our task as professionals working in the field to facilitate the incorporation of the abuse into the family's life-story so as to enable a new equilibrium to be established with, perhaps, different means of communication and interaction amongst members.

4.7 Coping with loss

Coping, adjustment and adaptation to the series of complex losses associated with CSA will be discussed according to the two primary sources of support identified by caregivers, as well as the identified cognitive strategies that were typically reported to assist with coping.

4.7.1 Social support

The presence of at least some support from friends, family and community members emerged as a significant buffer against the host of stresses accompanying disclosure and the consequent

involvement with the CJS. Furthermore, the perceived loss of anticipated support during and after the immediate crisis of disclosure emerged as an additional stressor, enhancing perceptions of hopelessness, despair and isolation within the broader family and community contexts.

4.7.1.1 Perceived loss of anticipated support

The majority of caregivers expressed a deep sense of sadness and disappointment at the generalized perception of inadequate emotional and practical support in the events following their "finding out". This was the case for all of them, irrespective of the length of time since disclosure, although the greatest frustrations were communicated by those most recently faced with the crisis.

Caregivers described a perceived lack of anticipated support from family (both household and extended), the greater community, as well as the CJS. Much of the perceived lack of support from family members and the greater community appeared to be closely linked with themes of secrecy, silence and shame, with caregivers generally fearful of approaching significant family and friends for fear of rejection and blame, yet simultaneously yearning for both practical and emotional support. Experiences of isolation and inadequate support were perhaps a function both of the caregivers' withdrawal (due to perceptions of self-blame, shame and guilt) as well as family polarization during and after the time of crisis. In a sense, it was as if the pre-existing norms, scripts or "rules" for family interaction and, hence, mutual support and comfort, were so fundamentally shattered that family members no longer knew how to comfort or support each other. Caregivers typically reported experiences of the family unit (whether the caregiving or extended family) feeling ill-equipped to manage such a crisis, with members typically withdrawing in their individual efforts to cope. Such findings, too, correlate with a model of family "myths" in which the basic family rules for interaction become severely challenged and compromised as a result of the family's distress and trauma (Van Scoyk et al., 1988).

Apart from perceptions of self-blame and the consequent isolation that no doubt perpetuated many of the caregivers' experiences of inadequate support, another reality was also expressed. Many caregivers described the overt blame and explicit withdrawal of support from both family members and friends/ community members whose support was anticipated. The pain and shock of this reality was experienced in terms of loss, as expected avenues for practical help and

emotional support were withdrawn, perhaps further impacting upon experiences of grief. When one considers, too, caregivers' reports of their contact with the CJS, the primary experience was that of their disappointment and frustration at the lack of anticipated support, as well as some experiences of direct blame. The cumulative effects of such losses (both at the individual level as well as at the family systems level) cannot be undermined. Considering the general lack of resources for most of the caregivers (including financial, practical and emotional resources), interventions aimed at providing care for families in such crisis perhaps optimally need to adopt a more comprehensive approach. As such, as many as possible of these needs should be addressed to some degree.

4.7.1.2 Valuable sources of social support

Those caregivers who perceived themselves and/ or their families to be receiving adequate social support reported the value of both household and extended family support, as well as the value of lay support from some friends, neighbours and (in the case of Helen) the domestic worker. In all such cases it was the perceived alliance, the sharing of burden, and the consequent decrease in perceived isolation that emerged as the central components that made up experiences of having received support. A further noteworthy aspect of support was the negating of self-blame and the re-positioning of culpability towards the perpetrator that caregivers so desperately needed to hear from significant others and friends. This was observed to be essential in shifting experiences of helplessness, that were so often associated with internal dialogues around self-blame, and mobilizing constructive and "hopeful" thoughts and actions. Furthermore, caregivers reported on the benefit not only of receiving emotional support from friends and family, but also of receiving practical advice and assistance. As caregivers attempted to negotiate a host of novel demands and experiences with their child, family, and the CJS, needs for practical advice (for example, on the processes and procedures within the CJS) as well as practical assistance (for example, babysitting while the caregivers are attending court hearings/ counselling sessions, and financial assistance for travel expenses incurred as a result) were high. In many ways, caregivers reported feeling unprepared for the many consequent demands placed on them as a result of their child's sexual abuse, and could perhaps benefit from intervention aimed at empowering them regarding the variety of demands and processes in which they are likely to become involved. One suggestion is that such areas be addressed and developed in the form of a protocol for working and intervening with families in such crisis. By being empowered and prepared gently in this way, caregiver

perceptions of control and competence may increase as demands arise, hopefully serving to improve their own experiences of coping.

4.7.1.3 Social support and resilience

A significant observation made in the current research, and which finds support in the literature on resilience and coping (Killian & Brakarsh, 2004; Masten, 2001; Rutter, 1999) was the relationship found to exist between perceived access to support, and experiences of emotional distress or resilience. It was noted that those caregivers who either received more support, or, perceived greater accessibility to emotional support (whether via the family, the community, or via social services) reported generally lowered levels of emotional distress, or, less persistent symptoms related to their distress. The corollary was also found to be true for those caregivers who were more isolated, received little support, or, who perceived little direct access to support – such caregivers were found to be experiencing heightened levels of distress, more severe and more chronic symptoms related to their distress. It would seem most significant that it was caregivers' perceptions of their "connectedness" that was so strongly related to subjective reports of enhanced coping and resilience. The researcher experienced these findings directly in the context of feedback during the second interviews, which were aimed at providing containment and debriefing, and receiving feedback on the process. Most caregivers reported on their positive experiences of having received support during the interview process, as well as receiving information to access supportive resources (for some), linking this with their increased feelings of hopefulness for the future. This was an unexpected, and yet positive, outcome and finding of the interview processes. Recognizing both the unique needs of caregivers of sexually abused children, and the particular relationship between caregiver and child mental health and well-being, such findings would perhaps be optimally translated into public health policy efforts towards increasing perceptions of access to resources for social and emotional support. This, no doubt, needs to accompanied by and followed-through with the provision of adequate public health services that address both the practical and emotional needs of families in such crisis.

4.7.1.4 Needs for professional support

A consistent need, expressed by all caregivers interviewed, was for professional support and advice regarding issues of child management, system involvement, as well as caregiver strategies for adaptive coping and adjustment. Those caregivers who had experienced professional support

(most often from social workers or psychologists involved in their child's counselling process) reported the enormous benefit of such input. Busi described her experience of having received professional support as follows (Page 7, lines 36-39):

> ***"I think that if you have a problem and don't talk about it, it can affect you much more than if talk about it...because the fact of being able to talk about it with [psychologist] has just made it a little bit easier to understand and try to know what the boy did to my daughter".***

Perhaps most central to such input, and addressing the resulting caregiver insecurities regarding issues of competence in relating to and raising their children, was the reassurance provided in their parenting abilities. Coupled with the dissemination of practical advice, skills and information for managing the consequent behavioural and emotional difficulties in their child, their families, and themselves, caregivers receiving such input reported experiences of feeling empowered in their knowledge and skills as caregivers. Very few caregivers interviewed were receiving regular, ongoing support, be it professional or not, and most expressed needs for such input over the longer term of adjustment. These findings perhaps highlight the dual educative and preventative aims that professionals working with such caregivers and families need to uphold – firstly, the need for a more active, directive professional role initially as the family adjusts to and manages the sequelae following disclosure; but with the underlying philosophy, and fundamental aim, of empowering, reinforcing and strengthening pre-existing caregiving skills, such that caregivers and families are ultimately able to cope independently and adaptively.

4.7.2 Faith in a higher power

For many of the caregivers interviewed, the centrality and significance of their religious and spiritual beliefs served as an enormous source of strength, facilitating subjective experiences of coping and hopefulness. Consistent with some of the literature on coping and resilience to adversity, caregivers' faith in a higher power appeared to function as an important protective factor, or buffer, against some of the stress and turmoil that accompanied the process of "finding out" and the sequelae of the sexual abuse (Mallman, 2002). In many ways, such beliefs emerged as the only constant that spanned the times pre-disclosure and post-disclosure, perhaps acting as a stabilizer or the one consistent "truth" for those with pre-existing religious beliefs.

4.7.2.1 "Managing through God"

It was a faith and belief in the protection offered by their God that emerged as the most reliable source of hope and strength for those caregivers with pre-existing religious beliefs. These caregivers consistently reported the comfort and peace offered through prayer, and the decreased sense of isolation in their coping (compared to those with no pre-existing religious or spiritual beliefs). The belief in a higher spiritual power thus emerged as an important vehicle for hope, as well as enhanced perceptions of personal resilience. In her descriptions of "managing through God", Shamila expressed the following about the time of her child's removal from the home as a consequence of the sexual abuse (Page 10, lines 35-46; page 11, lines 1-6):

> ***"Whatever I should do I just stand and cry and think about my child, where she is…I go to bed, I see her bed is missing, I sit, I cry…and pray. … I told God, answer my prayer. Forgive me for what happened. So He really forgave me. And He brought my baby back. He brought my baby back ok, so I said no, we must give our heart to Lord. … So that's how, you know my mind, whatever I think, it comes out. I don't keep it up like worries, so maybe if I got worries too I go sit and talk [to God]…I mustn't keep worries. I mustn't keep worries… You see what happened…it comes in my prayers…[tearful]".***

4.7.2.2 Faith in the "system"

Part of the subtext that emerged in interviews with all caregivers, irrespective of their religious beliefs, was the conflicted hope and faith placed in the CJS – a system initially representative to them of a higher, all-powerful entity with the promise of hope and assistance. As previously discussed in the context of the cycle of hope versus despair, caregivers' hope for salvation in the CJS became ambivalent as experiences of the systems' inefficiency became a reality, with the consequent disappointment and loss of hope. In many ways this tension represents our common human need to hold onto that which potentially represents hope, and the difficulties experienced when this belief is challenged. Another interpretation in the context of our collective national history (and, perhaps, collective unconscious) may also help to understand this tension, namely, the divisions of power that were so entrenched in the apartheid era and the collective experiences of oppression and powerlessness suffered by our Black, Indian and Coloured communities. Furthermore, our history of paternalism and unequal gender relations may facilitate an object relations interpretation of the faith and hope placed by caregivers in a paternalistic, all-powerful system. Taken together with an appreciation of our collective history of political division, such an interpretation may assist in our understanding of the desperate hope placed by caregivers in the CJS.

4.7.3 Coping strategies

Upon reflection, the researcher became aware of a number of common cognitive strategies employed by caregivers in their efforts towards coping. None of these cognitive strategies were reported on directly, but became evident in the context of the researcher's sustained engagement with the texts. While these cognitive strategies will be reported on as discrete mechanisms aimed at comprehending, constructing meaning around and accepting the abuse, it was observed that most caregivers used a number of strategies. In their efforts towards negotiating the reality of the abuse, caregivers were observed to use various coping strategies simultaneously, and in relation to different sets of issues. These strategies are reported on in no particular order, and keenly represent some of the internal dilemmas experienced by caregivers interviewed.

4.7.3.1 Wishful thinking

An element of wishful thinking, together with what may only be termed "blind faith" was observed in relation to caregivers' beliefs in a higher power, including beliefs in the CJS as well as in their God. Without undermining or underestimating the enormous faith placed in religious/ spiritual beliefs and the consequent effects on increased perceptions of resilience and coping, some caregivers were observed to place their hope and faith somewhat helplessly in an all-powerful God, or, in the all-powerful "system". While the possible reasons for this have already been discussed, it must be noted again that this emerges as a possible gesture of helpless desperation for some beacon or symbol of hope. The importance of retaining some element of hope is, thus, observed to be immensely important for caregivers and families in such crisis and should, thus, serve as a guide for professional intervention. One caregiver, Joyce, reported on her use of prayer and her reading of the Bible as mechanisms for avoiding, denying and escaping the pain and helplessness of her reality. Without taking away from, or undermining, the immense comfort that prayer held for her, it was also clear that she was defending strongly against the pain of her thoughts. In her words (Page 6, lines 25-27 and 41-45; script 2, page 29, lines 4-22; script 2, page 29, lines 6-22):

> ***"And you know, and sometimes I just blame myself...why did I allow the child to go? That's the thing that's been worrying me, but I tried to forget about it. I'm a person that sits and reads the Bible...and pray... Ja, just sometimes I feel, actually I really don't want to talk about it ...it's sore...and then I pray".***
>
> ***"...when it comes to the bus fares and all that things. And it's not only my responsibility, the food and all this up and down. But you know God is great. God will help me. I trust Him. At times, when I think of bad things, then I cannot lie...I will leave everything into God's hands. If [perpetrator] doesn't go to jail,***

then really…it's been too been too long with this up and down…I will pray. I will say to God 'everything is in your hands now'. You won't believe sometimes, I sit at home with no…nothing. I don't know what to do or where to start, but I pray. And I pray. God's helping me".

4.7.3.2 Finding "evidence" retrospectively

Another strategy employed by some caregivers, particularly those more recently affected by the news of their child's sexual abuse, were the attempts to find "evidence" for the sexual abuse retrospectively. Understood in terms of attempting to make meaning and sense out of the incomprehensible, and regain some measure of control, some caregivers reflected almost obsessively around signs and signals (for example, changes of behaviour in the child and/or others) that may have been missed and which were potential indicators or "evidence" for the child's abuse. Such efforts were closely linked with caregiver experiences of guilt and self-blame at not having noticed any signals of the abuse prior to the process of disclosure. The turmoil involved in such attempts was tangible for one mother (Helen), whose efforts to identify the unknown perpetrator developed into a somewhat unhealthy motivation towards interpreting others' behaviours in terms of their guilt or innocence in abusing her children.

4.7.3.3 Denial and thought avoidance

The use of denial as a strategy for coping was frequently reported in terms of "wishing away" the reality of the abuse, as well as the resulting emotional pain and the burden of responsibility experienced. Busi described her experiences of wishing away the pain as follows (Page 5, lines 36-41):

> ***"…I was thinking more about…about being somebody else. Because I couldn't… And now, I wish that I was somebody else, or somebody else could take that place for me. So I wouldn't be the one to just get the boy out…I didn't want to speak to that boy…so I couldn't do this thing so I had to just look [watch, wait]"***

Closely linked with strategies for denial were attempts at avoiding distressing thoughts. One caregiver (Gugu) presented with more overt symptoms of traumatization and distress in her attempts to avoid persistent "imaginings", or images, of her child's traumatic experience. Her experience of such attempts at thought-avoidance was distinctly distressing, resonating with classic symptoms of the post-traumatic stress model as described in the Diagnostic and Statistical Manual of Mental Disorders-IV-TR (American Psychiatric Association, 2000) (see Appendix A and B).

4.7.3.4 Justification and rationalization of losses

Another strategy employed by all caregivers at different stages in the interview process, was the self-talk observed not only around justifying and rationalizing the abuse in terms of their own perceived negligence or neglect, but also rationalizing the consequent losses experienced in terms of their relationships (with the child, with members of the caregiving family unit, with extended family members, and with the greater community). In many ways such strategies may represent efforts towards regaining a sense of control and mastery of the abuse and its many consequences.

4.7.3.5 Normalization and minimization of losses

Closely linked with the above were observed attempts to normalize the child's abuse in terms of the vast statistics of child sexual assault in our country, as well as minimize the far-reaching impacts of the abuse upon multiple relationships both within and beyond the family. Efforts at "playing down" the abuse and the consequent strains on relationships were not interpreted to indicate a lack of concern but, rather, helplessness at a pandemic that is starting to emerge as a "norm" within certain communities.

4.7.3.6 Isolation and withdrawal

As has been discussed in detail, family attempts at coping were largely reported to include the polarization and isolation of family members as dominant strategies. As previously mentioned, the centrality of shame and the consequent lack of a common language for the abuse, were typically reported to result in intra-family isolation while new parameters for interaction and communication were slowly and tentatively negotiated.

4.7.3.7 The cycle of hope versus despair

As previously described, the cycle of hope versus hopelessness and despair may also represent cognitive efforts towards coping and the negotiation of the current reality. Furthermore, the cyclical, fluctuating and often ambivalent quality of living both with hope and hopelessness represents the temporal tension that exists within any significant loss. In other words, the tension that results from living with the present reality and all that represents, while reminiscing over the stability of the pre-disclosure past, while longing for a place in the future when all is "forgiven and forgotten" and the loss has been successfully negotiated. Much of the distress described by

caregivers is likely representative of the difficulty in tolerating such uncertainty and ambivalence in their efforts towards coping.

4.7.3.8 The conflict of self-blame versus self-justification and defense

The conflicted positioning of blame and culpability as previously described may also represent cognitive efforts towards coping and adaptation. The cognitive transformation of shame and blame from an internalized towards an externalized positioning represents the continuum with which all caregivers interviewed were negotiating, and perhaps best represents their ongoing efforts towards acceptance and ultimate adaptation.

It must be noted that while some distinction was reported to emerge between maternal (or female caregiver) and paternal (or male caregiver) coping strategies in the face of, and subsequent to, the loss and trauma of the child's sexual abuse, these cannot be reported on with any accuracy and remain the domain for future research efforts into paternal responses to the child's sexual abuse. It would seem, however, that distinctions and differences between immediate and enduring patterns of coping for maternal and paternal caregivers would appear to follow the trends of gender role socialization for the expression of emotion.

4.8 Experience of the interviews

A final area that requires reflection on, in the researcher's attempts to adequately report and represent the experiences of caregivers, is their experience of the interview process itself - an area that was addressed in the second, follow-up and debriefing interviews. Due to the sensitive subject matter as well as the recency of disclosures for some caregivers, the researcher was aware from the outset that the interview process may, in fact, elicit painful emotions for some. On the other hand, the researcher was also cognizant of the potential cathartic value that the opportunity to express thoughts and feelings surrounding the abuse may have for others. Feedback (both during the first and second interviews) indicates that for all caregivers, both elements were present in their experiences of the interview process.

4.8.1 The pain of recollection

All caregivers were, during the recollection of painful memories and events, at times distressed. The researcher approached the task of interviewing with a clear understanding of the ethics of

interviewing around sensitive topics and resolved to cease pursuing any line of questioning that was causing unnecessary distress. This was not found to be necessary in any of the interviews, and the researcher was generally able to manage and respond with empathy to caregivers' distress as necessary. The pain of recollection was experienced more intensely for some than for others, with the length of time since disclosure not consistently emerging as a mediating factor in this regard. This suggests the presence of other protective or vulnerability factors (such as the presence and availability of social support) that may have served to ameliorate or exacerbate the levels of distress experienced by caregivers during the interviewing process.

One caregiver (Busi) reported on her distress at experiences of reliving and re-experiencing the trauma as it happened on the day she found out of her child's abuse seven months previously. For this caregiver her experience of being interviewed reportedly confronted her with the reality, again, of her child's abuse, challenging the denial that had served as her primary coping mechanism in the interim. In her words (script 2, page 6, lines 4-8):

> ***"Ja, after I talked to you I just felt like the thing that happened to my child was happening again. It felt like it was happening at that moment. I felt sad. I felt like I'm going to do something to the boy who did something bad to my child. It was like it was just happening all over again".***

The quality of the interview with another caregiver (Helen) was particularly vivid and highly indicative of high levels of distress. For both of these caregivers, levels of social support were minimal and family structures unstable. While the length of time since disclosure may possibly mediate the levels of distress experienced and the type of psychological sequelae unfolding over the short- and long-term, the researcher found that the availability, accessibility to and receipt of social support was a more consistent predictor of caregiver functioning and well-being at the time of the interviews.

4.8.2 The value of feeling heard

Despite the re-evocation of painful emotion described, all caregivers also reported on their positive experiences of feeling valued for their input and understood during the process of being interviewed. For most caregivers, it was their first opportunity to share freely their thoughts and feelings surrounding their child's abuse, and for many their first contact with someone interested in their perceptions and experiences. Positive feedback indicated that caregivers had benefited from experiences of feeling heard, valued, important, and (according to Busi) accepted and "not

judged". Reflecting on her experiences during the interview process, Busi stated (script 2, page 1, lines 8-10; script 2, page 7, lines 21-24; script 2, page 7, lines 40-45):

> ***"Even though I was...it was just painful last time...when you come and I talk I can feel that it's ok. When you understand what I am going through. And I just felt better each day".***
>
> ***"...What I just felt in the interview is that it was helpful to talk to someone who didn't just judge me, someone who tried to understand what I was going through. And I just want to thank you".***
>
> ***"She said thank you very much, because you have made her feel like an important person because of what she went through. You come and talk to her and try to show some understanding of what happened to her. You made her feel like an important person that makes her feel that she's not alone in whatever she tells you, and that makes her feel great about herself..."***

Furthermore, caregivers reported on the positive experience of unburdening the self and sharing their pain, an outcome that was linked directly by one caregiver (Gugu) to a decreased sense of isolation, and increased sense of hope as a result of her participation in the interviews. Speaking through the translator, Gugu said the following (script 2, page 15, lines 7-9; script 2, page 15, lines 18-22):

> ***"She said 'thank you for the advice' because you are just helping her to realize that she is not alone, she's got someone there to care and to carry it with her.... She said 'ja, the things we talk about in the last interview was much helpful because it feels like there is some kind of heavy things that you take off of' her shoulders...so by that time, when she got back at home, she just feels relaxed, she feels relieved to talk about the problems that's bothering her".***

Many, too, expressed a sense of relief at verbalizing, for the first time, their experiences of shame and self-blame. The researcher is grateful that these therapeutic outcomes had, in fact, formed such a significant aspect of experience for most caregivers during the interview process, countering the evocation of painful thoughts and memories.

4.9 Conclusions

The three dominant themes, representing major areas of experience, involvement and dilemma, for those caregivers of sexually abused children who were interviewed in the present study include the following: experiences of their contact and involvement with the multiple services comprising the CJS; experiences of attempting to manage their own, their child's and their family's responses to and distress following the process of "finding out" about the sexual abuse; and experiences of support, coping and adaptation over both the short- and longer term of adjustment for child, caregivers and family alike. While the results have been presented in

discrete terms, it is hoped that the complexity of experiences, as well as the multiple dilemmas faced by these caregivers, have been adequately illustrated. It has been the researcher's most earnest intention, and a most significant privilege, to "give a voice to" these caregivers and their unique experiences, and it is hoped that continued research in this area will contribute towards lifting the overwhelming sense of shame, silence and suffering experienced by so many in relation to CSA.

CHAPTER FIVE

RECOMMENDATIONS AND CRITIQUE

Two of the most pressing issues within the current South African context concern the proliferation of CSA and, closely related to this, the HIV/AIDS pandemic. Despite recent increases in public and research awareness of the prevalence, ramifications and likely implications of these ills for our society at large, it would seem that the translation of such awareness into appropriate public health policy and intervention, as well as criminal justice process, remains an urgent and ongoing task. Public health strategies aimed at optimizing both the physical and emotional well-being of our children, caregivers and families clearly need to be addressed in adjunct to the provision of financial assistance and basic needs.

While CSA is not particular to any social or class category, it became abundantly clear during the current research that poverty constitutes a major risk factor for child abuse in general and, more specifically, CSA. Furthermore, the lack of available resources for the impoverished (including financial, supportive and emotional resources) makes way for maladaptive coping and adjustment following CSA. Impoverished children, caregivers and families are, thus, at potentially increased risk for both physical and mental illness following such adversity as sexual assault, and intervention following sexual abuse perhaps needs to be guided by a multi-pronged approach towards physical, emotional and financial care. In accordance with some of the literature on building resilience (Masten, 2001; Rutter, 1999), such efforts towards upliftment perhaps need to be rooted more fundamentally in a philosophy of empowerment and capacity-building.

Based upon the above discussion, as well as the needs communicated by caregivers during the current research process, the following chapter will address not only the implications of the present research findings for policy development and intervention strategies with caregivers and families affected by their child's sexual abuse, but also the limitations of the present study. With regards to the latter, a number of recommendations will be made for future research in this important area.

5.1 Implications of the findings of this research

Perhaps the most dominant communication by caregivers interviewed was their sense of disappointment at a CJS that was supposed to uphold and protect the rights of themselves and their children, but which ultimately failed to do so. Pre-existing perceptions of the nature of services and assistance offered were not realized in actual experience. Common experiences of an unwieldy system, in which the constituent parts were not observed to be in effective communication with each other, typically left caregivers overwhelmed with helplessness, and with the perception of no direct point of contact for their assistance.

Two factors need to be acknowledged here. Firstly, the overwhelming and often ambivalent emotions experienced by caregivers of sexually abused children may precipitate a situation in which unrealistic expectations are set for those agencies and individuals involved in assisting them. This points, perhaps, to the recognition of the unique experiences and needs of such caregivers and families. Secondly, it must also be acknowledged that the CJS involves multiple services and role-players, some of whom are faced with enormous caseloads. The nature of the work with sexually abused children and their families is particularly taxing, with compassion fatigue and, hence, decreased efficacy and job satisfaction a reality for many. These two considerations aside, the apparent discrepancy between criminal justice policy and service on the ground is concerning. In light of the many children and their families coming into contact with the CJS, concerted and ongoing efforts need to be made not only towards policy development, but also towards the translation of policy into skilled and efficient service provision.

5.1.1 Caregiver-child functioning and well-being

As previously mentioned, there exists a complex interplay between child and caregiver mental health and well-being (Newberger et al., 1993; Rosenthal et al., 2003). Based on results of the present study, it would seem that the delicate relationship existing between child and caregiver functioning is reciprocal and mutual in influence – those caregivers who were observed to be coping more adaptively had children who were reported to be coping more adaptively and with fewer adjustment and interpersonal difficulties; and those children who were reported to be coping less adaptively and with more adjustment and interpersonal difficulties had caregivers who were observed to be coping less adaptively. While the reasons for adaptive coping and resilience to adversity are multiple and varied (Masten, 2001; Rutter, 1999), the availability of

social support as well as the presence of religious belief emerged in the present research as significant predictors of caregiver functioning at the time of the research. Recognizing the complex relationship between child and caregiver functioning and well-being, and recognizing the potential for longer-term interpersonal maladjustment in children who have been sexually abused (Killian & Brakarsh, 2004), it would appear that interventions aimed at optimizing caregiver coping, adjustment and functioning would likely have positive repercussions for the child's adaptation and ultimate adjustment. It would, thus, seem that the provision of more specific caregiver support would serve as a vehicle for recovery within the child-caregiver dyad as well as broader family relationships.

5.1.2 Guidelines for protocol development

With regards to the above, two findings from the current research emerged as relevant to the development of protocol and intervention strategies for caregivers of sexually abused children. Overall, it became apparent that the experiences and needs of such caregivers are multiple and unique, requiring not only a more specific response but also more coordinated management from the various members involved from the criminal justice and social service systems.

With regards to this, caregivers in the present study communicated four specific needs that may serve to guide intervention:

(i) needs for practical "advice" in connection with managing the child's distress, and behavioural and interpersonal responses;

(ii) needs for practical information regarding the criminal justice procedure and their involvement therein;

(iii) needs for their own emotional support and comfort;

(iv) needs for greater inclusion within the criminal justice procedure and their child's counselling, as well as for feedback;

Also mentioned as an additional source of stress for these caregivers was the financial implication of involvement with the CJS - needs for the financial reimbursement of costs incurred as a direct result of system involvement may be added to the list of needs above.

(v) needs for financial recompensation and assistance.

In terms of an underlying philosophy, or approach towards the development of policy and intervention, many of the fundamental aims of community-based psychological interventions would seem relevant (Orford, 1992). Primarily, these include the aims of empowerment, the mobilization of available resources and capacity-building. An approach towards education and prevention is also strongly advocated within community-based interventions (Orford, 1992) and would seem most relevant to the present recommendations.

5.1.3 Recommendations for intervention

In light of the above-mentioned recommendations for protocol development based upon an approach towards empowerment and education, certain strategies for intervention are suggested. Firstly, it would seem that specialized training into CSA and the unique needs and experiences of children and caregivers affected is required. Such training would need to be accessible to all role-players in the CJS in contact with sexually abused children and their caregivers, and would need to be specifically applied and made relevant to their discipline. The development of core empathy and sensitivity would, on the basis of the current results, appear to be most fundamental in terms of a general attitude.

It became more than evident during the current research that in their initial contact with the CJS, caregivers required a more directive and active approach from role-players. In a sense, they required someone or some institution to take an initial measure of control, actively assisting them to restore the order and continuity of family life. In this regard, specific information regarding child-management and their likely negotiation through the CJS was required. Caregivers needed, as it were, to be more adequately educated and prepared for the outcomes and events that would likely ensue. At the same time, the caregivers interviewed were found to be suffering enormous doubt, and silent shame, in their competence as mothers. The reinforcement and strengthening of pre-existing caregiving abilities and competence would also seem essential when intervening

with such caregivers. Overall, it would appear that caregivers needed to be responded to with a supportive and empathic approach, aimed at fundamentally educating and empowering caregivers through a gentle preparation of likely behaviours in their children, as well as their likely contact with the CJS. One suggestion is that such recommendations be developed into a protocol for intervening with such families. The danger, however, is that such protocol is applied mechanically and without the necessary sensitivity to unique situations and needs that may emerge.

In terms of intervention, a final point relating to the provision of more specific counselling and therapeutic services needs to be made. It would seem that individual child counselling remains the order of the day in terms of professional therapeutic input, while caregivers are typically either neglected in the process, or, referred elsewhere for their own individual professional support. In light of the current findings, a couple of factors need to be considered in this regard.

Firstly, caregivers expressed their needs for greater involvement and contribution to their child's process of healing. Secondly, the current findings suggest massive family polarization and interpersonal alienation as a direct result of the child's sexual abuse. This was reported most keenly within the child-caregiver dyad, with much anxiety and helplessness expressed around not knowing how to talk about the abuse with the child. Thirdly, and in relation to the consequent alienation within the family, the current results suggest that the major point of experiential convergence for both caregiver and child was in the silence of their shame. Fourthly, the numbers of sexually abuse children and their families coming into contact with the CJS and counselling services is vast, and available resources for therapeutic intervention clearly need to be optimized.

Bearing all of the above in mind, it would seem that a place exists for conjoint therapeutic intervention, including both child and caregiver in a process aimed at facilitating interaction around the sexual abuse and its meaning for the family and, hence, lifting the shame. This would also provide an ideal space in which to reinforce caregiver parenting skills and, hence, re-establish a sense of competence. As the results of this study highlight, the effects of the sexual abuse are felt most keenly within relationships and, hence, relationships should represent the key focus for intervention. In this regard, family counselling and therapy would also perhaps serve as an avenue for intervention. While specific training would be necessary in order to facilitate such

conjoint work, the potential benefits for the child, caregivers and family would likely outweigh such initial investments. The viability of such interventions would need to be assessed in ongoing research. The above-mentioned recommendations for protocol-development and intervention strategies are summarized in Figure 5.1 below.

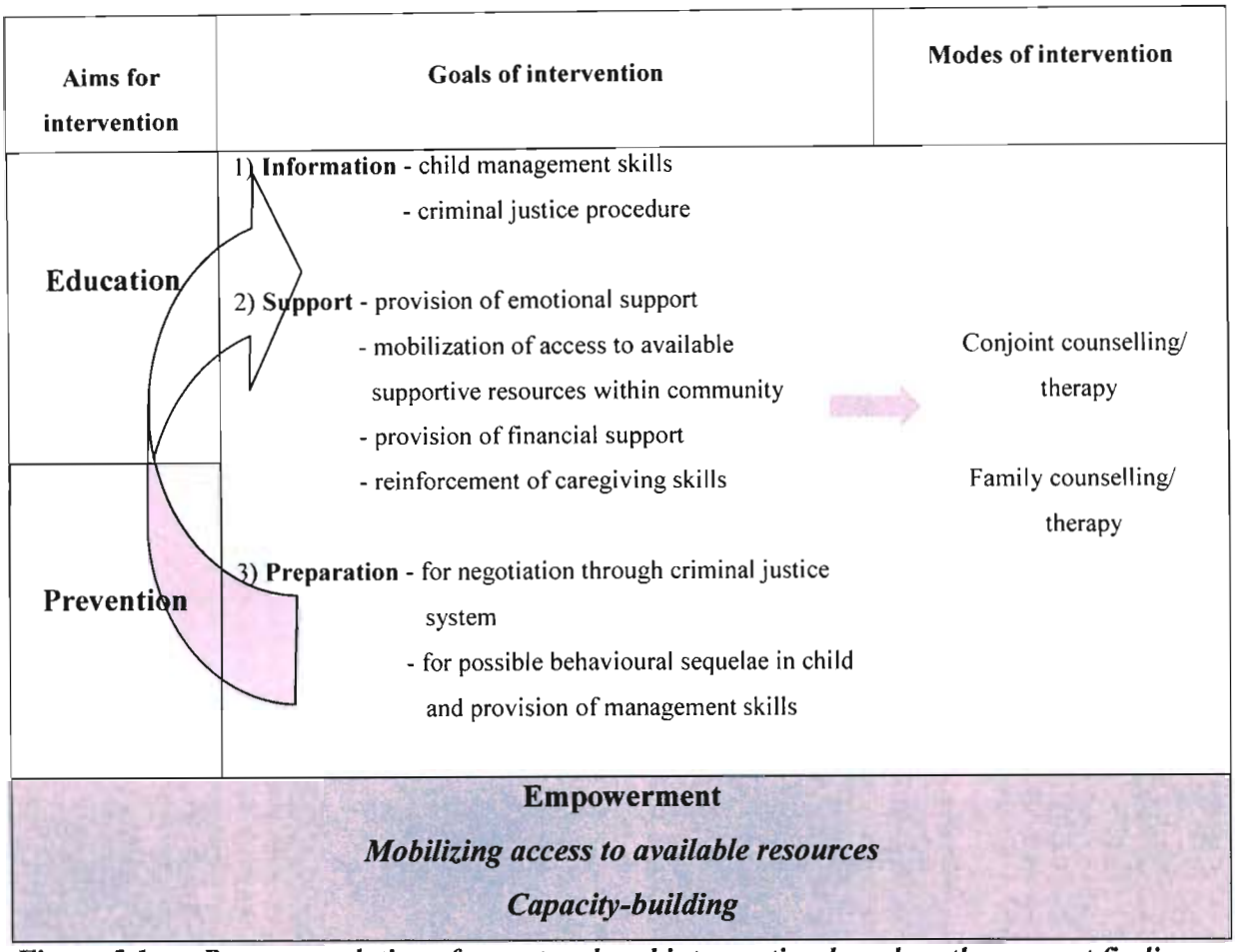


Figure 5.1: Recommendations for protocol and intervention based on the present findings

5.2 Limitations of the research

For the sake of transparency and ongoing efforts towards improving research methodologies (particularly within the field of qualitative analysis) a number of limitations within the present research need to be acknowledged. One of the greatest limitations was the small sample size – while significant, the experiences of the six participants cannot be generalized to understanding the total experiences of the greater population of caregivers of sexually abused children. Ongoing research efforts using larger sample sizes would assist in this regard.

In attempting to access the experiences of Zulu-speaking respondents, the use of a translator was necessitated. While every attempt was made on the part of the researcher to standardize the research questions in Zulu, the translation of responses and meaning back to the researcher was found to be inherently problematic. During the dialogue between two languages and two cultures, the researcher was aware that the subtle nuances of meaning and emotion conveyed may have been lost in the translation. Furthermore, the dialogue that occurred between the translator and participants outside of the formal interviewing time was lost to the researcher. Such informal interactions may have added much to the depth and richness of information conveyed, enhancing understanding of the lives of these caregivers.

The issue of triangulation is most pertinent to qualitative research methodologies (Giorgi, 1994; Giorgi & Giorgi, 2003; Peterson, 1994; Silverman, 2000), with validation by the respondents themselves a key element. For various logistical reasons this was not possible in the present research. For the Zulu-speaking respondents, validation would have required the translation of the transcripts and the findings into Zulu – a process for which the researcher did not have time. The researcher did, however, request the translator to independently verify all transcripts in which she had participated by a thorough reading and re-reading – while not ideal, this was found to be most useful in clarifying and honing meanings. For those English-speaking respondents accessed via Childline in Durban, the logistics of travel and time prevented respondent validation. Independent review during the process of data analysis for all scripts was, however, sought. This, too, proved to be most useful for the researcher in generating new insights and gaining necessary perspective.

Perhaps the single greatest shortcoming of the present research was the absence of paternal caregivers and fathers. While their absence was perhaps not surprising in terms of the traditionally female caregiving functions to which many in our society subscribe, paternal caregiving experiences are generally underrepresented and overlooked. The singular presence of maternal caregivers offered unique insights into their experiences and perceptions, but offered little in terms of paternal experiences, responses and coping. This represents a most significant population for ongoing research endeavors into caregiver responses to CSA.

5.3 Recommendations for future research

While the scope of the present study prevented a comprehensive exploration of broader family experiences and perceptions, the experiences of paternal caregivers as well as non-abused siblings of the abused child represent significant populations for future research. While strict ethical guidelines would need to be rigorously endorsed in research with the siblings of sexually abused children, their experiences, too, could shed more light on the intra-familial impact of sexual abuse. While their experiences are valuable in their own right, siblings also serve as potentially significant sources of social support to one-another – a dynamic that could be facilitated in our attempts to optimize coping of the family unit following CSA.

CHAPTER SIX
CONCLUSIONS

As our awareness of CSA and it's potential consequences at both the individual and systemic levels increases as a results of both media and research attention, so this needs to be responded to with the urgency and efficacy of intervention which it calls. While certainly not an excuse or justification for the increasing incidence of CSA in this country, various socio-economic and cultural factors need to be borne in mind when considering the phenomenon of CSA – not only for their potential contribution to a milieu in which such crimes are perpetrated, but also for their impact upon coping, adaptation and making meaning of such crimes when they do occur. While such socio-economic and cultural factors (such as the high rates of unemployment, poverty, the proliferation of HIV/AIDS, the patriarchal subjugation of women and children etc.) may help us to understand better why such crimes against children are perpetrated, they also need to be translated into urgent and effective strategies for prevention as well as post-abuse intervention and management. To date, there has been little local research into the impact of CSA on the caregivers and family systems of sexually assaulted children. Despite ongoing urbanization and the consequent impact on definitions of family and kinship structures, the institution of the "family" (including both household, or nuclear, as well as extended family systems) continues to serve as a most central and dominant unit for ties of kinship and fellowship, a sense of belonging, as well as mutual support. It would also seem that the significance and centrality of "family" spans all cultural groupings within our society, serving as one of our common points of connectedness.

The present study was a response to the situation discussed above, whereby family structures are perhaps becoming increasingly fragile and with more specific needs in order to retain their adequately healthy functioning, especially in relation to the proliferation of CSA and HIV/AIDS. The present study proposed to investigate, and better understand, the experiences and perceptions of caregivers affected by their child's extrafamilial sexual abuse. It was concerned with the ways in which caregivers comprehend, "make sense of", and respond to such a trauma. Furthermore, the researcher was interested in exploring the construct of "secondary traumatization" in relation to caregivers' experiences.

Six women responded to the invitation to participate in this study – three via Childine, Durban, and three via the Vulnerable Children's Programme, Pietermaritzburg, representing a sample more or less equally spread between an urban, peri-urban and rural dwelling. Participants were requested to take part in two semi-structured interviews each, the first representing the primary means of data collection around specific issues and themes, the second aimed more at debriefing and feedback. Three of the participants were unable to complete the second interview, for logistical reasons as well as family pressure (in one case) not to talk about the family's shame. It was a great pity that no fathers or paternal caregivers responded to the present research, and this represents a major population for future research efforts within this field.

The findings of the current study illustrate that the experiences of such caregivers and families are likely to be multiple, complex and resulting in much internal as well as interpersonal difficulty and dilemma. The series of dilemmas arising from the sexual abuse were reportedly experienced most keenly in relation to the child, family and broader community networks within which caregivers were embedded and dependent upon for support. Furthermore, caregivers' contact with and negotiation through the CJS represented a major additional source of strain and distress, with dominant themes of disappointment, helplessness and exclusion being reported in this regard.

Overall, and in response to the initial research objectives outlined in Chapter One, central themes of loss, grief and bereavement, as well as adaptation, adjustment and coping, emerged strongly. Experiences of overwhelming shame, and consequent desires to maintain secrecy and silence around the child's abuse were also dominant. The construct of secondary traumatization, while helpful in illuminating some aspects of experience for some caregivers, did not capture the essence or entirety of experiences or responses. Furthemore, different caregivers displayed varying levels of overt traumatic stress symptoms at different times, with different manifestations, and in response to different aspects of the abuse, its consequences and its meaning. There also appeared to be much fluctuation for most caregivers between experiences of depression (perhaps reflecting the significance of loss interpreted) and traumatic stress responses. Taking the significance of these two experiences together, the construct of "traumatic loss" may more adequately capture the central components described in the present research.

In light of the above, the presence or perceived access to social support (via friends, family, and the community) emerged as a strong protective factor, along with a faith in a higher power, such as God. The concept of resilience was found to be most pertinent in this light. In terms of risk factors for caregivers, financial pressures emerged as a significant and additional source of burden, perhaps exacerbating experiences of helplessness and depression. Little social support, as well as poor perceived access to social support, appeared to exacerbate feelings of isolation, helplessness and despair, enhancing experiences of depression. Finally, the present research appeared to confirm some of the literature linking a maternal history of sexual assault with poorer adaptation and parenting efficacy following their child's sexual abuse (Carter, 1993; Gomes-Schwartz et al., 1990; Hooper, 1992; Kelley, 1990; Kiser et al., 1991). The triggering of past traumatic memories appeared to impair such caregivers' emotional availability to the child.

Caregivers' experiences of the interview process itself included simultaneous feelings of painful recollection, as well as relief upon a sense of unburdening the self, and gratitude for feeling "important enough". The researcher was struck by the pervasive sense of interpersonal isolation, anxiety, mistrust and shame with which most caregivers presented and, upon reflection, finds the mechanism of projective identification (as described in much psychodynamic literature) a useful construct for making sense of caregivers' experiences (St. Clair, 2004). In many ways, caregivers' shame and fears of talking out about (or "disclosing") the child's abuse appeared to reflect many of the feelings which their children may have been experiencing, but not had words for. The close relationship between caregiver and child would facilitate the occurrence of such a process, whereby the caregiver is left containing and trying to make sense of their child's, as well as their own, reactions to the abuse.

While not specifically reported on, a number of risk factors for the occurrence of the sexual abuse also emerged in the present research. Although such factors would need to addressed in future research efforts, a lack of adequate child supervision emerged as one such factor. This appeared to have particular relevance to an ideology of shared responsibility for caregiving functions, child rearing and child supervision endorsed by some cultural groups. While practically beneficial in terms of sharing the burden of child-management and promoting the child's sense of a broader connectedness, it also appeared problematic in terms of greater exposure to risk for CSA.

While much has been illuminated during the present research, and many insights gained, many questions, too, remain. Perhaps the most pressing and central challenge we currently face is knowing how best to respond to sexually abused children and their families such that their optimal level of intra- and interpersonal functioning is restored. It is hoped that this research has highlighted some of the dynamic issues at play concerning CSA and its systemic impact, and that family mental health is increasingly better attended to in efforts towards more integrated management.

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Appendix A:

Diagnostic criteria for post-traumatic stress disorder (PTSD)

A. The person has been exposed to a traumatic event in which both of the following were present:

(1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others

(2) the person's response involved intense fear, helplessness, or horror. Note: in children, this may be expressed instead by disorganized or agitated behavior

B. The traumatic event is persistently reexperienced in one (or more) of the following ways:

(1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: in young children, repetitive play may occur in which themes or aspects of the trauma are expressed

(2) recurrent distressing dreams of the event. Note: in children, there may be frightening dreams without recognizable content

(3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). Note: in young children, trauma-specific reenactment may occur

(4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

(5) Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

(1) efforts to avoid thoughts, feelings, or conversations associated with the trauma

(2) efforts to avoid activities, places, or people that arouse recollections of the trauma

(3) inability to recall an important aspect of the trauma

(4) markedly diminished interest or participation in significant activities

(5) feeling of detachment or estrangement from others

(6) restricted range of affect (e.g., unable to have loving feelings)

(7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

(1) difficulty falling or staying asleep

(2) irritability or outburts of anger
(3) difficulty concentrating
(4) hypervigilance
(5) exaggerated startle response

E. Duration of the disturbance (symptoms in criteria B, C, and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:
Acute: if duration of symptoms is less than 3 months
Chronic: if duration of symptoms is 3 months or more
Specify if:
With delayed onset: onset of symptoms at least 6 months after the stressor

Appendix B:

Diagnostic criteria for Acute Stress Disorder

A. The person has been exposed to a traumatic event in which both of the following were present:

(1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others

(2) the person's response involved intense fear, helplessness, or horror

B. Either while experiencing or after experiencing the distressing event, the individual has three (or more) of the following dissociative symptoms:

(1) a subjective sense of numbing, detachment, or absence of emotional responsiveness

(2) a reduction in awareness of his or her surroundings (e.g., "being in a daze")

(3) derealization

(4) depersonalization

(5) dissociative amnesia (i.e., inability to recall an important aspect of the trauma)

C. The traumatic event is persistently reexperienced in at least one of the following ways: recurrent images, thoughts, dreams, illusions, flashback episodes, or a sense of reliving the experience; or distress on exposure to reminders of the traumatic event.

D. Marked avoidance of stimuli that arouse recollections of the trauma (e.g., thoughts, feelings, conversations, activities, places, people).

E. Marked symptoms of anxiety or increased arousal (e.g., difficulty sleeping, irritability, poor concentration, hypervigilance, exaggerated startle response, motor restlessness).

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or impairs the individual's ability to pursue some necessary tasks, such as obtaining necessary assistance or mobilizing personal resources by telling family members about the traumatic experience.

G. The disturbance lasts for a minimum of 2 days and a maximum of 4 weeks and occurs within 4 weeks of the traumatic event.

H. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition, is not better accounted for by brief psychotic disorder, and is not merely an exacerbation of a preexisting Axis I or Axis II disorder.

Appendix C:

Introductory pre-amble to interview schedules

Introduction

Thank you for your participation in this research. Please be assured that all information conveyed during the interviews will remain confidential and that your anonymity will be protected at all times. The identity and personal identifying details of yourself, your child, your family and the counselling institution will not be revealed at any stage in the research. Your participation in this research is voluntary and you have the right to refuse or withdraw at any time. This is a difficult topic and we appreciate your assistance with this.

The purpose of the interviews is to better understand the meaning to you and your family of your child's experience. I hope to understand what the abuse experience means for you, whether it has affected your daily and family functioning, and how you and your family have coped. The goal of the research is to understand the needs of families such as your own, so that we know their needs and how they can best be helped to cope.

The interview process will consist of two interviews, each of approximately 90 minutes. Both interviews will be tape-recorded. The first interview is aimed at understanding what has happened for you and your family since the news of your child's abuse; whether your daily and family functioning has been affected; what's been helpful in terms of coping; and what you feel would help you to cope better with the experience. The second interview is aimed at exploring your thoughts, ideas, feelings, questions and concerns raised in the first interview. There are no right or wrong answers to any of the questions – I am simply interested in understanding your experiences.

Appendix D:

Translator's pledge of confidentiality

I.....

hereby agree to participate in the research project in the capacity described to me by the researcher.

I understand that:

- The identity and personal identifying details of all participants need to remain strictly confidential in the name of ethical research practice.
- All information given during the interviews is privileged and will remain strictly confidential to myself and the researcher.
- Each participant will take part in two interviews of approximately ninety minutes duration per interview.
- The research is being conducted in partial fulfillment of the researchers' university degree at the Masters level. My supervisor is Bev Killian. If you would like to speak to her she can be reached at (033) 260 5853.
- Should I have any difficulty with arrangements for the translation, I will contact the researcher at least twenty-four hours in advance to allow for alternative plans to be made.

I have read and understood the above.

Signed

.....	.....
Translator	Researcher: S.M.Burton
.....	.....
Witness	Date

Appendix E:

Participant form of informed consent

Caregiver Consent Form

I, ...

hereby consent to participate in the research project as described to me by the researcher.

I understand that:

- My child feels comfortable about my participation in this research and my being interviewed.
- The identity and all personal identifying details of my family and myself will remain anonymous both during and after the interview process.
- All information given during the interviews will remain strictly confidential and purely for the benefit of research.
- I will not receive any financial compensation for my participation.
- The interviews will take a total time of between 2 and 3 hours over the next month.
- The research is being conducted in partial fulfillment of the researcher's university degree at the Masters level. My supervisor is Dr. Bev Killian. If you would like to speak with her she can be reached at (033) 260 5853.
- I reserve the right to refuse or terminate my participation at any point if so chosen.

I have read and understood the above.

Signed

....
Research Participant Researcher: S.M.Burton

.....
Witness

Date: .....

Appendix F:

Child assent form

Child Assent Form

I, ...

give assent for my caregiver/s to participate in the research project as described to me.

I understand that:

- I will not have to participate at any point in this research project.
- About 2 interviews will be done with my caregiver/s.
- The identity of myself and my caregiver/s will remain anonymous, both during and after the interviews.
- All information given during the interviews will remain strictly confidential and purely for the benefit of research.
- The research is being done for the purpose of a university degree.
- If I have any worries about the interviews, I will speak to my counsellor about it.

I have understood the above.

Signed

....
Counsellor

.....
Date

Appendix G:

Standard questionnaire: Participant demographics

A: Demographic Information

All questions presented to each member present)

Number of caregivers present: .....

Relationship to child: .....

Age of caregiver/s:.....

Gender of caregiver/s: M / F .....

Marital status: .....

Employment status: .....

Family membership: .....

Family members absent: .....

Child's age: .....

Child's gender: M / F .....

Length of time since disclosure: .....

Relationship of alleged perpetrator to child: .....

Do you give permission for me to access your child's file? Y / N .....

Appendix H:

Interview schedule: The first interview

Interview no:.....

Date: .....

B: The Family in Context

[Objectives: To facilitate the caregivers being able to tell their story; to facilitate the expression of experienced emotion; to explore the meaning of the abuse for the caregivers and family system.]

1. Would you like to tell the story of what happened to your child?
2. What thoughts and feelings do you have about what has happened?
3. Has the experience changed the ways in which you relate to one another? If so, how?
4. Is there anything else you'd like to say that may help me understand what the abuse experience means for you or your family?

C: Individual and Family Effects

[Objectives: To explore whether and how the abuse has affected individual members; to explore whether and how the abuse has affected the family's functioning, as well as sub-systems therein; to explore individual and family "myths" (values, beliefs, roles, ideology); to explore vulnerability to secondary traumatic effects of individual members and the family system.]

5. How has the knowledge of your child's abuse affected you and your family?
6. Has your daily functioning been affected in any way?

7.1 Has the daily and interpersonal functioning of your family been affected in any way?

7.2 Have particular family relationships been affected in any way?

8. Has this experience affected the way you think about yourself? If so, how?
9. Has this experience affected the way you think about your family? If so, how?
10. Is there anything else you'd like to say that may help me understand the effects this has had on you or your family?

D: Risk, Resilience and Coping

[Objectives: To explore how individuals have coped since disclosure; to explore how the family has coped since disclosure; to explore what factors have helped to protect against secondary trauma effects in individuals and the family system; to explore what factors have increased vulnerability to secondary trauma effects in individuals and the family system; to explore current needs of individuals and the family system.]

11. How have you and your family coped since your child's disclosure?
12. Has anything helped you to cope better with the abuse experience?
13. Has anything been particularly unhelpful in terms of coping with the abuse?
14. What would help you and your family to cope better?
15. Is there anything else you'd like to say that may help me understand how you're coping at the moment, or what you need?

Appendix I:

Interview schedule: The second interview

Interview no:.....

Date: .....

All questions presented to each member present.

E: De-briefing and Feedback

[Objectives: To facilitate the expression of thoughts, ideas, feelings and questions raised during the previous interview; to debrief and provide containment; to explore the family's experience of the interview process; to address any concerns or questions about the interview process; reflection on the process; assess possible needs for referral of caregiver/s.]

1. Have you had any thoughts about our last interview?
2. Was there any part of the interview that was particularly difficult?
3. Was there any part of the interview that was helpful?
4. Do you have any other comments, questions or anything else you'd like to say?

Interview J:

Data analysis: Thandiwe

Detailed Script Analysis, Thandiwe

1. Maternal Emotional Response

a) Initial - shock; confusion; helplessness - "shock..." **p1. 8-13**
- depersonalization - "in somebody else's body..." **p2.1-5**
- "doesn't feel like self..." **p4. 41-42**

b) Enduring - avoidance of painful thoughts/ feelings – "doesn't want to think about it" **p4. 41-42**
- symptoms - loss of appetite - "don't eat like I was before" **p4. 25-26**
- feeling "heavy" **p4. 27**
- loss of hope and despair for future - "it's just going away" **p5. 15-16**

(all possible symptoms of depression)

2. Managing the Child's Trauma

Confusion, anxiety, helplessness re. managing child's symptoms – bed-wetting (enuresis) and increased need for sleep **p1. 32-36**

3. Waiting for Justice

a) Inefficiency and failure of criminal justice system; nothing being done; waiting for action and just punishment of perpetrator.
- "they don't come...still waiting..." **p2. 21-26**
- "still waiting for something..." **p3. 30-32**

b) Feeling harassed by, yet simultaneously isolated and excluded from the process
- "police just kept phoning us..." **p2. 14-17**
- "doctor didn't want to tell us..." **p1. 20-28**

c) Helplessness in the face of system inaction and non-response **p2. 21-26** **p2. 31**

d) Justice/ retribution as vehicle for renewed hope and certainty regarding the future **p3. 29-33** **p8. 1-3**

4. Breakdown in Family Relationships and Communication

a) Conflict in 'household' family relationships — **p3. 4-11**
- family pain — **p3. 42-45**
- emotional isolation in the home
- abuse as 'taboo' or closed subject — **p4. 33-37**
- all sub-systems affected

b) Conflict with broader extended family system — **p2. 42-44**
- loyalty to extended family vs. loyalty to child (and consequent needs for justice) – perpetrator as "a family child" — **p7. 22-37**
- finding a substitute to blame/ punish (mother) — **p7. 32-37** (links with No. 5 below)

5. Culpability of the Mother

a) Implicit blame by criminal justice system – "keep asking me questions" — **p1. 25-28**

b) Explicit blame by: family members — **p3. 4-11**, **p3. 15-17**
: greater community — **p6. 27-33**, **p6. 43-45**, **p7. 9-12**

c) Maternal isolation - feeling "lost" — **p3. 42-45**
- inadequate social support (from family, system, community) — **p5. 21-23**, **p5. 28-36**, **p5. 40-43**, **p6. 16-17**

d) Mother as scapegoat for family and community anger — **p7. 9-12**, **p7. 32-37**

e) Shame and humiliation of mother - feeling ostracized — **p7. 9-12**

6. Loss of Hope for the Future (Despair)

a) For own sense of future — **p5. 15-16**

b) For child's future — **p5. 6-10**

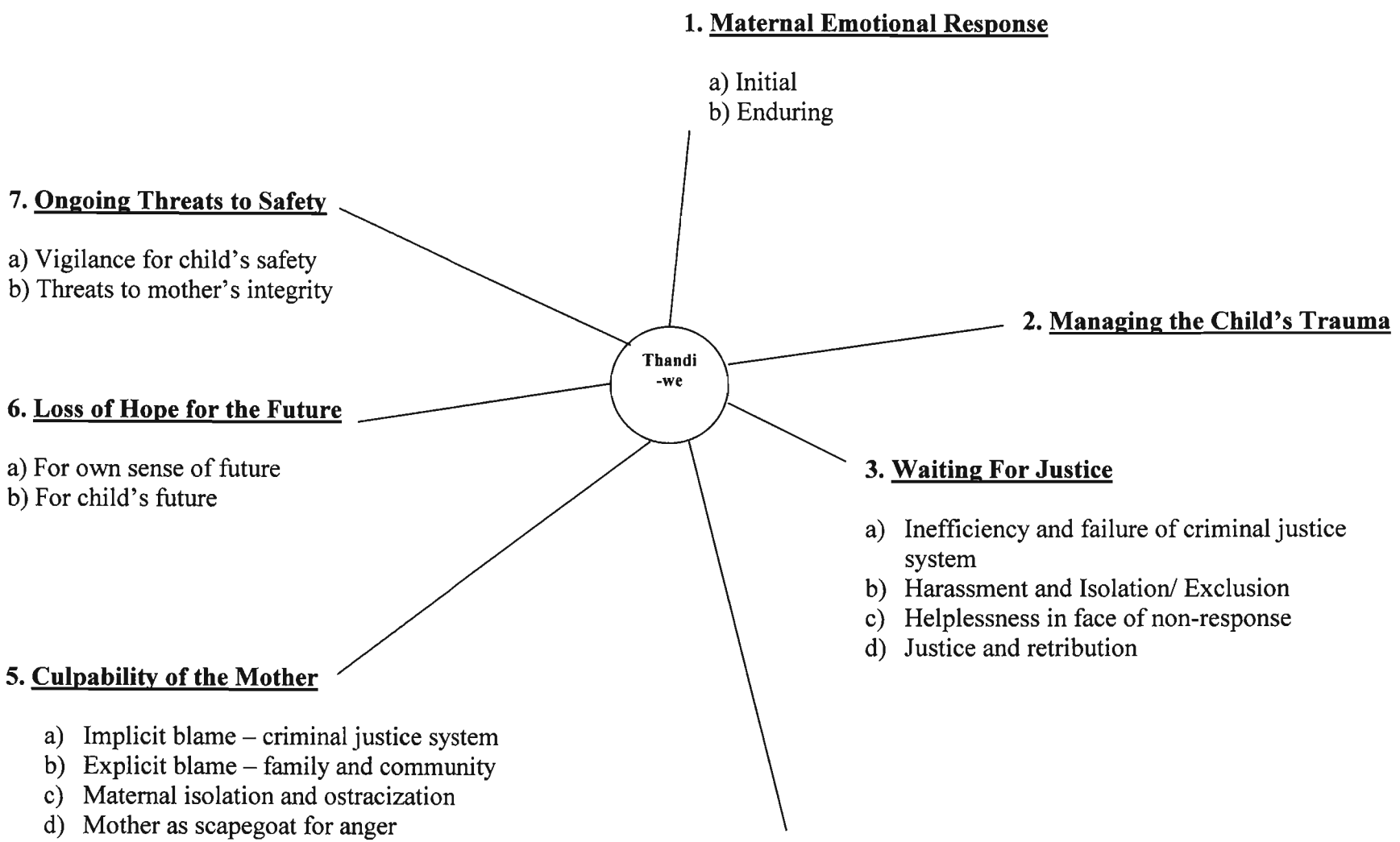
7. Ongoing Threats to Safety

a) Vigilance for child's safety - increased sense of responsibility/ burden — **p4. 9-16**

p6. 1-3

b) Threats to mother's integrity/ sense of self - mother vs. perpetrator **p7. 11-12**
- 'moving away' as only option for safety **p6. 43-45**
p8. 1-3

Thandiwe – Emerging Themes



1. Maternal Emotional Response

a) Initial
b) Enduring

2. Managing the Child's Trauma

3. Waiting For Justice

a) Inefficiency and failure of criminal justice system
b) Harassment and Isolation/ Exclusion
c) Helplessness in face of non-response
d) Justice and retribution

4. Breakdown in Family Relationships and Communication

a) Conflict in 'household' family relationships
b) Conflict with broader extended family system

5. Culpability of the Mother

a) Implicit blame – criminal justice system
b) Explicit blame – family and community
c) Maternal isolation and ostracization
d) Mother as scapegoat for anger
e) Shame and humiliation of the mother

6. Loss of Hope for the Future

a) For own sense of future
b) For child's future

7. Ongoing Threats to Safety

a) Vigilance for child's safety
b) Threats to mother's integrity

Appendix K:

Data analysis: Busi

Detailed Script Analysis – Busi

1. Managing the Child's Trauma and Distress

a) Initial shock, confusion, uncertainty re. finding out — **p1. 14-22**
- exacerbated by conflicting advice from friends, police etc. — **p7. 44**

b) The Fear of HIV Infection
- much relief upon negative test results — **p2. 42-45**, **p3. 1-2**

c) Links between Child and Caregiver Distress — **p2. 16-20**
- child symptoms eliciting mother's:
  - guilt at failing to protect — **p4. 34-46**
  - helplessness – "losing control" — **p4. 42-46**
  - fear for the future, and — **p4. 42-46**
  - loss of hope for the future
  - fear of men — **p5. 4-7**

d) Maternal Psychological Effects
- depressive symptoms — **p3. 14-15**
- attribution of symptoms to "stress" — **p4. 1-2**

2. Entry into the 'System' (doctors, police, social workers…)

a) Financial Implications of system involvement

b) Impersonal Nature of Contact - needs unmet — **p1. 22-34**
- passed from pillar to post

3. Protecting the Child VS Protecting the Family (internal conflict)

a) Conflicting advice and interests — **p1. 44-46**, **p2. 1-6**, **p7. 44-46**, **p8. 1-9**

b) Managing the problem "between families"
- "This is a family thing…" — **p7. 46**, **p8. 1**

p2. 2-6
p4. 8-16
p5. 20-24
p7. 44-46

c) The Pressure to Forgive — **p6. 29-33**, **p6. 37, 44-45**

4. Self-Blame VS Self-Justification and defense (internal conflict)

a) Maternal guilt, responsibility, culpability and Broken Family Trust (central conflict) — **p3. 15-22**, **p3. 30-32**, **script 2, p5. 33-38**

b) Self-Blame implying Onus of Responsibility
- sense of burden and responsibility to solve or fix the problem — **p8. 38-44**, **p8. 5-9**

c) The Transformation of Shame
- from self (mother)... to perpetrator — **p9. 6-9**, **script 2, p4. 28-36**

d) Maternal Blame
- by family members — **p3. 36-38**
- perception of community blame — **script 2, p5. 18-28**

e) Feeling Ostracized and Isolated by Community

5. Waiting For Justice

a) The Pain of Injustice and lack of action — **p2. 16-20**
- Anger, regret, and needs for retribution — **p2. 4-6**
- Disappointment at lack of justice — **p4. 8-16**

b) System Inaction (or failure to act/ respond) as Condoning of the Rape — **p4. 10-13**, **p6. 5-7**

c) Powerlessness and Helplessness to Effect Justice
- Gender roles, socialization, and the expression of anger
- The position of women and mothers within family and society — **p6. 3-9**
- Feeling taken advantage of (as woman and mother) by family and the system

6. The Meaning of "Being a Virgin" and Lost Virginity

a) "Being a Virgin" implying:

- a sense of belonging, fellowship, youth — **script 2, p1. 27-37**
- pride and self-esteem — **script 2, p2. 4-7**
- hopefulness for the future
- a 'sacred' element

b) Loss of Virginity implying:
- a sense of difference, isolation and not belonging — **script 2, p1. 27-37**
- loss of pride, esteem and self-worth
- loss of choice for the future
- uncertain future — **p7. 8-13**
- it's "taken for good" — **p9 (at end)**

c) Loss of Virginity links with Loss of Hope for the Future

7. Living with Fear and Loss of Hope

a) Ongoing Threats to Safety of child — **p3. 20-22**, **p6. 44-45**

- persistent threat of re-victimization — **p8. 19-20**, **script 2, p5. 1-3**

b) Changed Perceptions of Men
- mother's mistrust — **p5. 12-15**, **p6. 30-33**
- fears for child's future in relationship to men — **p5. 4-7**

c) Loss of Hope for Child's Future — **p4. 44-46**
- links with loss of virginity — **script 2, p2. 20-30**

d) Anticipation and Fear of Future Losses and Difficulties
- having to deceive child re. status as a virgin — **script 2, p1. 32-34**
- anxieties regarding how to tell, and how to talk to child about the rape in the future — **script 2, p2. 35-42**, **script 2, p3. 1-13**, **script 2, p3. 36-40**

(ie. in a sense, the mother's anticipated fears of 'disclosure' in the future)
(ie. it becoming the mother's event to 'disclose' to child one day in the future)
(ie. implicit and overwhelming sense of shame and fear around the rape; not knowing how to frame or talk about it).

8. Coping

a) Attempts to Comprehend and Make Meaning of the Rape
- Finding 'reasons' — **p2. 39-42**, **p6. 37-45**

b) Denial
- Wishing away the pain and burden of responsibility **p5. 36-41**

c) The Value of Professional Support and Advice **p5. 26-31**
p6. 18-21
p6. 25-27
p7. 27-31
p7. 36-39

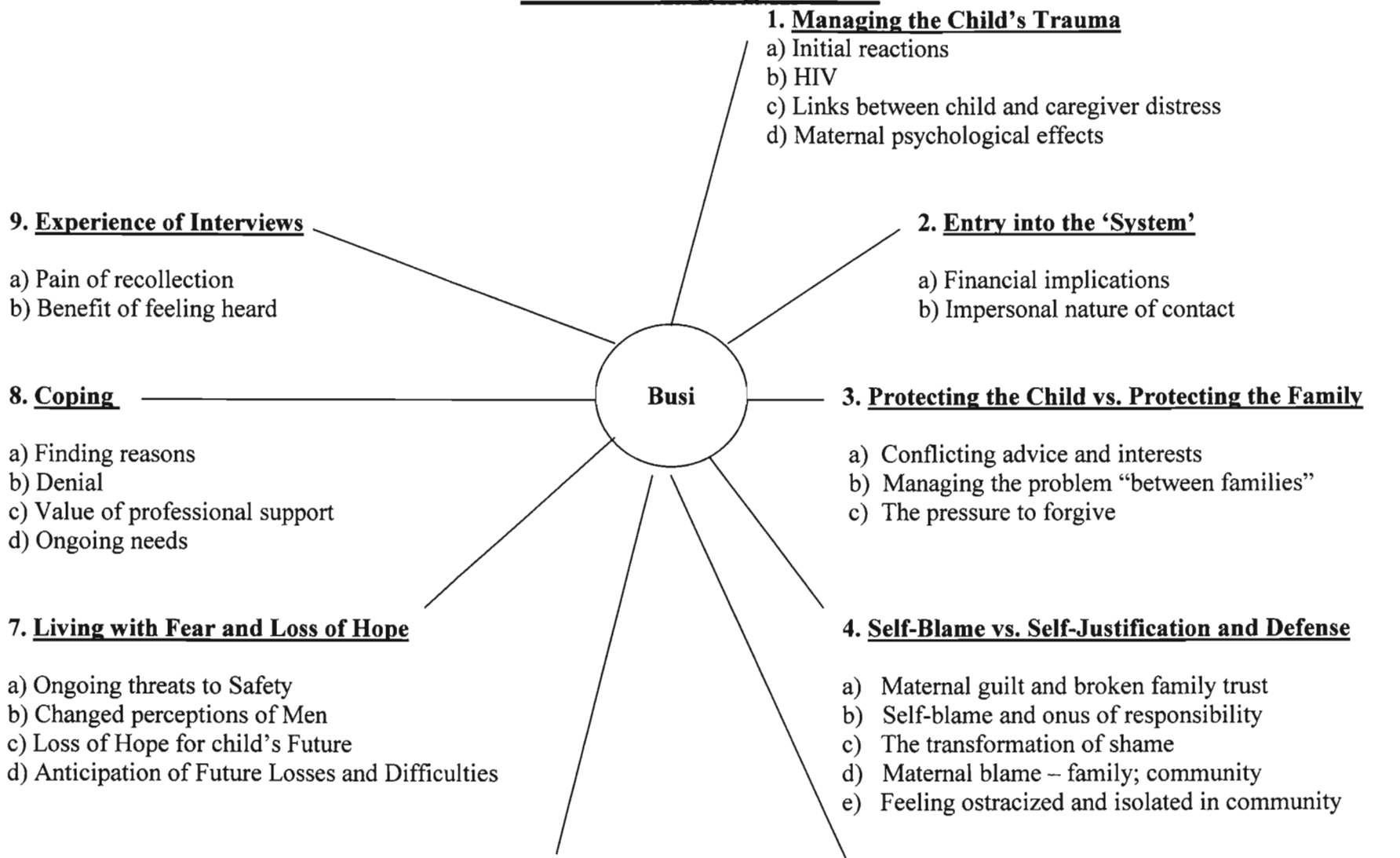
d) Ongoing Needs
- For continued support **p9. 5-6**
- For information - educative and preventative **p8. 28-33**
- For Problem-Solving Skills

9. Experience of Interviews

a) The Pain of Recollection
- re-experiencing and reliving of painful emotion **script 2, p1. 8-10**
script 2, p6. 4-8
script 2, p8. 18
script 2, p7. 4-9

b) The Benefit of Feeling Heard, Valued, Understood, Important and Not Judged (accepted) **script 2, p1. 8-10**
script 2, p7. 19-24
script 2, p7. 29-31
script 2, p7. 40-46

Busi – Emerging Themes



Appendix L:

Data analysis: Shamila

Detailed Script Analysis – Shamila

1. The Aftermath of Finding Out and Entry into the System

a) Initial Reactions - shock at being told
- anxiety, worry and distress — **p1. 11-27**
- 'release' and relief at removal of perpetrator

b) Following Directives - instructions and procedures — **p1. 31-44**

2. Frustration with the 'System' (police, doctors, social workers)

a) Insensitivity of the system - feeling bullied and patronized — **p1. 20-23**, **p2. 35-38**

- feeling pressurized — **p7. 11-14**
"too much pushing…" — **p7. 30-34**

b) Voicelessness - feeling silenced and unheard — **p2. 3-5**
anger at being silenced — **p2. 19-25**

c) Helplessness and Loss of Control — **p1. 31-46**, **p2. 1-25**, **p2. 29-42**, **p1. 44-46**

d) Exclusion and Isolation from involvement/ information — **p2. 5-8**, **p2. 9-10**, **p2. 19-25**

- feeling abandoned by the system — **p2. 37-42**, **p4. 9-20**

e) Failed Justice - perpetrator out, charges dropped
- incompetence of system: child and family 'punished' and bearing full consequences; no obvious consequences for perpetrator — **p4. 39-44**, **p4. 29-31**

3. The Consequences of sexual abuse, its disclosure, and system involvement

a) Loss of daughter – child's removal from the home — **p2. 5-10**, **p2. 11-17**

p2. 32-35

b) Psychological Effects – maternal

- vegetative symptoms
  - loss of appetite **p2. 46**
  - disturbed sleep **p5. 17-18**
  - physical illness and decreased sense of well-being **p3. 1** **p11. 12**

- the burdened self - feeling 'heavy' and loss of self - 'losing self' the dysfunctional self; loss of function (ie. changed conceptions of self) **p7. 18-20** **p10. 35-37**

- needing to escape pressure – suicidal ideation **p7. 30-34**

- mental confusion - "going mad..." **p13. 15-22** **p13. 29-32** **p13. 37-38**

- subjective sense of overwhelming stress - "stress rules your life..." **p13. 11**

(all symptoms possibly reflective of grief and/ or depression)

c) Psychological Effects – child

- social withdrawal and isolation **p8. 46**
- loss of appetite **p9. 1-2** **p11. 42-46**

d) The Horror of Sexual Abuse **p3. 5-8** **p6. 18-20** **p7. 43-46**

e) Loss of Perceived sense of Safety **p8. 12-16**

4. Maintaining the Silence

a) The Urgency for Secrecy - fear of others "finding out" **p13. 43-45**

b) Maternal Shame - embarrassment **p5. 30-32**
- fear of public humiliation **p5. 36-43**
- fear of judgement, especially by family **p6. 26-28**
- fear of blame and culpability; of being held responsible **p6. 30-33**

c) Maintaining Silence to Protect others – from reality of the abuse; especially other children and family **p6. 16-20**

d) Isolation and Withdrawal - "nobody knows..." **p8. 45-46**
p9. 34-42

e) Conflicted Positioning of Guilt (culpability)
Conflict - re-aligning blameworthiness and responsibility while simultaneously having to defend self **p6. 38-42**
ie. conflict of self-blame vs. self-justification and defense **p7. 1-3**
conflict fuelled by....

f) Implicit Blame of the Mother – by social worker **p3. 1-4**

g) Conflicted Maternal Response towards Child – blaming of the child **p9. 27-29**
p10. 4-8

5. Family Relationships and Functioning

a) Maternal Relationship with Abused Daughter
- increased perception of "closeness" as a result **p9. 8-17**

- sense of their sharing the secret; the silent, unspoken knowledge between them.

b) Maternal Relationship with Extended Family
- perception of lack of/ inadequate support and their blaming attitude towards her. **p8. 45-46**

c) Maternal Relationship with her Other Children
- links made between mother-child emotional stress and consequences for family environment **p12. 20-23**
- 'protecting' children from feelings **p12. 27-30**

d) The Pressures of Single Parenting
- 'keeping the self strong' for children **p12. 34-37**
p13. 3-7
- unemployment and financial concerns **p3. 17-33**
p12. 37-39

e) Identity and Self-Concept as "Mother"
- changed mothering towards child: softer discipline **p14. 21-34**
: moralistic advice-giving

f) Current Family Functioning – normalizing of difficulties **p11. 28**
p12. 4-6
p12. 16
p12. 44-45

6. Coping and Support

a) Perceived lack of Family Support – isolation and shame **p6. 5-11**

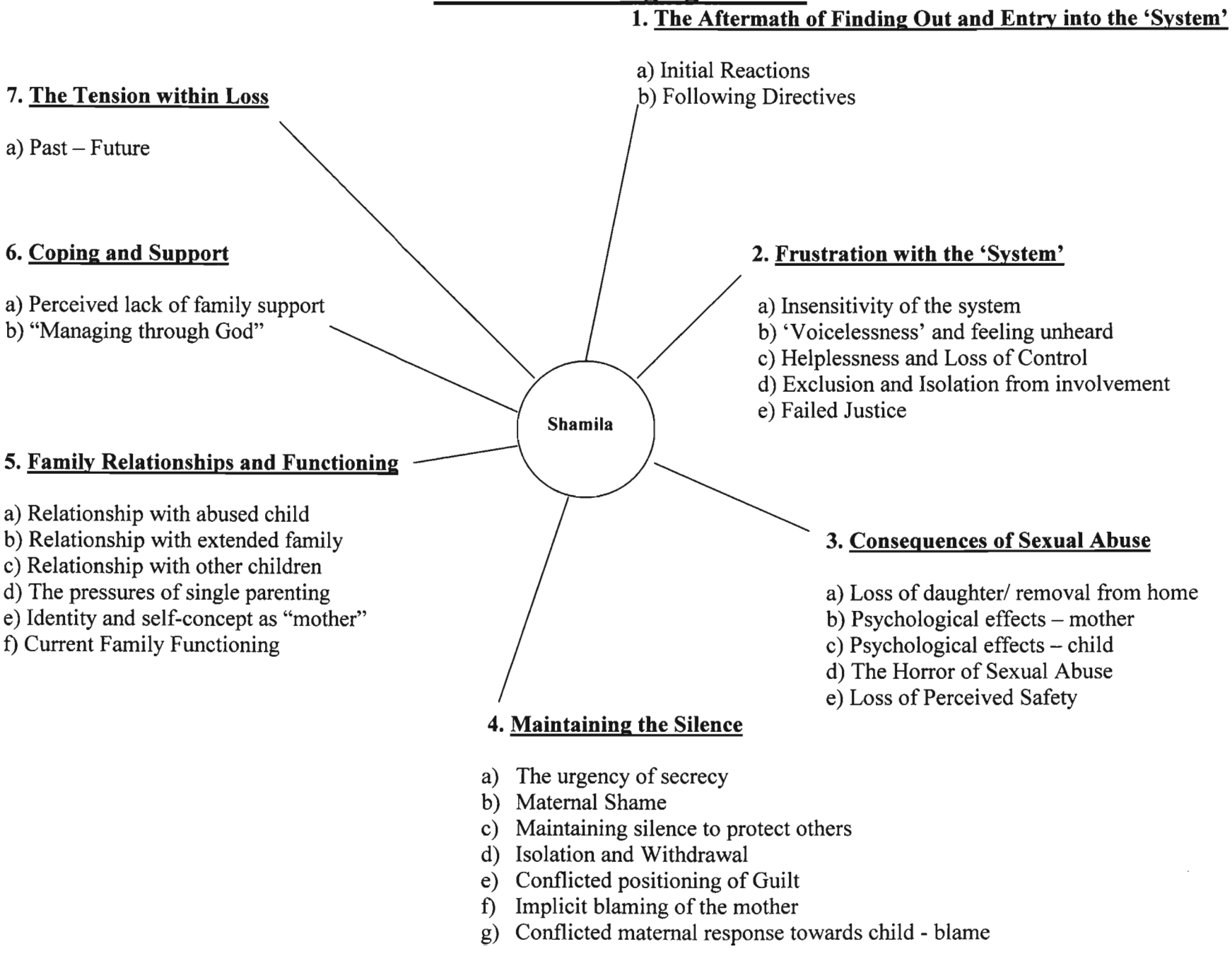
p8. 45-46
p10. 21-23
p11. 15

b) "Managing through God" **p12. 39**
- faith in a higher power; religiosity and spirituality as source of strength **p10. 41-46**
- "…mustn't keep worries…" **p11. 1-6**

7. The Tension within Loss (grief and mourning)

The past-present-future tension: desires to 'put it in the past' and move on; to 'forgive and forget'; reaching towards a place (idealized) in the future while being stuck in the present reality of grieving a series of losses. **p14. 7-16**

Shamila – Emerging Themes



Appendix M:

Data analysis: Joyce

Detailed Script Analysis, Joyce

1. Frustration with the System

a) Lack of support and empathy

- experience of interrogation **p1. 12-15**

- implication of caregiver blame and accusation **p1. 24-26**

- feeling neglected and disregarded by the system **script 2, p19. 1-16**
  frustration, hurt, anger **script 2, p19. 32-40**
  feeling ill-treated by system **script 2, p21. 43-46**

- feeling isolated within system **p8. 15-18**

b) Practical Consequences of System Involvement/ entry into the system

- expenses and sacrifices in terms of finances, transport, time **p3. 12-14**
  p3. 20
  script 2, p18. 31-34

- system inefficiency - being passed down the chain **script 2, p20. 39-46**
  script 2, p21. 25-31
  script 2, p28. 15-21

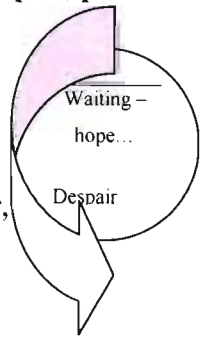
- "waiting" – child's court preparation **p3. 44-46**

c) Waiting for Justice

- "Justice" as necessary for resolution and closure (moving on; future orientation)

- "Justice" for trauma caused to child and family system (temporal orientation) **script 2, p28. 23-26**

- Links with the cycle of hope and despair (hopelessness)



"Waiting" – hopefulness
Disappointment – hopelessness, despair, anger and frustration

d) Disappointment and Feeling Failed by the System

- feeling failed by the system – ie. loss of anticipated support and action

- injustice at perpetrator's freedom **p5. 38-42**
  p6. 1-13

- lack of progress, and slow progress **script 2, p18. 29-34**

- role failure on part of social worker – failure to protect and support; failure of anticipated duties **script 2, p20. 1-14**
  script 2, p20. 19-25
  script 2, p20. 30-33
  script 2, p21. 39-46

e) Powerlessness and Helplessness in the face of system apathy

- powerlessness in the face of social worker's apathy **script 2, p19. 1-16**

- helplessness **script 2, p21. 39**
  script 2, p22. 6-8

- increasing sense of isolation

f) Perception of System Failure as additional source of stress

2. Consequences to Child and Family Relationships

a) The Process of Finding Out

- the unfolding nature of 'disclosure' **p9. 20-23**

- speculation and uncertainty regarding the unknown – anonymity of report; details of abuse. ie. Horror of the unknown **p1. 33-38**
  p4. 28-38
  p9. 20-33

- fear of HIV infection: terror followed by relief at negative status (emotional turmoil) **p3. 20-33**

b) The Sequelae of Finding Out

- child's removal from mother **p2. 12-22**
- child's separation from siblings **p2. 41-45**

- compounding child's lack of stable/ secure home environment **p3. 1-14**

ie. consequences to child and family vs. perpetrator (lack of consequences)

c) Managing the Child's Distress and Symptoms (trauma)

- initial symptoms - vaginal infection (horror at) **p8. 30-36**

- nightmares and sleep disturbance **script 2, p28. 26-40**
- enuresis **p9. 1-8**

- normalization of symptoms **p9. 16-17**

- enduring/ persistent symptoms - loss of appetite **p9. 43-45**

- anxiety, insecurity; "clingy" and fearful of being alone **p8. 3-6** **p8. 10-11**

- generalized fear of men **script 2, p16. 1-6**

- sexualized/ inappropriate and provocative behaviours; father's anger at **script 2, p24. 8-16**

- ongoing fears for safety and for the future – related to perpetrator being free **p6. 8-13** **script 2, p14. 25-31**

d) Differential Family Response – Individual Effects

- Caregiver response – maternal response (grandmother)
  : initial – attempts to 'negotiate' between families ie. mediating and peace-keeping role **p4. 44-46** **p5. 1-14**

  : enduring – psychosomatic complaints; high blood pressure; loss of appetite **p10. 7-10** **p10. 26-27**

- Paternal (father) : initial – anger; desires for revenge and physical aggression towards perpetrator **p4. 44-46**

  : enduring – helplessness and powerlessness; because perpetrator known to him and family; a "friend" **p5. 27-33**

e) Dynamic and Relational Effects

- Caregivers (maternal and paternal) - experience of rejection by child (isolation) **p6. 19-22**

- Maternal caregiver - conflict regarding child's "innocence" as a child **VS** sexualization **p 13. 1-5**
  - experience of decreased sense of closeness and increased isolation from child **p9. 17-26**

- Paternal caregiver - initial rejection of child, followed by later acceptance **p7. 9-17**
  - not knowing how to be with child
  - child's initial fear of being bathed by father **p9. 41-43**

- Maternal and Paternal caregivers
  - ambivalence towards son (as child's father and own son)
  - anger at paternal lack of support **script 2, p22. 40-46**

- Links between child symptoms and caregiver distress/ hopelessness **p9. 1-8**

f) Polarization and Isolation within family unit

- the "silent" topic – "we don't talk to the child..." **p6. 21-22**
- the unspoken, secret topic – "we don't talk about it at home..." **p7. 31-34**

g) Conflicted Loyalties and Changing Perceptions

- ambivalence towards perpetrator as known and previously trusted
  :wanting to punish **VS** wanting to "help" perpetrator **p5. 43-46**
  : difficulty reconciling person with the act

- conflicted relationship with son (paternal figure to child) ie. difficult parenting relationship; anger at son's lack of support to her or child **script 2, p22. 40-46** **script 2, p23. 8-13** **script 2, p24. 1-4** **script 2, p24. 20-27**
- ambivalence exacerbating helplessness

- conflicted perception of child's innocence as a child **p13. 1-5**

h) Negotiating New Parameters (rules) for Interaction

- child - biological mother **p2. 41-45** **p10. 42-46** **p11. 1-5**

- child - grandmother(maternal figure) – role conflict (cross reference)

- child - biological father **script 2, p23. 46**
script 2, p24. 1-4
- 'compensating' for abuse by decreasing discipline and parenting
script 2, p30. 6-9

ie. becoming less harsh and punitive towards child; softer approach to discipline; more protective over child.

3. <u>Anger at Biological Mother</u>

a) <u>Implication of Blame and biological mothers' Culpability</u> (guilt)

- Failure to protect and neglect of child **p2. 22-30**
- Irresponsibility and incompetence as a mother **p2. 34-39**
p4. 4-11
p10. 42-44
script 2, p26. 42

- Speculating mother's complicity in the abuse **p4. 31-38**

b) <u>Anger at mother's apathy and helplessness</u> **p1. 15-17**

c) <u>Anger at mother's deception regarding grant money</u> **p10. 12-21**

d) <u>Resentment towards mother</u>

- Attributing all negative consequences of the abuse to mother's incompetence

- Resentment regarding new child-rearing responsibilities ; ie. the new duty to protect and raise the child **script 2, p26. 19-38**
script 2, p27. 22-26

4. <u>Caregiver Isolation and Burden of Responsibility</u>

a) <u>Lack of anticipated support</u>

- From the 'system' **(cross-reference)**

- From the community - denial of responsibility and involvement
- apathy and helplessness **p5. 1-23**
- anger at lack of support **p5. 19-23**

- Family isolation **p7. 31-32**
- 'silence' and 'secrecy'; "we keep it quiet" **p7. 31-33**

b) Shame

- Family shame
- Caregiver shame – implication of child's 'body shame' **p9. 33-37**

c) Stigmatization within the community

- Community/ public fear of 'contamination' by child; fear of the child **p12. 34-39** **p13. 1-7** **script 2, p18. 5-18**

- Defending/ protecting the child

- Effects on child's self-perception **p13. 17-18**

d) Practical and financial burdens related to child-care and system involvement **p3. 12-14**

- Financial implications **script 2, p23. 15-25** **script 2, p29. 6-8**

- Transport

- Child rearing **script 2, p16. 29-34**

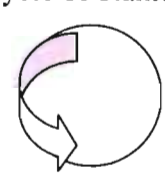
5. Coping and Support

a) Coping Mechanisms

(i) The conflict of self-blame **VS** self-justification and defense

implying guilt, shame, personal accountability **p6. 24-27** **p6. 34-36** **p10. 39-42**

ie. The cyclical and shifting quality of the cycle of blame; the constant re/ positioning and alignment of blame



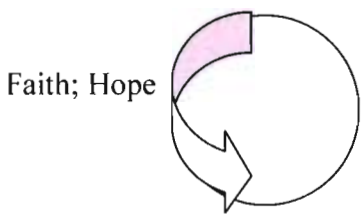
(ii) Managing the conflict through prayer; Faith in a higher power
- Faith/ prayer as a source of comfort, strength, support **p11. 28-32** **script 2, p29. 20-27**

(iii) 'Blind Faith' and wishful thinking

- in God
  - sense of handing over to God
  - prayer as a means of thought avoidance; as means of denying reality **script 2, p29. 6-12**
  - helplessness resulting in prayer **p5. 37-38**
  - trying to forget by reading the Bible (avoidance/ denial) **p6. 25-27**, **p6. 41-45**
  - prayer as defense against the pain of her thoughts **p6. 41-45**

- in the 'system'/ law
  - ultimate disappointment

ie. the cyclical quality of "hope" and "faith" vs. disappointment; despair; loss of hope and faith; hopelessness



(iv) Polarization and Isolation
- as a means of coping – 'silence'; 'secrecy' and denial

b) Social Support

(i) Perception of inadequate support - by family - son **script 2, p22. 40-46**, **script 2, p23. 8-13**
- by community **cross-reference**
- by the 'system' **cross-reference**

(ii) Neighbours as only source of support and "advice" **p11. 24-26**

(iii) Expressed needs for professional support and "advice"
- value of opportunity to talk **p12. 29**

6. Role-Conflict (as consequence of post-disclosure events)

a) "Playing Parts" as source of personal discomfort/ distress and loss **p12. 1-6**, **script 2, p15. 17-19**, **script 2, p23. 32-36**

(i) Definition of role of "mother"
- teaching manners **script 2, p24. 35-36**

- disciplinarian **script 2, p25. 22-35**
- teaching rules **script 2, p25. 39-45**
- teaching morals and values (right from wrong)

(ii) Definition of role of "grandmother"

- grandmotherly role defined in negative terms ie. in terms of what it's not
- idealized conception in terms of traditional role identification
- 'all-good' qualities
- someone who pampers and spoils children

script 2, p24. 35-46
script 2, p26. 8-17

b) Difficulty Reconciling apparently Divergent/ Conflicting role functions in her interaction with the child

script 2, p23. 40-46

ie. dilemma and difficulty managing simultaneous/ dual role functions (mother/ maternal figure) and grandmother to child/
Dilemma a consequence of the sequelae of sexual abuse disclosure, the child's removal from the home, and new arrangements for caregiving.

c) Disappointment at loss of "grandmotherly" role **script 2, p25. 14-20**

d) Resentment at mothering duty
- source of additional strain
- conflicted regarding:
  resentment/ anger at mothering responsibilities **VS** duty to protect

e) Needing to Legitimize/ Formalize new caregiving function
- as a possible means of resolving role-conflict
- wanting to foster the child **script 2, p19. 20-28**
- fear of child's return to biological mother

f) Conflicted parenting roles
- parenting of son (child's biological father)
- parenting of child (grandchild)

7. Concerns for the Future

a) Feeling Immobilized in the present - waiting, hoping; in 'limbo'

b) Uncertainty regarding the future

- links with perpetrator's freedom **script 2, p14. 25-31**
- needing closure and resolution **script 2, p28. 15-20**
- call for ultimate justice – law; God **script 2, p28. 23-26**

c) Ongoing Fears for Child's Safety

- and fear of child's return to biological mother — **p11. 3-5**, **script 2, p26. 32-38**

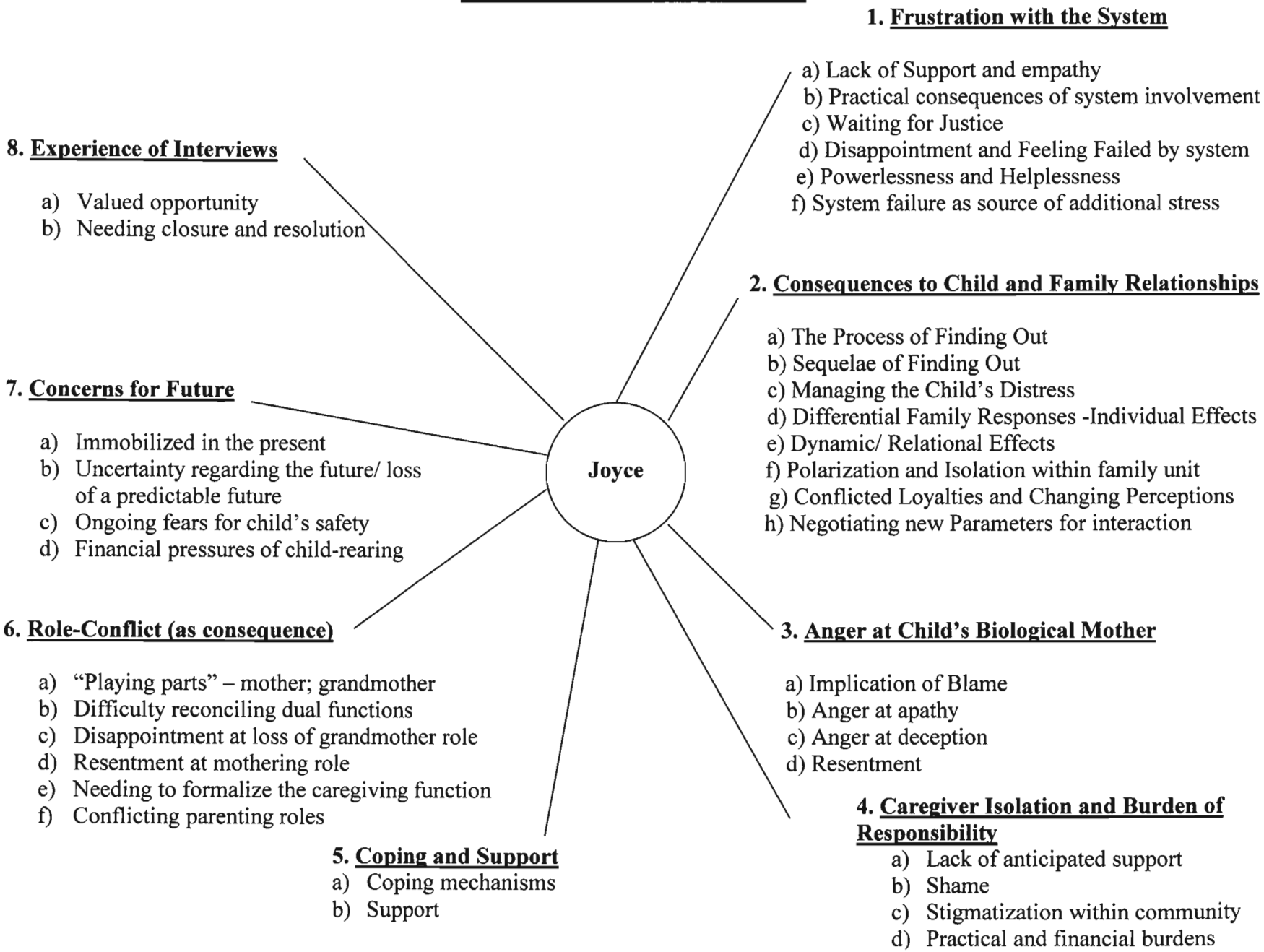
d) Financial pressures of child-rearing and education — **script 2, p22. 25-30**, **script 2, p30. 11-26**

8. Experience of the Interviews

a) Value of opportunity to talk openly — **script 2, p30. 43-46**, **script 2, p31. 1-4**, **script 2, p31. 26-31**

b) Needing resolution and closure
- searching for answers and clarity
- pleading for professional advice and direction

Joyce – Emerging Themes



Appendix N:

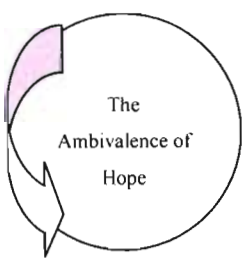
Data analysis: Gugu

Detailed Script Analysis, Gugu

1. The Process of Finding Out

a) The Unfolding Nature of Disclosure — **p1. 8-20**
- initial confusion and lack of clarity — **p1. 24-27**

b) Entry into the Criminal Justice System
- being passed along down the chain; from pillar to post — **p1. 38-46**, **p2. 1-2**, **p2. 4-7**, **p7. 13-16**
- frustration at inaction — **p1. 42-45**, **p6. 4-6**
- experiences of neglect, exclusion and isolation from system — **p2. 6-13**, **p7. 4-6**
- placing hope in the system - hope for protection, justice, perpetrator's punishment — **p7. 23-25**, **p7. 35-40**, **p11. 30-33**



- the ambivalence of hope; cyclical quality of 'hope' vs 'hopelessness' in the system; the ambivalence of living simultaneously with both hope and feared hopelessness in receiving help.

ie. **The cycle of Hope vs. Despair** **p11. 38-45**

- Hopelessness and disappointment in the system — **p7. 29-31**

2. Living In Fear

a) Ongoing Threats to Safety
- genuine ongoing threat of violation, revictimization, death at hands of perpetrator
- threats to integrity of self — **p1. 15-17**, **p3. 1-8**, **p4. 24-35**, **p8. 25-33**

ie. perceived vulnerability of self

- "Running away" – daughter's escape from danger — **p1. 17-20**, **p1. 34**, **p4. 24-32**

- "What if...?" – the constant anticipation of danger/ threat — **p2. 23-24**, **p2. 36-43**
  - "he's still living here..." — **p5. 1-5**
  - hypervigilance, especially at night — **p3. 27-29**

- Perceived powerlessness against perpetrator – "bully" — **p2. 30-32**, **p7. 6-8**, **p4. 23-24**

b) Conditions for Relief and "Release" from perpetual fear
- desires for retribution/ punishment/ revenge — **p3. 15-21**, **p12. 9-11**, **p12. 20-21**

- desires to inflict pain upon perpetrator — **script 2, p17. 34-38**

c) Daughter's return home holding potential for increased vulnerability
- increased fear and anxiety in mother; — **script 2, p13, 24-27**
- possible guilt at desiring her daughter's absence

3. The Centrality of Shame

a) Perception of Community Shame
- shame and humiliation within broader community — **p3. 36-44**

- humiliation of self, as mother – "embarrassment"; carrying burden of shame — **p3. 36-44**

- humiliation of daughter – dehumanization; effects on her worth and personhood as result of rape — **p3. 39-41**

- humiliation and shaming of the family name

- humiliation and shaming of the female vs. male family members ie. in relation to her sons ; the female shame of rape — **p11. 4-11**

b) Perception of Difference and Isolation within community — **p4. 5-13**
- subjective sense of being ostracized — **p10. 24-32**
- perception of judgement and evaluation by broader community — **p10. 37-42**

c) Maternal Self-Blame (self attribution of shame and responsibility)

- perceived failure to protect child **p4. 19-23**
- self-blame as means of sense-making (coping mechanism) and dealing with helplessness
- helplessness to protect child **p4. 19-23** **p4. 39-41**

Self attribution of blame linked with strength of gender role identification…

4. Culturally and Socially defined Gender Roles

a) The Role of Women and Mothers
- primary role to protect and nurture children and family **p6. 38-39** **p6. 40-42**

- role fulfillment as condition for women earning "respect" in community

- perceived role failure (ie. failure to protect) implying loss of respect and worth within the community [ie. the conditions for 'respect' of women and mothers] **p10. 24-32**
- self-attribution of role failure as mother according to such norms

- duration of abuse equated with extent of maternal failure

b) Sexual abuse/ rape as Perceived Threat to Masculine Identity of male family members (sons)
- threats to male authority and standing within family; threats to conceptions of manhood **p5. 42-46** **p6. 1-2**

- male family member desires for 'revenge', as an act of physical violence towards perpetrator **p5. 23-36** **p6. 2-5**

c) Protecting Sons from their Anger
- protecting sons from their desires for revenge **p5. 23-36** **p6. 26-32**

- maternal conflict of anger: desires for revenge vs, consequences of sons' revenge-taking

- meaning of "revenge" as a physical act of aggression towards perpetrator **p6. 2-6** **script 2, p17. 26-30**
- the threat of sons' anger to mother **p5. 25-29**

d) Maternal need to "Come Clean" to male family members (sons) regarding the rape

- answering to her sons; mother's/ women's positioning in relation to sons (men)

- the mother's 'disclosure' or admission as statement of her innocence/ non-complicity **p7. 5-8**

- "coming clean" in anticipation of blame/ culpability/ responsibility **p6. 21-25**

- conflict: self-blame vs. self-exoneration ("coming clean") **p6. 38-46**
  : self-blame vs. self-defense/ protection **p7. 1-4**
  p7. 5-8

e) Re-evocation of maternal history of sexual violation

- Maternal/ female powerlessness to negotiate sex **p10. 4-17**
- Maternal/ female subordination to male desires (sexual)
- Maternal/ female duty to 'respect' men (husband) ie. self-assertion or challenge of late husband as sign of disrespect

5. Family Effects

a) The meaning of the abuse/ rape to family

- "worst thing imaginable for family" **p11. 4-5**
- as a sign of disrespect to family – insulting dignity and standing of family in community; abuse as an injustice to family dignity and worth; as a sign of disrespect to mother, sons and family as a whole **p5. 40-46**

b) Family Conflict as a Consequence

- disagreement regarding appropriate method of punishment for perpetrator **p5. 23-26**
  p5. 35-36
  p5. 40
  p6. 4-6

c) Family Isolation as a Consequence (intrafamily)

- the 'silent' and unspoken topic within family **p9. 30-45**
- polarization of family members **p11. 4-11**
- "secrecy" and family shame

d) Mother Suffering in Silence…

6. Secrecy and Isolation (links with family effects)

a) Maintaining Secrecy

- mother's internally motivated pressure "not to tell" **p8. 42-46**

b) Family Isolation and Secrecy

- the silent and unspoken topic — **p9. 30-45**, **p11. 4-11**

- secrecy even from (abused) daughter regarding mother's participation in interviews — **script 2, p14. 9-11**

c) Mother's Suffering in Silence

- persistent thoughts and traumatic images — **p9. 33-34**

- psychosomatic consequences - loss of appetite
  - sleep disturbance and hypervigilance
  - high blood pressure — **p8. 1-5**
  - headache and migraine — **p8. 13-20**, **p8. 39-46**

- attribution of psychosomatic symptoms to distressing thoughts and images — **p8. 13-20**, **p8. 39-42**

d) Imagining the Trauma

- sense of self-traumatization in imagining daughter's experiences — **p10. 4-17**

- imagining others' reactions — **p11. 4-11**

e) Perception of Community Isolation

(cross reference)

7. Coping With Loss

a) Cognitive Strategies employed by mother and family for making sense of losses"

- Thought avoidance and denial (vs. intrusive and persistent imaginings of the trauma) — **p9. 30-36**, **p11. 38-39**

- Justification and rationalization of loss – self-talk
- Normalizing resultant strains on relationships, especially with daughter — **p9. 19-25**

- Self-Blame, as means of aligning blame – self-talk — **script 2, p18. 33-36**
- Minimization/ normalization of sexual abuse/ rape as a phenomenon experienced by many — **script 2**

(NB, the shifting alignment of blame)

b) Social Support — **p11. 22-26**

c) Hope — **p11. 30-33**

p11. 44-45
(cross reference)

8. Experience of the Interviews

a) The value of support
- feeling heard, understood
- unburdening of self (relief); "not carrying my stress alone"

script 2, p14. 39-46
script 2, p15. 1-3
script 2, p15. 18-22

- decreased sense of isolation **script 2, p15. 7-9**

b) Requests for Assistance (ongoing) **script 2, p18. 42-46**

9. Changing Perceptions...the shifting alignment and positioning of blame

In Interview 2, contradicted many of the perceptions of community shame and isolation mentioned in first interview. Experience of empathy and support possibly aided in shifting perceptions of guilt, blame and community isolation.

Int 2 - more experiences of community support - protection; concern
- served to increase hope
- served to decrease sense of isolation

script 2, p15. 38-46
script 2, p16. 4-11
script 2, p16. 29-34
script 2, p16. 40-46

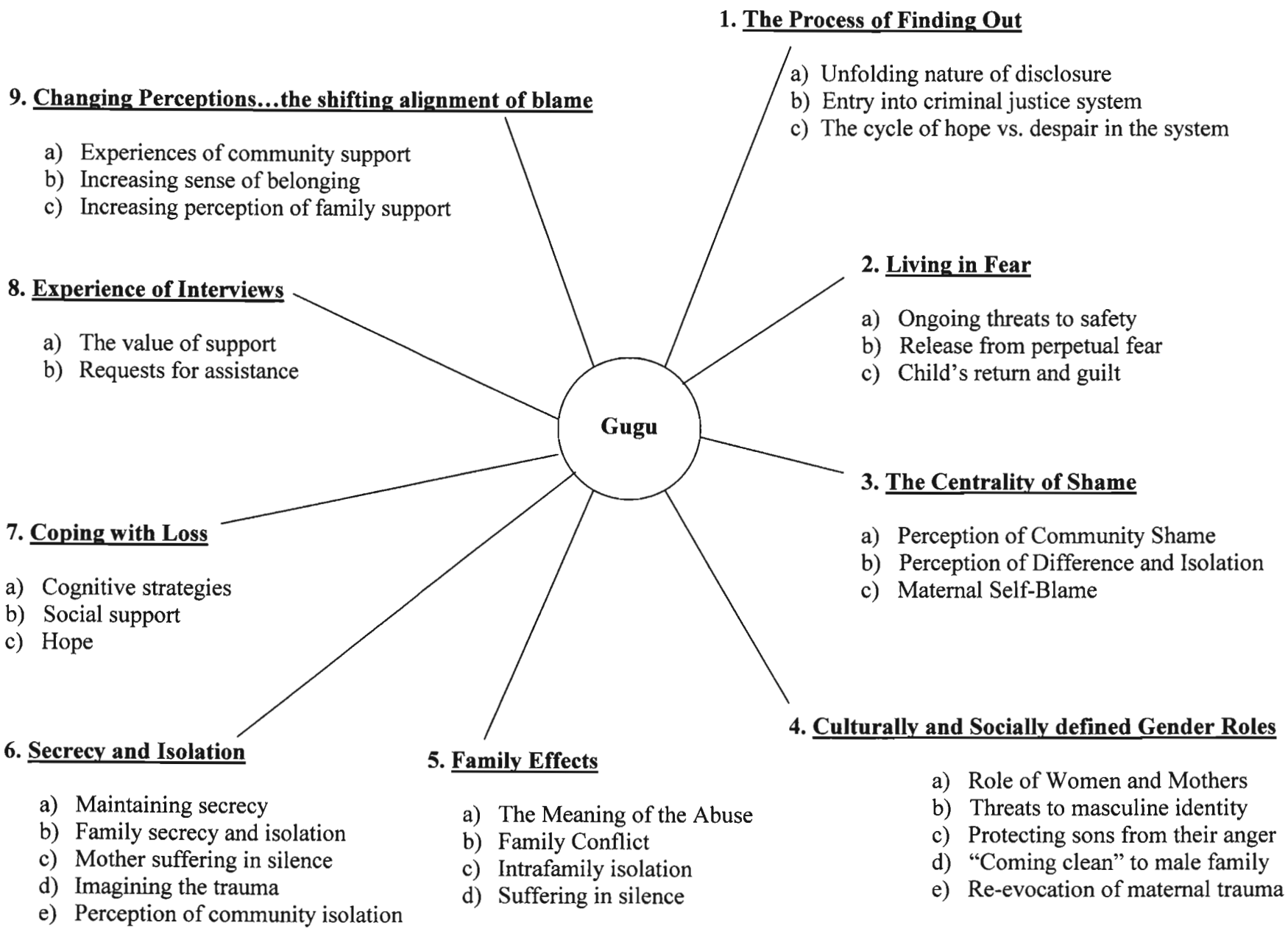
- increasing sense of "belonging" within community -'insider' perspective
- perpetrator as 'outsider'

script 2, p16. 15-22

- increasing perception of family support (sons) - realigning of responsibility
- redeemed self in face of sons

script 2, p18. 5-12

Gugu – Emerging Themes



Appendix O:

Data analysis: Helen

Detailed Script Analysis, Helen

1. The Process of Finding Out

- the unfolding nature of disclosure
- initial suspicions **p1. 43-46**
- building of suspicions over time **p2. 1-2**
- denying the signs **p2. 4-38**
- confrontation with the reality of the abuse

2. The Aftermath of Initial Disclosures

a) Systems Responses

- (i) Entry into the system - whirlwind of system involvement
  - loss of control; helplessness; powerlessness **p18. 3-7**

- (ii) Sequelae of post-disclosure processes **p3. 5-15**
  - being passed down the chain **p3. 43-46**
  - delays in systems processes **p4. 1**
    p5. 25
  - feeling neglected and abandoned by the 'law' **p2. 2-3**
  - resignation (powerlessness) as system takes over; directives to back off **p14. 33-37**
  - unfolding horrors and fears – child's physical examination **p4. 9-19**
    p13. 18-25
    p12. 44-46
    p13. 1-4
  - aftermath of novel and stressful demands placed; juggling demands **p25. 23-27**

b) Emotional Responses

- (i) Initial emotional responses
  : maternal - shock, horror, disbelief, helplessness, anger and frustration **p4. 9-38**
    p5. 1-23

p15. 21-23

- yet trying to remain calm for children

- vacillating quality of emotional response, with much fluctuation between different emotional states; the simultaneous existence of a host of emotions related to the shock of discovery

- centrality of anger as dominant emotion
  Anger towards unknown perpetrator
  Anger at ex-husband
  Anger at child/ren
  Issues of 'morality' **p2. 24-26**
  Truth or lies **p10. 21-26**

: paternal - apathy; denial and minimization **(cross reference Coping)**
- centrality of anger as dominant emotion
  Anger at ex-wife **p2. 39-44**
  p3. 1-5
  Anger at child - blaming child for disrupting status quo; for upsetting the balance and illusion of normality; for disrupting the rhythm of family life
  Child as 'liar'
  Threats to 'jail'/ punish child **p6. 1-9**
  p7. 38-40
  p8. 20-35

: child (male) - confusion **p6. 39-45**
- guilt **p10. 21-26**

- (ii) Enduring emotional responses
: maternal - "internal" – severe state of internal emotional conflict and discomfort/ distress;
- cognitive aspects of traumatization: thought intrusion and avoidance; "fighting my thoughts" **p22. 43-46**
- effects thereof: demotivation at work; distractibility; poor concentration **p20. 28-32**

- "external" (observable) – frustration and anger at ex-husband and child **p6. 44-45**
p7. 1-4
- helplessness at managing child's symptoms **p10. 30-32**

: paternal – anger - at ex-wife

- at child

:child – guilt and confusion

3. Pre-Existing Parental Discord

a) Parents' recent divorce as the primary trauma

- sexual abuse secondary to family history of dysfunction and violence (spousal physical and verbal abuse; family violence; alcohol and drug abuse) **p9. 8-13**

b) Precursors and Vulnerability Factors (to child/ren's sexual abuse)

- family dysfunction and violence **p11. 41**

- parental psychopathology -maternal – depression, dependency
  - paternal – alcohol and drug abuse

- history of parental sexual abuse – maternal and paternal **p7. 31-35**

- recent divorce (deterioration of family structure)

- lack of adequate supervision for children **p1. 43-46**
  p2. 1-2
  p18. 14-33
  and consequent exposure to adult sex and sexually explicit materials **p15. 5-14**
  p6. 10-20

c) Parental Discord dominating both parents' agendas

- de-prioritization of children's best interests

- mutual and reciprocal anger of parents dominating current focus

- interested in hurting eachother primarily; "vendettas" and vengeance (vs. protecting the children) **p10. 1-4**
  p12. 13-15

- dominant issue of supervised visitation, access, and custody battles ie. new rules for contact as consequence of divorce and sexual abuse disclosure **p5. 35-38**

d) Host of Complex Losses related to the divorce (maternal)

- loss of (ideal) marriage and family **p11. 10-12**

- loss of practical and financial resources **p18. 10-20**

- loss of support from paternal extended family **p21. 40-45**

p22. 1-12

e) Consequences to Child/ren of divorce and parental conflict

- children caught in the middle

- emotional and behavioural responses of child/ren:
  - depression, withdrawal, isolation **p19. 9-40**
  - anxiety and insecurity **p7. 6-12** **p17. 28-43**
  - perception of rejection and isolation from father **p8. 7-16**
    - by paternal extended family **p21. 40-45**
      - paternal grandfather **p22. 1-6**
  - feeling unheard by mother **p15. 31-46** **p16. 1-20**
  - guilt and confusion
  - somatic complaints **p9. 34-38**

- managing child's distress – anxiety-related symptoms and insecurity (nightmares) **p12. 31-45**

4. Consequences/ Effects of Recent Family Traumas – Divorce and Sexual Abuse

a) Parental Discord
- due to recent divorce
- exacerbated by disclosures of child sexual abuse
- children as victims
- consequences to children (emotional) **cross reference above**

b) Relational Effects of Sexual Abuse Disclosures

(i) Maternal-Paternal: exacerbation of pre-existing discord

(ii) Maternal-Male Child: series of conflicts and tensions emerging in relationship to child/ ren:

- Perception of increased/ intensified emotional bonding (closeness)

VS

Perception of distanciation from child/ren; due to child's withdrawal and isolation, and not knowing how to talk to child/ ren about the abuse.

- Wanting to believe the child/ren and support their account **p15. 10-15**

VS

Doubting and questioning the validity of child's account; questioning the truthfulness of the child's assertions **p10. 21-26**
p14. 3-5

- Feelings of support and affection towards the child; wanting to react towards the child as "normal"

VS

Resisting feelings of aversion and rejection towards the child; the child as "abnormal" **p13. 42-45**

- Children as source of stress and maternal distress

VS

Children as source of comfort **p21. 1-6**

(iii) Paternal-Male Child: increased distanciation and separation; deterioration in relationship
: father's anger towards child for disrupting the balance of family life; for disrupting the status quo; for upsetting his girlfriend
: threats made towards child

(iv) Paternal Extended Family – Male Child:
: increased distance and child's loss of support from paternal grandfather

c) Conflicting Needs

(i) Maternal needs – for "truth" regarding identity of perpetrator and nature of events; motivation for creating openness for children's disclosures based on maternal needs for answers (vs. support-based towards children)
p18. 41-46
p19. 1-8

(ii) Children's needs – for security, stability, parents' reconciliation
(iii) Maternal difficulty in responding to children's needs as a result; maternal frustration with children's stated needs for parents' reconciliation
p19. 9-40

5. "Not-Knowing" and The Quest for Truth

- ie. identity of perpetrator presently unknown ; confirmed child-on-child sexual abuse, however.
- Not-knowing as the source of much frustration, helplessness and anger

p20. 16-21

a) Consequences of 'Not Knowing' for Mother

(i) Behavioural consequences:

- desperate search/ quest for clarity and answers; for the "truth"
p3. 25-41
p6. 44-45
p7. 1-4
p18. 8-11

- motivation for help-seeking (Childline) to "crack the child" **p24. 46-47**
(such that the truth may be revealed)

- testing the child; "playing psychology" **p14. 12-31**
challenging the truthfulness of the child's account (doubt)
attempting to implicate the child's father (ex-husband)

(ii) Cognitive and Emotional consequences:

- emotional: 'not knowing' fuelling helplessness, frustration and anger

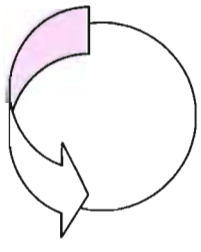
- perceptual: loss of a predictable future **p23. 6-9**
: mistrust and suspicion (re motives of others)
: threats to safety and integrity of self **p12. 1-12**
: ongoing fears for safety of self and children
: trying to sort 'truth' from 'lies'

- cognitive: trying to comprehend/ make sense of others' responses in terms of their guilt (culpability) or innocence (freedom from guilt or responsibility)
: finding 'evidence' retrospectively
: "things brewing in my head..." **p16. 34-44**
cross reference cognitive strategies in "Coping"

6. Coping and Sense/ Meaning- making

Various maternal coping strategies employed:
a) The Positioning of Blame and Culpability

- as a mechanism for channeling and managing anger and helplessness
- the conflict of blame and guilt: blame, anger, suspicion of ex-husband
(ie. implicating him and finding reasons for his culpability) **p9. 15-32**
p14. 12-31
p23. 13-20



VS

: self-blame and guilt – at absence **p21. 1-15**
p21. 28-33
- "what ifs" **p22. 21-32**

ie. Cyclical quality of externalized vs. internalized blame (anger)
Much ambivalence, fluctuation and tension in the positioning of anger and Blame.

b) Meaning-Making: finding evidence retrospectively
: trying to comprehend and make sense of others' responses in terms of their guilt or innocence.

(i) Ex-husband - apathy; lack of anticipated response — **p10. 32-37, p10. 41-45, p13. 26-29, p17. 1-14**

- "lack of remorse" shown — **p21. 32-39**

(ii) Child - Lack of apparent (overt) trauma or distress — **p4. 24-30, p13. 42-45**

c) Defending against Helplessness - perceived powerfulness and control over ex-husband — **p11. 29-37, p18. 33**
- trying to stay strong (denial of meds) — **p20. 34-45**
- needing to stay strong for children

d) Prayer - as source of strength — **p18. 7-8**

e) Paternal Coping Strategies - denial – "worms" — **p4. 9-23, p6. 1-5, p6. 30-37, p13. 18-29, p13. 30-38**

- minimization and normalization as "experimentation" and "exploration" — **p6. 39-43, p20. 1-21**

- redirecting anger towards ex-wife and son (threats of jail etc) — **p6. 1-8**

7. Maternal History of Childhood Sexual Abuse
- story of maternal childhood sexual abuse — **p7. 31-35, p23. 28-45, p24. 1-27**

a) Shame regarding Sexuality — **p23. 36, p23. 40-41**

b) Conflicted re. duty to protect perpetrator (as family member) vs. wanting vengeance (to hurt him) — **p24. 18-27**

c) Continued effects on intimacy and adult relationships with men — **p24. 29-38**

d) Effects of past sexual traumatization on managing current crisis:

- re-evocation of past sexual trauma - self (maternal) — **p24. 7-17**
  - maternal aunt

- over-compensation for childhood experiences of abandonment **p25. 10-13**
- over-identification with children **p7. 31-38**

8. <u>Support</u>

a) <u>Perceived lack of support</u> (practical) from ex-husband **p9. 39-45** **p10. 1-4**

b) <u>Loss of support</u> from paternal extended family (as consequence of divorce) ie. family alignment **p22. 6-12**

c) <u>Existence of maternal family support</u> – family mobilized around her; mother and twin sister **p14. 37-38**

d) <u>Domestic worker</u> as source of support and affirmation **p14. 38-45**

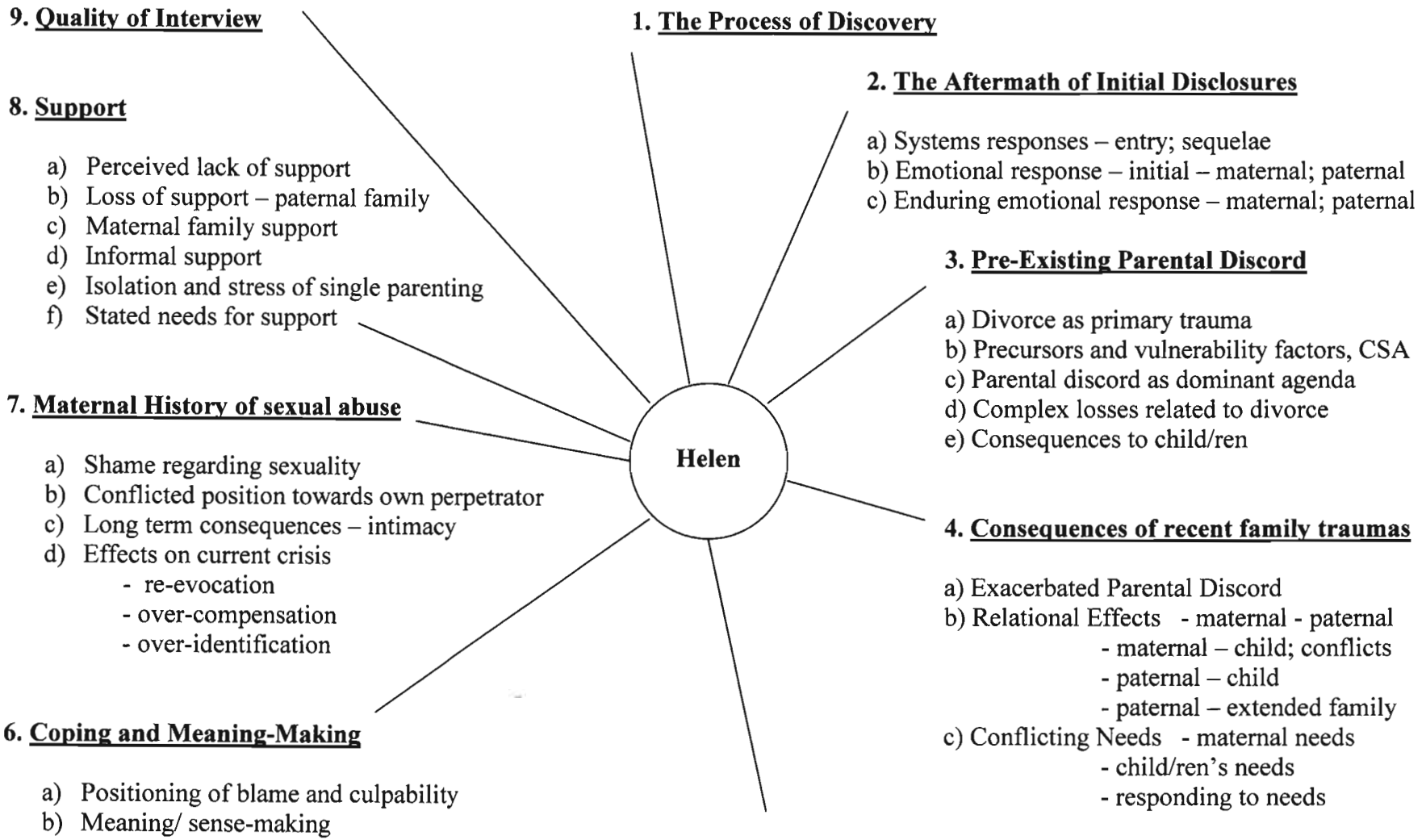
e) <u>Isolation</u> and the <u>Stress of Single-Parenting</u>

f) <u>Stated needs for support</u> from similar others (support groups, Childline) **p22. 12-16**

9. <u>Quality of the Interview</u>

- sense of her 'reliving' / re-experiencing scenes from recent past (in her family, and in the 'system'); sense of self-traumatization
- speaking in the different 'voices' of the different characters;
- very vivid and detailed quality to interview
- much sarcasm and hurt in the tone of the interview
- chaotic, distressed; flashback quality to her recollections and descriptions.

Helen – Emerging Themes



9. Quality of Interview

8. Support

a) Perceived lack of support
b) Loss of support – paternal family
c) Maternal family support
d) Informal support
e) Isolation and stress of single parenting
f) Stated needs for support

7. Maternal History of sexual abuse

a) Shame regarding sexuality
b) Conflicted position towards own perpetrator
c) Long term consequences – intimacy
d) Effects on current crisis
- re-evocation
- over-compensation
- over-identification

6. Coping and Meaning-Making

a) Positioning of blame and culpability
b) Meaning/ sense-making
c) Defending against helplessness
d) Prayer/ faith in a higher power
e) Paternal coping strategies

1. The Process of Discovery

2. The Aftermath of Initial Disclosures

a) Systems responses – entry; sequelae
b) Emotional response – initial – maternal; paternal
c) Enduring emotional response – maternal; paternal

3. Pre-Existing Parental Discord

a) Divorce as primary trauma
b) Precursors and vulnerability factors, CSA
c) Parental discord as dominant agenda
d) Complex losses related to divorce
e) Consequences to child/ren

4. Consequences of recent family traumas

a) Exacerbated Parental Discord
b) Relational Effects - maternal - paternal
- maternal – child; conflicts
- paternal – child
- paternal – extended family

c) Conflicting Needs - maternal needs
- child/ren's needs
- responding to needs

5. 'Not knowing' and the Quest for Truth

a) Consequences of 'not knowing' for mother
- behavioural
- cognitive, perceptual
- emotional