Uncovering symptoms of child abuse and sexual violence: A medico-legal and psychosocial perspective

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By

Mpumelelo Hadebe

STUDENT NUMBER: 207522276

Supervisor: Dr Nontobeko Buthelezi

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ABSTRACT

Child abuse is a pervasive problem in South Africa, with many cases neither disclosed nor reported. Identifying symptoms of sexual and physical abuse in children can be difficult. This study, therefore, sought to uncover symptoms of sexual violence and child abuse from a medical, legal and psychosocial perspective. The primary objectives were, firstly, to establish presenting symptoms of sexual violence and child abuse; secondly, to highlight the associated risk factors; thirdly, to ascertain factors that influence the impact of sexual violence and abuse on the child; and, lastly, to gather knowledge that will assist in developing an evidence-based screening tool for sexual violence and child abuse. The study adopted a qualitative and interpretive approach, drawing mainly on betrayal trauma theory in the discussion of findings. Data were collected through interviews with six participants, namely a medical doctor, a criminologist, two psychologists, and two social workers. Data were then analysed using thematic analysis, in which themes and subthemes were identified in relation to the research questions. The findings suggested that indicators of child abuse are linked to a range of notable physical symptoms as well as sudden behavioural, emotional and psychological changes. Participants noted parent intrinsic characteristics that put children at risk of abuse included the detached parent with avoidant attachment style, and the inconsistent parent with anxious attachment style. Risk factors identified included family and environmental factors such as family discord, parental stress, and parents or caregivers with unresolved trauma. Furthermore, protective factors, which influence the impact of sexual violence and abuse on the child, were identified as family and environmental support, where the family listens to and believes the child, and takes the necessary steps to protect them; access to services such as medical, legal and psychosocial support for the child; and the child's own resilience. From these results, a diagram was developed to help parents and practitioners to screen for symptoms of child abuse. This diagram could assist other sectors to take suspicions or reports of child abuse more seriously, which could encourage more timely interventions.

Key words: Betrayal Trauma Theory, child abuse, risk factors, screening tool, symptoms

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CHAPTER ONE: INTRODUCTION

1.1. Background of the study

Child abuse is a pervasive problem that affects many children in South Africa, with a large number of cases going unreported (Meinck et al., 2017). There are various types of child abuse, including physical, emotional and sexual abuse, and child neglect.

Physical abuse of a child is defined as acts by a caregiver that cause actual physical harm or have the potential for harm (World Health Organisation, 2002). This can include the caregiver hitting the child with a hand or an object, kicking, shaking, throwing, burning, stabbing or chocking the child.

Seth (2015) defines emotional abuse as the caregiver's failure to provide an appropriate and supportive environment, and includes acts that have adverse effects on the child's emotional health and development, such as "repeatedly communicating to the child that they are worthless, flawed, unloved, unwanted, endangered, or only valued when meeting another's needs" (American Professional Society on the Abuse of Children, 1995). This includes having family members who constantly call children stupid, lazy or ugly. Whereas, neglect involves the caregiver's inattention to aid the development of the child, where they are in a position to provide adequate resources. It involves failure to provide the child with adequate health care, education, nutrition, shelter, safe living conditions, and support for the child's emotional development (Meick, 2014).

Sexual abuse is defined as "the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared, or else that violates the laws or social taboos of society" (World Health Organisation, 2010, p. 16). This includes any type of inappropriate touching; forced oral, genital or anal penetration; forced exposure of private parts; forced viewing of pornography; and sexual harassment by adults, older children or peers (World Health Organisation, 2010). Reports on child abuse estimate that one in three girls and two in seven boys are victims of sexual abuse worldwide (UNICEF, 2014). The Southern African AIDS Dissemination Services (SAFAIDS) executive reported that Southern African countries have the highest rates of sexual abuse globally (UNICEF, 2013).

A parent, guardian, teacher or any professional has a duty to report suspected child abuse when they hear about it from the child, co-abused or third-party witness (KwaZulu-Natal Department of Education, 2010). A person may suspect child sexual abuse from observable symptoms in the child such as lower abdominal pain, frequent visits to the bathroom and/or abnormal discharge (Department of Paediatrics, 2007). Moreover, parents who observe behavioural changes in the child, such as a decline in school performance, and sexualised language and behaviour, have reason to be concerned.

According to the KwaZulu-Natal Department of Education (2010), if parents or guardians observe any of the above-mentioned indicators in their children, they need to seek the services of the following people: A healthcare worker for a medical examination of the child; a social worker for a risk assessment of the child; the South African Police Services to investigate a criminal offence; and a mental health worker for counselling. Many of the symptoms highlighted above, however, are not identified as potential symptoms of child abuse. Hence, they go unreported by unsuspecting parents, guardians, teachers and members of the community (Meinck et al., 2017). It is therefore imperative to develop evidence-based tools to screen for signs of child abuse in order to refer children without delay for professional assessment, and management of child abuse and sexual violence.

1.2. Purpose of the study

A study conducted in two provinces in South Africa investigated children's knowledge of post-abuse services and showed that only 20% of abuse victims reported the abuse (Meinck et al., 2017). Of those children who reported the abuse, 72% received care and support. Of all the children abused, 85.6% did not receive help due to not reporting the abuse or lack of services (Meinck et al., 2017). Of the 14.4% that received help, 4.9% obtained it from formal health and social services.

Likewise, Jewkes, Penn-Kekana and Rose-Junius (2005) emphasised that although communities are opposed to sexual violence and child abuse, no tough action is taken against the perpetrators; rather, the victims are mostly blamed. This could be one of the reasons why few victims report the abuse. Perpetrators are usually protected when they are family members. For example, a parent who had observed her stepson make sexual advances towards her daughter did not try to stop the behaviour until her daughter was

sexually abused, as she initially did not see anything abnormal with her stepson's conduct (Jewkes et al., 2005). This shows that early identification and intervention is necessary to fight sexual violence and child abuse.

The purpose of this study is therefore to uncover symptoms of sexual violence and child abuse from a medical, legal and psychosocial perspective. It aims to do so by collecting and analysing data from a medical doctor, a criminologist, psychologists and social workers.

1.3. Objectives of the study

The main question of this research is centred on uncovering symptoms of sexual violence and child abuse from a medical, legal and psychosocial perspective. In addressing this topic, it is critical to define child abuse, risk factors, and factors that influence its impact. To answer the main questions of this study as adequately as possible, the research will focus on the objectives listed below:

1. To establish presenting symptoms of sexual violence and child abuse from a medico-legal and psychosocial perspective.
2. To highlight risk factors associated with sexual violence and physical abuse from a medico-legal and psychosocial perspective.
3. To ascertain factors that influence the impact of sexual violence and child abuse from a medico-legal and psychosocial perspective.
4. To produce knowledge that will assist in developing an evidence-based screening tool for sexual violence and child-abuse symptoms.

1.4. Research questions

1. What are the presenting symptoms of sexual violence and child abuse from a medico-legal and psychosocial perspective?
2. What are the risk factors of child sexual violence and physical abuse from a medico-legal and psychosocial perspective?
3. What are the factors that influence the impact of sexual violence and child abuse from a medico-legal and psychosocial perspective?
4. What is an appropriate evidence-based screening tool to be used to screen for sexual violence and child abuse symptoms?

1.5. Significance of the study

Child sexual behaviour is one of the signs of sexual abuse, but does not verify sexual violence. Behavioural symptoms, positive physical symptoms, and disclosure of sexual abuse are normally associated with guilty verdicts (Palusci et al., 2006). This indicates that a variety of factors must be taken into consideration when uncovering symptoms of sexual violence and child abuse. Although physical examinations conducted by health practitioners are useful, they do not rule out or support allegations of sexual abuse when physical examination results are normal, since not all sexual abuse leaves identifiable evidence (Palusci et al., 2006). As a result, fewer perpetrators of child abuse are convicted.

A screening tool can help parents, guardians, doctors, psychologists and social workers to identify victims of child abuse. The tool can also provide practitioners with additional information in uncovering the symptoms of potential sexual violence and child abuse. Some of the available tools that parents can use to screen for sexual behaviour in children are the Child Behaviour Checklist and Child Sexual Behaviour Inventory (Palusci et al., 2006). These screening tools discriminate well between children who show normal behaviour and those who have been sexually abused; however, they do not discriminate well in children who are already receiving psychiatric or psychological treatment. According to Palusci et al. (2006, p.410), “A review of several existing assessments and screening tools for trauma in children and adolescents concluded that no one measure is conditioned to every situation and that new instruments are needed to fill gaps in current assessment procedures.”

Therefore, this study will help to generate knowledge that will contribute to the development of a screening tool to assist persons working in the medical, legal, mental health and social services fields to screen for symptoms of sexual violence and child abuse. Early identification is a necessary step to timely intervention, or even prevention of more traumatic forms of abuse. The screening tool will aid parents and specialists in referring children appropriately, to meet the children’s medical, psychological and social needs, thus creating informed practitioners.

1.6. Conclusion

In this chapter, the following were discussed in detail: The background of the study, purpose of the study, research questions, and the significance of the study.

CHAPTER TWO: LITERATURE REVIEW

2.1. Introduction

The previous chapter highlighted the purpose and objectives of this study. This chapter will go beyond that to review foreign and local studies on indications of sexual violence and child abuse, and the associated risks factors, as well as practitioners' experiences in identifying and reporting child abuse. It will also explore disclosure issues and cultural norms that contribute to sexual violence and child abuse, and look at evidence-based screening tools used in the South African context. Finally, it will review the betrayal trauma theory, which is used as the theoretical framework for this study.

2.2. Review of foreign and local empirical studies

Sexual violence and child abuse are pervasive issues both globally and locally. The United States National Child Abuse and Neglect system data (2011) announced an 18% prevalence of physical abuse, 10% of sexual abuse, and 8% of emotional abuse, and other cases of child neglect. A Ministry of Women and Child Development (2007) survey released by the Government of India, a developing nation with adverse socio-economic factors and a huge population, revealed a 66% prevalence of physical abuse, 50% of sexual abuse, and 50% of emotional abuse, which is extremely high (Seth, 2014).

Evidence of child abuse prevalence in South Africa, however, is limited and inconsistent (Meinck et al., 2018). Results of a research study on patterns of child sexual abuse in the Northern Province of South Africa showed a prevalence rate of 54.2% for males and 60% for females (Madu & Peltzer, 2001). A 'friend' or acquaintance was a common perpetrator, with many victims having perceived themselves as not being sexually abused as a child. In another study designed to explore the prevalence, incidence, perpetrators and locations of child abuse in South Africa, the prevalence among teenagers from all households in two South African provinces of lifetime physical abuse was 56.3%; lifetime emotional abuse 35.5%; and lifetime sexual abuse 9% (Meinck et al., 2016). The findings indicated that caregivers and educators committed most physical abuse, while sexual abuse was most committed by strangers, peers and relatives.

That said, identification of physical and sexual abuse can be difficult. Other than the child or perpetrator, witnesses of abuse are rare, with the perpetrator often denying victimisation.

In addition, child victims are either too young to verbalise what happened to them, or are severely injured or too frightened or traumatised to disclose the abuse (Geldenhuys, 2018). For this reason, medical, legal and psychosocial practitioners play a vital role in the investigation and treatment of suspected child abuse.

2.2.1. Indications of child abuse

Medical personnel are often the ones who examine the child's injuries; they need to determine whether the injuries are accidental or intentional. During the examination of the child, the medical practitioner needs to look at the position, size, colour and shape of the injury along with wounds, bruises and fractures in the period of healing (Geldenhuys, 2018). In severe cases, the death of physically abused children is often a result of head injuries or injuries to internal organs (Seth, 2015). Other patterns of injury may include skin bruising and skeletal fractures at different stages of healing. The medical practitioner, therefore, needs to examine the child properly so that they are able to provide a detailed report when testifying under oath in a court of law (Geldenhuys, 2018). In other cases, a child's parent may notice bloody or suspiciously stained underwear, or trauma of sexual abuse through the child experiencing difficulty walking, a chronic sore throat, or somatic complaints such as constant headaches or stomach aches (Fontes & Plummer, 2010). Children may arrive at a hospital emergency room with a genital injury, sexually transmitted infection (STI) or pregnancy, which may raise the parent's suspicions of child sexual violence.

The child needs to be examined within 72 hours of the abuse for easier collection of the necessary evidence. Before the medical examination, the practitioner needs to record the child's medical history. During the examination, DNA or blood samples need to be taken, and the child's clothing, hair and any bite marks need to be tested and stored as evidence along with STI test results, to help in the legal investigation of the case (Geldenhuys, 2018). To detect child sexual abuse, one needs to have a high level of awareness of the verbal, behavioural and physical indicators of abuse (Seth, 2015). Mothers in a study by Plummer (2006) indicated they were convinced their child had been sexually abused: 74% as a result of their child's disclosure; 66% after noticing a change in their child's behaviour; and 60% after observing their child's emotional reactions.

Child sexual violence and child abuse not only has immediate consequences for the child, but also long-term implications. Research results by Currie and Spatz Widom (2010) indicate that survivors of childhood sexual abuse have lower levels of education, employment and salaries when compared to those who were not abused as children.

Emotional abuse is one of the least studied forms of child abuse. Menck (2014) mentions that acts of emotional abuse include repeated exploitation; corrupting, insulting, threatening, ignoring or isolating the child. Emotional abuse does not only have harmful effects on children, adversely affecting emotional development, but also affects them in their adulthood. For example, in the study by Dias et al. (2014), emotional abuse was the strongest predictor for psychological symptoms such as paranoid ideation, depression, anxiety, negative self-evaluation, and interpersonal sensitivity.

Child neglect also has adverse effects, causing harm to the child's physical, mental, spiritual, moral or social development. Likewise, Seth (2015) mentioned that a neglected child could be exposed to environmental hazards, substance abuse, inadequate supervision, poor hygiene and abandonment. Child neglect not only affects the child in its early stages of growth and development, but also has an adverse effect during adulthood. The study by Dias et al. (2014) indicated that child neglect was found to be directly related to adult psychological distress such as somatisation, anxiety and phobic anxiety. Furthermore, neglect tends to occur with emotional, sexual and physical abuse, which makes it difficult to identify. However, it is important to note that neglect is distinctly different to a caregiver being unable to provide for adequate care for their child due to their impoverished circumstances (World Health Organisation, 2002). That said, neglect and emotional abuse is difficult to identify, and require improvement in detection and intervention tools – as do sexual and physical abuse.

2.2.2. Risk factors for child abuse

The findings of a study that examined patterns of physical abuse in the United Kingdom, in which the participants were children in hospital who were suspected of being physically abused, indicated that 59% of the children exhibited symptoms of physical abuse to the head, face and neck. More than half of the perpetrators were the child's biological parent; 26% being their mothers, 25% their fathers, and 12% their mother's partners (Cairns et al.,

2005). Most of the abuse occurs in the child's home, public areas and school. The study showed that young children and adolescents were at greater risk of victimisation due to their challenging behavior and vulnerability, and adolescents' tendency to challenge their parents' authority (Cairns et al., 2005). Seeing that most of the physical abuse occurs in the home, it makes it more challenging for witnesses to give evidence in the case.

In India, a developing country with high rates of poverty, illiteracy and poor access to health services, country context contributes to the very poor care of children during their first years of life (Seth, 2015). In contrast, in the developed country of Canada, most maltreated children are taken to child welfare services by health practitioners or the police following reported cases of domestic violence (Fallon et al., 2013). That study investigated risk factors that placed abused infants with child welfare services; the findings showed that the most common caregiver risk factor for child abuse was parents' domestic violence, followed by parents' mental health issues, and drug and alcohol abuse (Fallon et al., 2013).

2.2.2.1. Child risk factors

Factors that make children vulnerable to abuse are not only characteristic of the children themselves, but also their parents. Flaherty et al. (2010) mention that the characteristics of a child that might trigger abuse include emotional and behavioural difficulties, physical or developmental disabilities, and unwanted pregnancies. However, a child who does not know how to control his emotions or acts out may be trying to communicate his unmet needs to his caregiver; while unwanted pregnancies may prevent the caregiver from bonding or forming a secure attachment with their child, depending on the circumstances contributing to that pregnancy. Although there are higher rates of girls reporting sexual abuse than boys, both genders of all ages are at risk of victimisation. In South Africa, boys are less likely to report or disclose sexual abuse because of the fear of being stereotyped as gay, especially when victimised by a male perpetrator (Pereda et al., 2009). Even though both females and males are identified as perpetrators of sexual violence, both international and national studies have identified males as the common offenders of sexual abuse, with females tending to abuse younger children, whereas males abuse children of all age groups (Peter, 2009).

2.2.2.2. Family risk factors

At the family level, research in the United States, Europe and Zimbabwe indicates that the perpetrators of child sexual violence are often identified as biological parents, a stepfather, family member or acquaintance (Fouche, 2012). Likewise, in South Africa, 63% of child sexual abuse perpetrators are parents and persons known to the child, as reported to the South African Police Services (SAPS). Family characteristics that place a child at higher risk of abuse include family discord and domestic violence (Finkelhor, 2009), parents abusing drugs and alcohol (Cox et al. 2007), poor family communication and diffused family roles (Scheepers 1994), lower parental economic status and societal isolation (Black et al., 2001), and poor parent-child relationships (Finkelhor & Baron, 1986). Likewise, Flaherty et al. (2010) highlight the characteristics of a parent or guardian that may put the child at risk as low self-esteem, poor impulse control, substance abuse, being abused as a child themselves, parental depression or other psychological illness, and negative perception of normal child behaviour. Another factor that may put a child at risk for sexual abuse is the absence of one or both parents. Statistics South Africa (2010) states that only 34% of South African children live with both parents, and approximately 95 000 live in child-headed homes, without the supervision or protection of parents (Fouche, 2012). That said, research also indicates that the presence of stepfathers in the home doubles the chances of sexual abuse of girls (Putnam, 2003).

2.2.2.3. Environmental risk factors

Environmental factors that place a child at risk of maltreatment include, but are not limited to, social isolation, poverty, unemployment, single-parent households, and family or intimate partner violence. Similarly, Minnie (2009) states that poverty and unemployment force some children to exchange sex for money in order to provide for themselves and their families. In addition, in South Africa, there is a harmful cultural practice of violence against women and children, sexual norms and cultural silencing when it comes to speaking out against sexual violence and child abuse (Plummer & Njuguna, 2009), and the rife practice of the “cleansing myth of HIV” (Madu & Peltzer, 2000; Collins, 2007). The South African context, therefore, presents a variety of unique conditions that place a child at risk of abuse, such as different cultures, languages, environmental factors, socio-economic backgrounds, and available resources.

In South Africa, the majority of child abuse victims are attended to in government hospitals or clinics with limited resources for treatment and case management (Preston, 2016). In many settings where child abuse victims seek treatment, doctors are often overwhelmed with high workloads (Naidoo, 2013), stressful situations (Khan, 2013, Govender, Mutunzi & Okanta, 2012), limited resources and insufficient training (Jina et al., 2013). Additionally, in the South African context, "poverty, patriarchy and gender violence, as well as the socialised obedience, dependency and silence of women and children, create conditions in which abuse can occur, often with few consequences" (Richter & Dawes, 2008, p. 79). An example of the impact of poverty is seen in a study in Zimbabwe, a country neighbouring South Africa, where a 16-year-old orphaned girl revealed that she frequented local bars and nightclubs to pay rent and provide food for her three younger brothers, thus falling prey to sexual exploitation (Masuka, 2013). It is often difficult to establish the extent of child abuse in South Africa, partly due to illicit and often hidden symptoms as well as complexities and differences in definitions, with variations in understanding of reporting levels. A comprehensive approach comprising medical practitioners, psychologists, social workers and law enforcement is, therefore, critical for case management.

2.2.3. Criminal justice

Inasmuch as South Africa has many laws and constitutions against child abuse, there is a huge gap between open cases and conviction rates. Data from the Family Violence, Child Protection and Sexual Offences (FCS) show 7% of convictions in 2003-2004 (Richter & Dawes, 2008). Likewise, some medical and mental health clinicians have expressed concern about the safety of children after reporting suspected abuse, especially with the scarcity of human and financial resources (Hendricks, 2014). This is justifiable considering that in South Africa there is a shortage of social workers to fulfil roles in child protection, with one social worker in a population of 3 187 (1:3 187), and one policeman serving 336 citizens (1:336) in 2012 (Hendricks, 2014).

2.2.4. Practitioners' experiences in identifying and reporting child abuse

In an American study that explored healthcare providers' experiences of reporting suspected child abuse, 56% of providers reported treating children with suspected physical and sexual abuse in the past year; most reported suspected cases to Child Protection

Services (CPS), but 5% did not. The majority of those who did not report stated they did so because they were unsure of the diagnosis, while others said they provided the family with assistance themselves, had experienced previous dissatisfaction with CPS, or did not want to harm the relationship with the family (Flaherty et al., 2000). Of those who did report the suspected cases to CPS, 33% faced negative consequences such as losing clients and spending a lot of time in court or other legal proceedings (Flaherty et al., 2000). Likewise, South African journalist Geldenhuys (2018) stated that long periods can pass between the time of maltreatment and when the victim is brought in for medical examination, often resulting in a discrepancy between the caregiver's report and the doctor's findings. Furthermore, of those healthcare providers who reported the suspected abuse, the findings indicated that their recent education about child abuse improved their chances of reporting (Flaherty et al., 2010). However, only one-third believed that reporting the case to CPS benefitted the child, whereas two-thirds did not. That study's results, therefore, suggest that positive outcomes for children suspected of maltreatment increase the probability of medical practitioners reporting the case, and that one of the most important barriers to reporting is the belief that it would less likely benefit the child (Flaherty et al., 2000). A person might ask then why most children and adolescents do not disclose until they reach adulthood, when disclosing has the potential to stop the maltreatment or even alleviate the symptoms associated with the abuse.

2.2.5. Disclosure and gender dynamics

A large number of children and adolescents do not disclose sexual abuse, and therefore endure it and are left untreated when suffering from its negative outcomes. Paine and Hansen (2002) stated that even when children do disclose the abuse, they may have to deal with negative consequences such as not being believed, being blamed for it, or facing a family breakdown following the disclosure. Likewise, O'Leary and Barber's (2008) study from Australia, which looked at silencing following childhood sexual abuse, showed that only 26% of males versus 63% of females disclosed abuse around the time the victimisation had occurred, with males taking longer to discuss their experiences than females, finding it more difficult to discuss the maltreatment and to seek assistance. Another study in Canada that explored gender dynamics around disclosure of child sexual abuse found that males delayed disclosure because of the fear of being viewed as homosexual, feeling isolated as most

people believe boys are seldom victimised, and not wanting to be seen as a victim (Alaggia, 2005). One of the reasons that motivated some men to disclose was the fear of becoming an abuser. Women, in contrast, had different reasons for delaying disclosure of sexual abuse. The results of the study indicated that women who had difficulty disclosing felt conflicted about who was responsible for the abuse and thus blamed themselves, while others were scared that they were going to be blamed or not believed (Alaggia, 2005). Although many studies indicate that fewer males report child sexual abuse, the Canadian study suggested that this may be due to internal and environmental conflicts around sexuality. Younger children, however, have different reasons for not disclosing sexual violence and child abuse.

2.2.5.1. Younger children and disclosure

Fontes and Plummer's (2010) study in the US noted that sexually abused children often battle with whether to disclose the abuse, to whom to disclose, and how to disclose without facing negative consequences or disrupting their families. What adds to their confusion is their linguistic or cognitive inability to understand what happened to them, and the perpetrator further adds doubt by telling the child it was just 'a dream', 'a nightmare' or their wild imagination (Everson, 1997). Similarly, Morris's (1999) study identified the perpetrator's use of maternal alienation within domestic violence and child sexual abuse, making it difficult for the child to disclose abuse to their mothers. Using a variety of techniques these perpetrators discredit the mother's role in order to undermine the trust between children and their mothers, thus making it more challenging for maltreated children to seek support from their mothers. Without a voice, these abused women are left in fear of their lives, opportunities to keep their children safe are missed, and dangerous men are overlooked (Morris, 2009). That said, the decision to disclose abuse is not just an individual or family issue, but rather should be seen as a contextual issue considering that some cultural norms and values perpetuate the spread of sexual violence and child abuse.

2.2.6. Cultural norms and values

The findings of a study that compared Hispanic and African-American families showed Hispanic girls were more likely to be sexually abused, waited longer to disclose, and were more likely to be victimised by their fathers and stepfathers than African-American girls

(Shaw et al., 2001). It is often difficult to disclose sexual abuse in cultures where speaking about sexuality is taboo. For example, one Puerto Rican therapist mentioned that Puerto Rican families normally react to the topic of sex education with, “Hush! We don’t speak about that” (Fontes & Plummer, 2010). In Fontes’s earlier study (1992), Elaine, a victim of sexual abuse, mentioned that after several years of abuse by her father, she finally disclosed the abuse to her class teacher at the age of 15 during sex education class, stating that her teacher was the only person she felt comfortable talking to about sex. Likewise, a girl in India recalls being told that she was a dirty girl with a wild imagination when she told her mother that a neighbour had taken her to the park and sexually abused her (Gupta & Ailawadi, 2005). This confirms the values of modesty and shame or embarrassment in Arab Spanish cultures that contribute to the silencing of sex education and disclosure (Fontes & Plummer, 2010). Just as cultural norms and values play a role in the silencing of sexual violence and child abuse, so does gender inequality.

2.2.6.1. Cultural norms and gender inequality

In India, “the girl child is systematically neglected before birth right through her life cycle” lacking formal recognition, legal protection and social support; these girls are married early in their childhood, and exploited both in their homes and their marriages (Seth, 2015, p. 710). Similarly, in many families and communities in South Africa, men are accorded power over women and children. This results in some men thinking they have the right to beat women and children, and take sexual advantage of them (Richter & Dawes, 2008). In the patriarchal context, men are assumed to have a biologically driven sexual appetite that demands release, therefore, justifying abuse of children as “the force of nature” (Townsend & Dawes, 2004).

Like the South African norm, most cultures internationally traditionally view sex as something men should always want and women should always try to avoid, especially out of wedlock (Fontes & Plummer, 2010). This is seen where parents teach young girls to keep their legs closed or boys will take advantage of them, which inadvertently teaches young girls that if they expose themselves they will suffer since boys and men cannot control themselves (Fontes, 1992). For instance, in a discussion about the differences in teaching boys and girls, a psychoeducational group consisting of low-income Puerto Rican parents mentioned that from a young age girls are taught to close their legs, cover their bodies and

not arouse men (Fontes & Plummer, 2010). Similarly, one South African girl remembers hiding her body from her male family members, and not wearing tight pants in front of her father, uncles and brothers, reasoning that if they were to rape her she would not have the right to blame them (Jewkes et al., 2005). In such cultures, it is easy to see why a child would blame themselves or not disclose sexual abuse. The same gendered view makes it difficult for boys to disclose sexual abuse by a woman or a man, as the boy would be seen as not manly enough for trying to refuse sexual acts from a woman or as gay for disclosing sexual abuse by a man. Just as cultural norms contribute to the spread of child sexual violence, they also perpetuate the spread of child physical abuse.

2.2.6.2. Cultural norms and physical abuse

With regard to physical abuse, in India, 99% of schools still use corporal punishment, where slapping, kicking, punching and beating are the norm (Seth, 2015). Likewise, many communities in South Africa view corporal punishment as an appropriate way to discipline a child, whereas the South African Constitution and Children's Act define it as abuse (Richter & Dawes, 2008). That said, in South Africa, women tend to smack and beat children more frequently than men (70% as compared to 30%) (Richter & Dawes, 2008). Parents and teachers are the most common perpetrators of physical abuse, while teenagers and young adults are the common perpetrators of sexual violence (Richter & Dawes, 2008).

Having highlighted the context in which sexual violence and child abuse occurs as well as the different theoretical frameworks in which it can be understood, this study will focus on the betrayal trauma theory to understand the diverse outcomes associated with sexual violence and child abuse. Before doing so, however, it will look at the evidence-based screening and assessment tools used in the South African context for sexual violence and child abuse.

2.2.7. Evidence-based screening and assessment tools used in South Africa

Due to the pervasive and debilitating effects of sexual violence and child abuse on the child itself and society as a whole, it is important to screen and assess the symptoms of child abuse in order to prevent, intervene and manage it timely. What makes it difficult to uncover the symptoms of child abuse is the lack of a clear set of agreed-upon standards of what are acceptable and unacceptable behaviours in different cultures. For example, one culture may see overt physical signs such as scars and bruises as more representative of

child abuse than unseen psychological or emotional consequences (Ritacco & Suffla, 2012). Like other countries, South Africa lacks rigorous monitoring systems of sexual violence and child abuse, making it harder to obtain valid and reliable statistics of child abuse (Dawes & Mushwana, 2007). The following sexual violence and child abuse screening and assessment tools have been used in the South African context.

2.2.7.1. Adverse Childhood Experiences (ACE) and Adverse Childhood Experiences International Questionnaire (ACE-IQ)

The ACE was developed in 1995 to assess long-term risky behaviour and health outcomes seen in adults with adverse childhood experiences (Meinck & Steinert, 2015). These experiences have been associated with many negative health and psychological outcomes such as premature death, delinquency, teenage pregnancy, drug abuse, and other psychological and social problems (Ritacco & Suffla, 2012). The ACE is a self-report tool for adults that has 68 items, while the ACE-Screening tool has 10 items used to screen for adverse childhood experiences. The ACE, ACE-IQ, and ACE-Screening tools are all available freely online, but have been shown to have little cultural acceptability and thus need to be used with qualitative research (Meinck & Steinert, 2015). These tools are used for prevention, early detection, and intervention of health and psychological outcomes that arise as a result of adverse childhood experiences. However, the ACE is administered to adults, not children.

2.2.7.2. Child Maltreatment Interview Schedule – Short Form (CMIS-SF)

The CMIS-SF is an 11-item self-report tool used to measure physical, emotional and sexual child abuse victimisation that occurred in the past (Meinck & Steinert, 2015). The tool has been adapted for use in South Africa, takes about five minutes to complete, and is free to obtain online. The CMIS-SF is exclusively used by adults to investigate abuse that occurred in childhood, measuring the presence, frequency, severity and duration of the abuse (Meinck & Steinert, 2015), and, therefore, helps to prevent further emotional and psychological consequences of abuse.

2.2.7.3. International Association for the Prevention of Child Abuse and Neglect Child Abuse Screening Tool (ICAST)

The ICAST is one of the few well-recognised and established questionnaires used to measure the prevalence and frequency of physical, emotional and sexual abuse, neglect and domestic violence experienced in childhood (Meinck et al., 2018). It comprises the self-report ICAST-CH (home) and ICAST-CI (institution) for children aged 11 to 18, the parent version ICAST-P, and a retrospective (young adult) version ICAST-R (Meinck & Steinert, 2015). These different versions have the advantage of measuring the prevalence of the abuse in different timeframes, such as abuse perpetrated within the past year (current) and lifetime child abuse, and abuse by any perpetrator or a parent (Meinck et al., 2018). The ICAST scales were developed internationally, come with easy administration, and can be found online for free. As an international and multilingual tool, the ICAST enables the systematic collection and comparison of research data across cultures with regards to the depth of parental child abuse (Meinck et al., 2018). This helps to measure the true scope of the problem and assists in preventing child abuse globally.

2.2.7.4. Things I've seen and heard Scale (Community Violence)

This tool assesses the frequency of children's exposure to violence, using 20 items that are rated using a 5-point Likert scale (Meinck & Steinert, 2015). It is designed for children aged six to 14 who are normally interviewed face-to-face regarding symptoms of post-traumatic stress disorder (PTSD). The scale correlates well with children who have experienced high ratings of psychological stress and anxiety (Meinck & Steinert, 2015). The tool is a short scale that takes about five to 10 minutes to complete, however, it mainly focuses on witnessing community violence, does not screen for physical, sexual and emotional abuse, and needs to be obtained from the developer.

2.2.7.5. Alabama Parenting Questionnaire (APQ)

The APQ is a tool containing 42 items that are filled out by both parents and children, and cover five dimensions of the parent-child relationship (Meinck & Steinert, 2015). Among those dimensions are positive involvement with the child, and the use of corporal punishment. The APQ has mainly been used in prevalence studies that assess corporal punishment or harsh parenting, and is normally associated with negative parenting styles

and conduct problems. The APQ has been used to understand the causes of conduct problems and delinquent behaviour of youth (Essau et al., 2006). This tool is free of charge and has been used to measure the risk of physical abuse at home; however, it does not measure other forms of abuse.

2.2.7.5. Violence against Children Surveys (VACS)

The VACS is a national survey that measures the prevalence, nature and consequences of sexual, physical and emotional child abuse within households (Chiang et al., 2016). It collects information on multiple perpetrator types, draws out where the abuse took place, and shows health outcomes as well as risk and protective factors. The VACS has been implemented in 11 African countries – including South Africa's neighbouring countries of Swaziland and Zimbabwe – providing baseline data on child abuse in each country (Chiang et al., 2016). The tool collects data from boys and girls aged between 13 and 24 years, looking at abuse that occurred within the past year and lifetime exposure. The VACS, however, has not been administered in South Africa.

The tools identified above generally measure the prevalence and frequency of childhood abuse in adults. These tools identify different types of abuse that occurred in childhood, therefore, helping to prevent further health and psychological outcomes in those adults, and collecting research data that could be used to prevent sexual violence and child abuse for children at heightened risk. However, no evidence-based screening tools for sexual violence and child abuse symptoms in particular were identified. As a result, this study's findings will develop a checklist to help in the screening of symptoms of sexual violence and child abuse.

2.3. Theoretical framework: Betrayal Trauma Theory

Betrayal trauma theory suggests that abuse perpetrated by a caregiver or someone close to the victim contributes to more adverse physical, emotional, social and mental health outcomes when compared to abuse perpetrated by someone who is not close to the victim (Edwards, Freyd, Dube, Anda & Felitti, 2012). In a study by Edwards et al. (2012), which tested health outcomes according to the closeness of sexual abuse perpetrators, the results indicated that women were twice more likely than men to report abuse perpetrated with high betrayal. Among those individuals with high betrayal trauma, 42.1% of victims reported

multiple cases of abuse, indicating they were more at risk of being revictimised sexually. Victims with high betrayal trauma also reported significantly more adverse childhood experiences than those with low betrayal trauma (Edward et al., 2012). This indicates that betrayal trauma is related to harmful effects on the victim's health-related quality of life, and psychological symptoms and conditions. Victims are in turn less likely to develop or use effective emotion regulation skills over time, which also increases psychological symptoms (Gagnon et al., 2017). Furthermore, victims are less likely to recognise betrayal in those relationships and label their experiences as abuse. Without appropriate intervention, this may contribute to the worsening of their symptoms. Likewise, Goldsmith et al. (2012) stressed that traumas high in betrayal are associated with severe dissociation, PTSD, depression, anxiety, alexithymia, STIs and chronic pain relative to traumas low in betrayal. Betrayal trauma theory thus offers a framework for understanding diverse outcomes associated with physical, sexual and emotional abuse.

2.3.1. Minimising awareness

Betrayal trauma theory proposes that the degree of betrayal affects how the traumatic event is processed and remembered, which subsequently impacts how the trauma affects the victim's psychological well-being (Gagnon et al., 2017). Abuse perpetrated by a caregiver threatens the attachment relationship with the victim; therefore, the victim has to isolate the knowledge of abuse to maintain a relationship with the caregiver for survival purposes (Freyd, 1996; Freyd et al., 2001). Betrayal trauma theory suggests the dependence of the child on the perpetrator puts pressure on the child to adapt to the abuse in order to preserve the relationship for survival needs such as shelter and food (Gagnon et al., 2017). Therefore, the child must maintain attachment with the abusing caregiver by minimising awareness of the abuse, which subsequently leads to cognitive and emotional processing that prevents awareness. Freyd et al. (2001) mention that victims decrease awareness of information related to the abuse by employing survival strategies such as dissociation, emotional numbing, and alexithymia – that is, the inability to recognise and describe one's emotions – which is also linked to depression and suicidal behaviour. Repressing awareness of the abuse helps the victim to detach the self from the abusive relationship, but it also increases the risk for revictimisation and other psychological and health outcomes.

2.3.2. Psychological outcomes

Betrayal trauma theory suggests that to maintain the necessary attachment with the perpetrator, victims may try to process their experiences of abuse by focusing on the self – that is, self-blame – rather than on the perpetrator (Gagnon et al., 2017). These victims also tend to think of themselves as dirty or bad – that is, feel shame – thus minimising the focus on the perpetrator's actions. Gagnon and colleagues (2017) indicate that the victim may think of the self as disconnected from self and others, thus feeling alienated, to increase the emotional distance between the self and the perpetrator. The manner in which these victims process their experiences serve as a defence mechanism in the context of abuse, helping them to adapt to the situation and to stay for survival needs (DePrince et al., 2010). Such defence mechanisms, however, contribute to multiple forms of distress such as depression, dissociation, PTSD and identity problems (DePrince et al., 2010). Betrayal trauma not only contributes to psychological distress, it also affects the victims' cognitive functioning.

2.3.3 Deficits in executive functioning

Gagnon et al. (2017, p. 377) highlight that "executive functioning are cognitive skills that control goal-directed behaviour, such as attention, self-monitoring, remembering and manipulating information in working memory, while inhibiting information unrelated to the task at hand". Victims of betrayal trauma are more at risk for deficits in executive functioning such as problems of working memory, auditory attention and processing speed when compared to those exposed to low betrayal trauma (DePrince, Weinzierl & Combs, 2009; Stein, Kennedy & Twamley, 2002; Twamley et al., 2009). Therefore, children and adults who were victims of betrayal trauma may engage in cognitive avoidance such as dissociation and emotional numbing, which may in turn negatively impact the development and utilisation of executive functioning strategies (Gagnon et al., 2017). As a result, this impacts the victim's academic, psychological and social functioning, such as being late for class or appointments, seeming distracted or disorganised, and the inability to pay attention in class or at work. In terms of social functioning, the abuse perpetrated by a trusted other affects the victim's relationships with others in the future.

2.3.4. Dysfunctional relationships

Betrayal trauma theory proposes that abuse perpetrated by a close other impacts the victim's cognitions and behaviours in other relationships, disrupting healthy relationship schemas in such a way that individuals form automatic associations between relationships and harm (Gagnon et al., 2017). Therefore, the risk for revictimisation is increased because victims are more likely to experience the abuse as a normal part of a relationship (Lee et al., 2015). These individuals are then more likely to stay in abusive relationships that become violent, feeling powerless to leave. Since these victims tend to feel alienated from others, they may be less likely to seek help when revictimised. Without appropriate intervention, the cycle of abuse may continue. To help stop the cycle of abuse, the medical, legal and psychosocial practitioners have an important role to play in identifying symptoms of sexual violence and child abuse.

2.4. Conclusion

In conclusion, this literature review explored indications of sexual violence and child abuse, and risk factors. It highlighted the criminal justice associated with it and practitioners' experiences in identifying and reporting child abuse. It also attempted to explain disclosure and gender dynamics, as well as cultural norms and values associated with chid sexual violence and abuse. Furthermore, it highlighted evidence-based screening tools used in South Africa. Lastly, the betrayal trauma theory was used to understand the phenomenon of sexual violence and child abuse from a medico-legal and psychosocial perspective.

CHAPTER THREE: METHODOLOGY

3.1. Introduction

This chapter gives detail to the methodology used in this study to uncover the symptoms of child abuse and sexual violence from a medical, legal, and psychosocial perspective. It also outlines the specific procedures the researcher has undertaken to analyse and understand the experiences of the medical doctor, criminologist, psychologists and social workers who participated in this study. Finally, the chapter presents the ethical considerations addressed when conducting this study.

3.1.1. Research design

Qualitative methods offer richness of data whereas quantitative methods focus on numbers and statistics. According to Howitt and Cramer (2011), human interactions and experiences are too complex to be simplified into variables such as those used in quantitative methods, therefore qualitative research provides a more humanistic approach to data. It values rich descriptions by examining the constraints of everyday life with the use of in-depth observation or interviewing of people. The researcher used a qualitative approach to explain child abuse, describe its risk factors, and interpret what influences its impact. This allowed the researcher to explore the symptoms of sexual violence and child abuse using a richer, informative and in-depth understanding of the participants' social reality. This study, therefore, used a qualitative approach to uncover symptoms of sexual violence and child abuse from a medical, legal and psychosocial perspective.

This study applied purposive sampling, using in-depth interviews to collect data from six practitioners, namely, a medical doctor, criminologist, psychologists and social workers. The interviews were recorded, transcribed and analysed using thematic analysis. The study provided an emphasis on the interpretation of sexual violence and child abuse by looking at associated contexts and environmental factors. Similarly, Guetterman (2015) indicates that studying a central phenomenon in a certain context with the aim of not generalising but explaining, describing and interpreting that phenomenon is valuable. Qualitative data-collection approaches offer extensive data for exploration of the topic with the participants for rich analysis (Howitt & Cramer, 2011). Qualitative methods provide an in-depth understanding of sexual violence and child abuse. The knowledge gained through qualitative

investigations is far more informative and richer, and offers enhanced understanding when compared to that gained from quantitative approaches. Likewise, Tewksbury (2009 pp. 28 & 39) highlighted that "qualitative research focuses on meanings, traits, and defining characteristics of events, people, interactions, settings or cultures and experience".

3.1.2. Rationale for the research design and paradigm

Qualitative research draws from an interpretivist paradigm that strives to deeply understand a research subject rather than predict its outcome (Denzin & Lincoln, 2011). This involves moving beyond a description of child abuse and sexual violence. It seeks to build knowledge from understanding people's unique viewpoints, and the meanings attached to those viewpoints (Creswell & Poth, 2018). Therefore, qualitative research values the participants' lived experiences and biases, and is sensitive to the participants' and researcher's subjective perspectives. Kuhn (1970, p. 175), as the first researcher using paradigms, defines them as "a set of values and techniques which is shared by members of a scientific community, which act as a guide or map, dictating the kinds of problems scientists should address and the types of explanations that are acceptable to them". These paradigms are further based on three perspectives: The nature of reality (ontology); how knowledge is acquired (epistemology); and the process and method through which the researcher acquires knowledge about the world (methodology) (Denzin & Lincoln, 2003). In this study, the researcher seeks to discover how practitioners uncover symptoms of child abuse and sexual violence from their own perspective and their perception of the world. This is further explained by the researcher's view of reality in order to find meaning or to understand the symptoms of child abuse and sexual violence, by interpreting the practitioner's experiences of working with abused children.

3.2. Sampling

This study used purposive sampling, which is a non-random sampling strategy that ensures certain cases of participants are included in the sample universe for the study (Robinson, 2014). This research made use of a medical doctor, a criminologist, two psychologists and two social workers who have more than three years' experience working with abused children or adults who were victims of abuse as children. The researcher collected data from practitioners working around Pietermaritzburg, KwaZulu-Natal. The practitioners were

asked to voluntarily participate in this research in order for the study to report on their perception of the symptoms of sexual violence and child abuse.

The sample size consisted of six practitioners. Robinson (2014) stressed that a small sample of three to 16 participants allows individual cases to have locatable voices within the study and for intensive analysis to be conducted. Similarly, Cresswell (2013) emphasised that citing small sample cases allows for the collection of extensive details to understand the essence of that individual's experiences. The participants in this study were sourced from the researcher and her supervisor's professional network in non-governmental organisations (NGOs), non-profit organisations (NPOs) and the private sector. Some participants were referred to the researcher by her supervisor, a few were referred by her friends and family, and others were searched on the internet and called directly. State workers were excluded from this study owing to the complexity of gatekeepers, which would have delayed obtaining approval for this research. Getting gatekeepers' permission from different departments would have taken much longer than approaching individual professionals in their personal capacity, which was more convenient. To secure permission from the individual practitioners, the researcher contacted them via phone, and followed up with an email stating who she is and what her study was about, and asking for their participation.

A target population or sample universe must specify the inclusion and exclusion criteria, that is, the attributes the participants to be chosen for the study must possess, and the factors that will disqualify potential participants from the study. The inclusion criteria in this study were medical doctors, criminologists, psychologists and social workers in Pietermaritzburg with at least three years' experience working with victims of sexual violence and child abuse or adults who were victims of child abuse. Those excluded from the study did not meet the criteria, or did meet the criteria but did not agree to participate. According to Mason (2002), the more clearly the sample universe is described, the more valid, transparent and generalisable the study can be.

3.3. Data collection

Studying people in their natural environment can take the form of observation, talking to or interviewing people, conducting focus groups or reading what they have written (Pope et

al., 2000). This study used the interview method to collect data from six practitioners on their views and experiences in working with sexual violence and abused children. Interviews are generally structured conversations that researchers have with their research participants. Just as one would ask an individual about a certain topic, people, event or activity, so would interviewing people who have knowledge about a topic be one of the most useful ways to learn about that phenomenon. By doing so, "qualitative researchers aim to provide a fully rounded empathetic understanding of issues, concepts, processes and experiences" (Tewksbury & Louisville, 2009, p. 51).

Participants received an information sheet (see Appendix A) that explained the nature of the research, and were asked to sign a consent form to indicate their voluntary participation in the study and consent to be audio-recorded (see Appendix B). This study interviewed six practitioners to explore their understanding and views of the symptoms of sexual violence and child abuse according to their experiences of working with victims of child abuse. Qualitative methods investigate a phenomenon in its naturalistic setting, and the researcher therefore presented herself as warm, non-threatening, and interested in spending time with each participant. The researcher was open and friendly in her interactions with the participants, introducing herself and spending some time getting to know about who they are and their work experience. This is because interactions are at the heart of qualitative data collection, where the researcher relies on the participants to agree to give of their time to narrate the phenomenon of study with the researcher (Tewksbury & Louisville, 2009). The researcher allowed for a degree of exploration with the participants to form an in-depth understanding of the phenomenon. She recorded the conversation to analyse it in depth later. Some interviews were conducted in the participants' workplaces prior to the national lockdown, while others took place via telephone during the national lockdown due to the Covid-19 pandemic. The data collection method was amended slightly with the latter participants to avoid face-to-face data collection. One of the major differences noted between face-to-face and telephonic interviews was that telephonic interviews were shorter and to the point, whereas face-to-face interviews were longer and more descriptive with lots of repetition. The interviews were semi-structured, consisting of guideline questions and exploring further issues that emerged in the conversation (see Appendix C). The questions were developed by the researcher with the intention of answering the

research questions and objective of the study. The questions were formulated from the literature, guided by the gaps identified from past studies. The recording of the interviews was done using a quality recording device to facilitate the speed and quality of the transcription. The semi-structured or in-depth interview allow for more natural conversation characteristics. This type of interview is extensive for both the researcher and participant as it requires the researcher to prepare thoroughly for the interview, to pay attention to what the participant says, and to probe effectively (Howitt & Cramer, 2011); and the participant to provide more information than in daily conversation. According to Howitt and Cramer (2011), the formulation of questions and probing allows the researcher to clarify and extend the details of the narrative given by the participant. Likewise, Jackson and colleagues (2007) stress that utilising the semi-structured or unstructured, open-ended, informal interview allows for flexibility and responsiveness to emerging themes from both the researcher and participant.

3.4. Ethics

Research ethics aims to protect participants and promote good science (Wassenaar & Mamotte, 2012). The researcher applied for and was granted ethical approval to conduct the study from the Human Social Science Research Ethics Committee (HSSREC) (see Appendix D).

Practitioners who have three or more years' experience in working with sexual violence and child abuse were selected to participate in this study to uncover the symptoms of sexual violence and child abuse. Likewise, Emanuel et al. (2008) state that the population to be selected for the research needs to consist of people who can answer the research question. This study investigated the relevant practitioners' opinions and perceptions of the symptoms of sexual violence and child abuse to provide information practitioners might need for further programmes of intervention. It also considered the risk factors associated with sexual violence and child abuse from the betrayal trauma approach, taking into account the interaction of a victim's physical, psychological and social functioning. This information can be used for the early identification of child abuse, and timely management of sexual violence and child abuse victims. This study will contribute to a body of knowledge for parents and practitioners working with sexual violence and child abuse to help develop a child-abuse-and-sexual-violence screening tool for informed practice. Similarly, Emanuel et

al. (2008) indicate that research should specify who will benefit directly or indirectly from the study conducted. Therefore, the social value of this study will contribute to the body of knowledge for medical, legal and psychological practitioners, and social workers working with sexual violence and child abuse.

According to Emanuel et al. (2008), a favourable risk or benefit ratio involves a fair distribution of research burdens and benefits. One of the risks identified in the study was the naming of participants and their clients who were victims of abuse, or the inclusion of information that could identify them. To minimise the risk, participants were asked to neither name clients nor refer to physical locations when talking about their experiences of working with abused children. Where participants did give their own names and places of work, their names were changed and identifying information was excluded from the study to protect their identity. This ensured the confidentiality of study participants. When participants spoke about clients, they did not mention names or locations, and clients were given pseudonyms to ensure anonymity. In cases where practitioners may have experienced distress due to participation in the study, they were notified that they would be referred to the UKZN Child and Family Centre (see Appendix E). This Appendix contains a letter from the Child and Family Centre indicating that support will be provided for participants involved in the study. Keith-Spiegel et al. (2006) highlight the importance of the researcher identifying all possible study risks and specifying ways in which to reduce them.

Furthermore, the researcher submitted her study to Turnitin (see Appendix F). The Turnitin Similarity Report quantifies how similar the researcher's work is to other pieces of writing, for examiners to determine if the matches are appropriate.

Before data collection, participants received an information sheet that explained the nature of the research and were required to sign a consent form indicating their voluntary participation in the study and consent to be audio-recorded. Likewise, Wassenaar and Mamotte (2012) stress that the standard components of informed consent include the appropriate information sheet, participants who are competent to take part in the study, confidentiality of research participants, and anonymity of clients. In addition, this principle entails respect for participants from beginning to end of the study (Emanuel et al., 2008). This means participants can withdraw from the study at any time without incurring any penalties. It includes safe storage of data collected, the dissemination of research findings to

the research participants, and the shredding of data five years after the study has taken place.

3.5. Data analysis

Data analysis is the process of converting raw data into information useful for decision-making (Judd & McCleland, 1989). It involves breaking down data into its separate components. To facilitate data analysis, the researcher transcribed verbatim the tape-recorded conversations. Bailey (2008) indicates that transcribing the recordings into written form allows the researcher to study the data in detail. The researcher wrote field notes during and after the interview. According to Gill et al. (2008), this allows the researcher to make note of observations and thoughts about the interview. The researcher made use of detailed transcription to capture aspects such as speed, tone, timing and pauses, which are important in interpreting data. Once the data was transcribed, the researcher used Braun and Clarke's thematic analysis to identify and record patterns containing symptoms of sexual violence and child abuse.

Thematic analysis is a method of analysis that assists in converting raw findings into information that is useful for answering the research questions (McCleland, 1989). It involves searching across the dataset to identify, analyse and report themes. Braun and Clarke's (2006) thematic analysis involves six stages, that is, familiarisation of data, generating initial codes, searching for themes, reviewing themes, defining and naming those themes, and producing a report. In this study, the researcher, firstly, read and re-read transcripts containing narratives of practitioners' experiences with sexual violence and child abuse to familiarise herself with the data. Secondly, to generate initial codes, the researcher identified patterns of sexual violence and child-abuse symptoms, and organised the data according to different groups. Thirdly, the researcher searched for themes by looking at the important information that serves as indicators of sexual violence and child abuse, using the betrayal trauma theory. Fourthly, the researcher reviewed the themes, by reading all the transcribed data for each theme to check if it formed a coherent pattern. Fifthly, the researcher defined and further refined those themes that were presented for analysis. Lastly, the researcher produced a report of findings.

3.6. Credibility, transferability, dependability and confirmability

3.6.1. Credibility

Credibility involves linking the findings with reality. A qualitative study can ensure credibility by using triangulation or member checking. Triangulation can be done using multiple methods, observers or theories to gain a more complete understanding of a phenomenon being researched. This study ensured credibility by using triangulation of sources. It used different data sources, that is, different practitioners within the same method. Medical, legal and psychological practitioners and social workers were selected to participate in the study to determine symptoms of sexual violence and child abuse. However, it was challenging for the researcher to get more medical and legal practitioners to participate in the study.

3.6.2. Transferability

Transferability is the degree to which results can be generalised or transferred to other contexts or settings. It gives readers evidence that the findings can apply to other contexts, situations or populations. This study ensured transferability by providing a thick description of data collection and a detailed account of the researcher's experience during data collection. According to Robinson (2014), providing a fully articulated and contextualised sample universe helps to locate the study within place, time and a meaningful group.

3.6.3. Dependability

Dependability refers to the consistency and reliability of research findings and details where research procedures are documented. It allows someone outside the research to follow, audit and critique the research process to ensure that other researchers can come up with similar findings when using the same methods. This study ensured dependability using inquiry or external audit. This process involved having a researcher outside of the data collection and data analysis examine the process of data collection, data analysis and results to confirm the accuracy of the findings and ensure they are supported by the data collected. Likewise, Jackson et al. (2007) highlighted that using peer briefing or external auditors serve to enhance the credibility of the research by examining whether the results resonate with other researchers who were not part of the study.

3.6.4. Confirmability

Confirmability refers to the degree to which the results could be confirmed or corroborated by others. This includes the level of confidence that the research study's results are based on the participants' narratives and words instead of the potential biases of the researcher. This study ensured confirmability by using an audit trail that details the process of data collection, data analysis, and interpretation of data. It included recording topics that were interesting during data collection, writing down interesting thoughts during coding, and noting unique themes during data analysis, as well as providing a rationale for why certain codes were merged and what the themes mean. According to Jackson et al. (2007), a stepwise replication or audit trail serves to verify the substance of what participants said to ensure that interpretations are not subjective iterations of the researcher's own beliefs.

3.7. Conclusion

In this chapter, the following were discussed in detail: The qualitative research design of this study; sampling; data collection; ethical considerations; data analysis; and the quality of this study (credibility, transferability, dependability and confirmability).

CHAPTER FOUR: FINDINGS

4.1. Introduction

This study explored the symptoms of child abuse and sexual violence from a medical, legal, psychological and social perspective. The data was collected through interviews with a medical doctor, a criminologist, two psychologists and two social workers who worked with abused children in the Pietermaritzburg area of KwaZulu-Natal. To ensure anonymity, pseudonyms have been used for the research participants and the study does not reflect any information (other than career and work history) that could identify the participant. For this purpose, the interview research participants have been give the following pseudonyms: 1) medical doctor – Fezeka (Doc), a paediatrician with a MSC in Neurodevelopment, who has been working for more than 26 years with children with mental and behavioural issues; 2) criminologist – Emily (Crim), who worked for three years at a child protection unit assisting abused children, before moving to an NGO and working there for several years; 3) psychologist – Jacky (Psyc), who worked for 15 years at child welfare centre, dealing with matters of physical and sexual abuse, before going into private practice; 4) psychologist – Cebo (Psyc), a clinical psychologist for more than 10 years, who has been working with adults and children in private practice; 5) social worker – Patrick (SW), who has been working with disadvantaged children for more than 13 years at child welfare, before joining an NGO that provides care and support to children and disadvantaged families; and 6) social worker – Samu (SW), who has worked for more than four years at a child and youth centre and a child protection organisation. The findings from the study are presented according to four themes and corresponding sub-themes based on the three research objectives (see Table 4.1 for an overview of themes and sub-themes). Chapter Four presents each theme and sub-theme in detail.

Table 4.1: Summary of themes and sub-themes of this study's findings

Research objectives	#	Theme	Sub-theme
To establish presenting symptoms of sexual violence and child abuse from a medico-legal and psychosocial perspective	1	Child outcomes	Physical indicators
			Sudden behavioural, emotional and psychological changes
			Impaired cognitive functioning
			Impaired social functioning

Research objectives	#	Theme	Sub-theme
To highlight the risk factors of child sexual violence and physical abuse from a medico-legal and psychosocial perspective	2	Parent intrinsic characteristics	Detached parent
			Controlling parent
	3	Risk factors in the socio-ecology	Family and environmental factors
			Socio-economic factors
			Gender-based violence
			Unresolved past traumas
To ascertain the factors that influence the impact of sexual violence and child abuse	4	Protective factors in the socio-ecology	Family and environmental support
			Access to services
			The child's resilience

4.2. Child outcomes

4.2.1. Physical indicators

The participants suggested that physical and sexual abuse in children is linked to a wide range of noticeable symptoms such as bruises, scars and cuts. Adults close to the child, such as caregivers, neighbours or teachers, may be the first to notice some of these indicators. Emily (Crim) mentioned the observable indicators of a child who was physically abused by the mother. "She used objects … she used an iron … piercing the skull of the child … she used a wooden spoon, she used her fists, anything that she could get her hands on, the child was uhmm bruised, she had uhm scar marks." Likewise, Patrick (SW) explained his client was physically abused "in a way that she (the mother) would beat a child, you know, with anything in the house. I just had a recent case like that, you know, the child came with stitches." Fezeka (Doc) stated, "He (the client) was hit with uhmm, uhmm, he was hit with a cane, and he had previous fractures as well." Emily (Crim) further highlighted the observable indicators of children who are physically abused: "Where there was a physical beating or stabbing or stuff like that … you can see the marks the scars, you can see if the child was strangled, you can even see the finger marks." This shows the gross bodily harm experienced by these abused children. Speaking of her client who was sexually abused, Cebo (Psyc) raised a critical point, "So the J88 would show there is definitely sexual assault, but the child is too scared … to talk about it." The J88 form is a preferred method of presenting evidence to be used by a medical practitioner in the South African courts regarding injuries of rape or assault. However, some sexually abused children may not

present physical indicators. Fezeka (Doc) admitted that the lack of sufficient physical symptoms complicates the legal case: “From the medical side those are the things we are sometimes confronted with; the physical evidence is turned around, broken down, or explained by some other reason, and we cannot actually go further.” Emily (Crim) stated what normally happens with these cases:

> “…so, in that instance, we rely heavily on witnesses, and on the circumstantial evidence if it was present; for an example, if you’re wearing a panty and you didn’t wash it … and you kept it for that long, at least a certain uhmm uh uh semen or DNA can be extracted from that to match with the perpetrator.”

That would be the case if there were physical indicators of sexual abuse, but in cases where sexual abuse occurred several weeks or years prior, and where no evidence was collected and stored, there may be no physical indicators of the abuse.

4.2.2. Sudden behavioural, emotional and psychological changes

Child abuse may change the child’s behaviour. Children who were normally calm and collected may suddenly become aggressive. Some children may become withdrawn, while others may start to behave out of control. Other children may become involved in risky behaviour such as the use and abuse of drugs and alcohol, promiscuity, cutting themselves, or constantly running away from home. A child who is physically abused may start dressing inappropriately to hide the bruises or scars. Emily (Crim) mentioned a behavioural change she had noticed in a client who was physically abused: “You know she dresses inappropriately for weather; when it’s hot she would have a jersey on and stuff like that you know so suggesting something has been going on.” Fezeka (Doc) highlighted other changes in behaviour observed in abused children: “Some of them act out, some of them present with emotional and conduct problems. Many will just be more quiet and things like that.” Likewise, Patrick (SW) stated, “They tend to cut themselves and uhmm want to be alone, and when she is alone maybe, maybe the youth and childcare worker might say just go and sleep; she won’t sleep, but she’ll ensure that she destroys the place that she’s in or she draws the wall, or make it dirty.” Some abused children who are unable to cope with their emotions act out and cut themselves. Cebo (Psyc) mentioned, “Sometimes we see kids start acting out or the teenage start drinking or smoking and not coming home.” Emily (Crim)

expected that a sexually abused child would be afraid of men, but was surprised to find "a child being promiscuous, sleeping around, falling pregnant, terminating the pregnancy, fall pregnant again, not knowing who the father and stuff like that. I don't know if that is a neutralisation technique they use." Likewise, Samu (SW) mentioned,

> "There was another case of a sexually abused child who would like call males to come and have sex with her ... sometimes because this thing happens when they were young, it became part of their growing up so if it's not happening, they kinda like miss it, you know."

Being more familiar with the sexualised behaviour of sexually abused children, Cebo (Psyc) was not surprised, mentioning, "we had realised that the child had sexualised himself doing interesting things, exposing himself, sexualised behaviour, nightmares, scared of the dark, wanting to sleep with mom the whole time due to fear, enuresis encopresis."

Emotional and psychological indications of child abuse may include deep feelings of anger, resentment, anxiety or depression. An abused child who could regulate their emotions before could suddenly have problems doing so, and may constantly feel angry, scared or numb. Others may become easily triggered by people or things that remind them of the abuse, exhibiting an inability to control their feelings. Some children may blame themselves for the abuse, feel dirty, bad or ashamed. Others may feel unworthy, and not good enough for love and attention from others. Without any interventions, these children may develop long-lasting psychological conditions such as PTSD, anxiety, depression or a personality disorder. For example, Cebo (Psyc) observed behavioural, emotional and psychological changes in her client who was sexually abused twice by different people: "It may be psychological, behavioural or physical (changes) … low affect, self-esteem issues and towards the perpetrator reserved and withdrawn uhmm … looks depressed, anxious … flashbacks, avoidance, nightmares." Another child, however, may show no emotional signs of abuse, appearing unconcerned or unbothered. Jacky (Psyc) stated how some children numb their emotions in response to the abuse:

> "Ja, so the girls that I talked to they say I was completely confused, I mean often they is irresponsive to trauma, they is shut down of emotions that I even felt like I left my body and its even shutdown or dissociation to think that I need to tell."

This makes it more difficult for children to know if the behaviour of the perpetrator is appropriate or inappropriate. Samu (SW) noted different indications of sexually abused and physically abused children, mentioning that "those who are sexually abused uhmm they fear to be alone … they would soil their pants, they would wet their beds; those who are physically abused, they become aggressive themselves … to protect themselves and see everyone as a physically abuser". Similarly, Jacky (Psyc) recalled a client who lived in fear following the release from prison of her perpetrator: "Uhmm sooo to have a space where she could say this I'm fearful every single day." The same could be said of those children whose perpetrators are never imprisoned, who constantly live in fear. Abuse also affects the victim's self-esteem and can lead to self-blame. Jacky's (Psyc) client mentioned, "Uhmm the sense that I'm damaged goods, no one will love me; all those issues that girls or women go through when they had been raped."

Other indicators of abuse could be psychological. Jacky (Psyc) highlighted symptoms she had observed in abused children: "With a triggering event, so all the things we know about acute stress she was hyper-vigilant … Everything that one would see, flight, avoidance everything as one would see acute stress disorder." Furthermore, Fezeka (Doc) mentioned: "And then (there is) also a child that, that, is just teary and doesn't want to eat and things like that." This may indicate a child with depressive symptoms. Unfortunately, sudden behavioural, emotional and psychological changes alone do not hold weight in court as indicators of abuse. Emily (Crim) admitted:

> "It won't hold weight, because as you read the behaviourist theorist some believe that environment determine one's behaviour … You know, eh eh, but the defendant can easily rubbish it as to say that could be something else, it could be all those factors because the child is failing or it's because it's living in poverty."

This makes it difficult to identify symptoms of abuse or to prosecute the perpetrator. The inability to prove abuse and thus prosecute the perpetrator in court can result in secondary trauma for the abused child. "A child attempt(ed) suicide because of such challenges," stated Emily (Crim). This followed a case that was not properly managed, where the perpetrator was still freely roaming around the neighbourhood and community. Jacky (Psyc) shared a similar view, stating that without emotional support or proper intervention "basically, you looking at a child who is a risk for depression or suicide attempt, or self-

harm; all those kinds of things". That said, short-term therapy does not always work for every child. Patrick (SW) believed that providing a child with a few sessions of counselling would be helpful: "She (the child) attended six sessions with the psychologist and then I said maybe things are going to be fine … But! There was no change, you know." This indicates that child abuse and sexual violence have a long-lasting impact on the child, who may require long-term support. Similarly, a woman who had been sexually abused as a child by her stepfather displayed long-term psychological symptoms. Jacky (Psyc) stated, "It was known between the perpetrator and the adult woman that you did this to me … and when she was going through some anxiety and depression, he even said ... to her I'll pay for you to have some sessions." However, Fezeka (Doc) indicated that behavioural, emotional and psychological changes can be missed as indicators of abuse: "Those are the classical of things, but I'm not convinced that you could only go on those things … you might miss… a part of the patient that was actually abused, that don't show these signs but being the opposite." This further emphasises that children react or respond differently to abuse.

4.2.3. Impaired cognitive functioning

Participants suggested that child abuse may impact the child's cognitive functioning. Some children may experience difficulties concentrating in class or paying attention to the task at hand. Others may have challenges with their working memories and processing speed, which in turn may negatively affect their academic performance. These children may seem distracted or disorganised. Without the appropriate intervention, some may experience a significant drop in academic results, fail or even drop out of school. Likewise, Jacky (Psyc) stated that trying to determine whether the abuse happened to a younger child is like trying to piece together a puzzle; "you need to question where the change is and whether it's scholastic change or whether the child is withdrawn, that part of the puzzle". Cebo (Psyc) raised a critical point that some changes could be observed in the child's executive or cognitive functioning, highlighting that "sometimes (children) become more aggressive or become more quieter in class; a lot of the kids you see it in their marks, a sudden drop in marks, no real understanding … or … uhmm absenteeism". In this case, Cebo (Psyc) was talking of a child who didn't have the linguistic or cognitive capacity to explain what had happened to her at the time.

Jacky (Psyc) mentioned, “The mother says ‘I’m not sure if this is important or even whether she remembers, but a family member abused this child at the age of four years old’… and a lot of what she understood about that at that age, she would be viewing it differently now.” For this child what seemed to have been sexual molestation was actually full penetration. In another case, Jacky (Psyc) recalled a young child who was sexually abused and had no cognitive understanding of what was happing to her at the time. “Ja, and (she as an adult had to) kinda forgive herself because she could forgive this little child was too young to know and too young to understand, because I think it was one of those complex cases where they was such a lot of long period of grooming that she had felt is partly my fault.” Jacky (Psyc) further raised a critical point on how sexual abuse had impaired a client’s cognitive functioning, noting the changes in the child’s behaviour and cognition:

> “She was acting out at school she wasn’t performing academically, and she was very disruptive in class and she was rebellious so teachers had called the mother in and said we’re concerned about your daughter … she shuts down completely and she can’t perform scholastically, she has dissociated in her lessons and she gets so anxious that she needs to get up and leave.”

Patrick (SW) mentioned how impaired academic performance could have long-term implications for the child who does not receive appropriate interventions timeously, “cause she can’t focus, in a way that when you place a child in a mainstream school she finds it so difficult, you know, and she ends up being a candidate for a special school”. Some children struggle so much that they end up dropping out of school, leaving their homes or places of safety. Patrick (SW) noted that “later you find that they don’t cope at school cause of these abuse they have been happening in their lives … you know they end up being in the street”. In contrast, Emily (Crim) mentioned that “some will excel at school cause they rather study then (focus on the abuse)”. This indicates that children exhibit different indicators of abuse, and no one child’s symptoms will present the same as another.

4.2.4. Impaired social functioning

Interpersonal trauma usually impacts negatively on the child’s social functioning. A child who was an extrovert, social or outgoing may become introverted and withdrawn. Others may develop low self-esteem, believing themselves to not be good enough for love and

attention from others. This may impact the way in which they view those who are close to them, as either untrustworthy or unavailable. To the contrary, some adults who were abused as children may consider harm and abuse to be a normal part of relationships. For example, Emily (Crim) highlighted how abuse impaired a child's social functioning: "The child was quiet, timid, uhmm regressing, you know, uhmm not interactive … Yes, she was, timid in a way that she was quiet, not talking, and the mother said that the child is bubbly." Jacky (Psyc) also mentioned how sexual abuse affected her client's social functioning, in that the child became aggressive when interacting with other children following the abuse: "Ja, the flight or fight because she was just fighting with everybody and running away to go to the bathroom and cry and wash her face." Similarly, Samu (SW) mentioned how the abuse affected her client, stating, "It was hard for her; it wasn't easy for her to make relationships with other people and other children at the centre, and she was always fighting with other children." Emily (Crim) shared a similar experience:

> "Ja, of course, the child won't cope socially, two at school the incident, that how the incident has damaged the child ok, uhm the child won't be able to associate with other children cause now the child it feels that now she is an adult or feels that she is not loved, she's disgusted with herself."

This shows how abuse impacts several aspects of a child's life, resulting in impaired social functioning and academic performance, and low self-worth. In addition, the abused child may not have gotten the chance to learn to play with the parent or other children, which affects the way in which they relate to or socialise with others. Furthermore, a child may blame the non-abusing parent for failing to protect them. As Samu (SW) stated, "Ja, there were not like a relationship, like mother-daughter relationship. I think the child was still angry with the mother that you left me with that abuser, you know." Likewise, Jacky (Psyc), when relating about a child who was sexually abused by an adolescent uncle living in the home, mentioned how relationships at home are impaired following the abuse: "All of that is impacting on her behaviour at home, uhmm she gets quite angry at mom."

Fezeka (Doc) stated how abuse may have long-term implications for the child: "They not doing as well as, uhm, and later on they, uhm, their attachments to the better halves and significant others, it's probably going to be affected." Similarly, Jacky (Psyc) mentioned,

> "You know a lot of women who were abused as children, when they want to marry they will have issues around trust, and when they have their own child, particularly a girl child, it triggers the memory of what happened. You know a lot of these moms come and say I'm scared that something has happened, and as you talk to them they say, well it happened to me and I'm fearful of my child."

This indicates how abuse may negatively affect one in terms of trust and future relationships, as well as the development of an anxious personality. Jacky (Psyc) stated how one women's abuse in her childhood impacted her relationship with her partner in adulthood: "Ja, I think they had been a history of being victimised was very much with her, of keeping silence and had led her into this abusive relationship where she tolerated infidelity and tolerated a whole lot of stuff and without it a sense of worth."

4.3. Parent intrinsic characteristics

4.3.1. Detached parent

One of the caregiving styles that may place a child at risk of abuse is avoidant attachment. This parent may discourage or be dismissive of their child's need for attention or affection, are less helpful and supportive, and tend to be cold or unavailable when their child needs them. This caregiver may end up emotionally, physically or sexually abusing their child due to the insensitive and disconnected parent-child relationship. For example, Fezeka (Doc) mentioned how a detached caregiving style can affect the child:

> "If the mom doesn't attach to the baby, for me, it's, it's a big issue that tends to lead to lots of other problems in the future. Uhm because you have an attachment problem between the mom and the baby and the mom and the partner, it's going to play out to conduct problems, possibly in the future."

Another child may be at risk of sexual abuse due to having a detached parent. Such a child may be lacking love and attention from their caregiver, and be unable to identify appropriate and inappropriate attention and behaviour, to the point that when the perpetrator sexually abuses the child, the child may blame themselves for allowing such behaviour and find it hard to disclose the abuse. Jacky (Psyc) stated how children who have insecure attachment with their parents or caregivers are vulnerable to abuse:

> "It's often (children) who are targeted cause they are already vulnerable in some way, they were particularly receptive needing attention or affection and that makes them confused about … what appropriate and inappropriate, especially if the perpetrator says things to the child like you're so cute, you're so special."

With regards to physical abuse, a detached parent may not be able to control his or her emotions and this may lead to abuse. As Cebo (Psyc) stated, "You see quite often in physical abuse, it has to do with anger from the parents or adult side."

4.3.2. Controlling parent

Another caregiving style that may contribute to child abuse is a parent who has an anxious attachment with their child. These caregivers are normally angry and controlling in their parent-child interactions. They may at times be warm, but at other times angry. They tend to restrict or limit their child's social activities and may not want their child to do anything with friends. If the caregiver feels out of control with regards to the child, they may experience fits of anger to the point where they physically harm the child. When asked what she thinks are the main factors that contribute to child abuse, Cebo (Psyc) mentioned, "I think one of the main things are adults, adults who can't deal with children in the sense of a child who is not living up to their expectations of what the child ought to be." This indicates controlling caregivers who may be unable to regulate their emotions when overwhelmed by anxiety, and thus overreact and physically abuse the child in response to what the child did or did not do. A controlling parent with unrealistic expectations may not view the child as a person with their own thoughts and feelings, but rather as an object. Similarly, Jacky (Psyc) noted, "The objectification of children, that I own this child or it's not a real person, or failure to empathise with children as human beings" may contribute to the abuse of a child. Emily (Crim) shared the same viewpoint, "Family members uhmm the grandmother of course and the uncle came to play, and they said they have been trying to intervene, but the mother would say 'this is my child, you can't tell me nothing; I can do whatever'." This is an example of a case where the family members tried to stop the mother from physically abusing her child. Children may become victims of sexual abuse in cases where parents do not value them or view them as mere objects. Cebo (Psyc) indicated,

> "Sexual assault the reason, I do not know, uhmm I think it's that thing I think about a lot what could say is it power eh it could be about lust eh, I really don't know. I sometimes think the child was there and fulfilled a certain need that the adult experienced, so I think it's often it's not valuing children."

Jacky (Psyc) mentioned something similar when talking about how her client viewed her stepfather who had sexually abused her in her childhood: "The terror continued; he was extremely controlling. Harsh; punitive towards them, towards her and her brother." This shows how a controlling parent can end up abusing their children, be it physically and/or sexually.

4.4. Risk factors in the socio-ecology

4.4.1. Family and environmental factors

Participants suggested that a family and environmental factor that may put a child at risk of abuse is ongoing family discord. This may include parents who are always verbally or physically fighting over infidelity, financial issues, alcohol or drug abuse, or how to raise or discipline their children. Children may find themselves caught in the middle, and used as scapegoats or punching bags due to their vulnerability and inability to defend themselves. Fezeka (Doc) stated,

> "They is some neglect in the whole system … the parental part there is underlying many other marital problems, alcohol abuse, drug abuse, financial issues … One should not underestimate the community because the community sometimes accepts forms of physical abuse as needing a hiding he was just naughty and stuff like that … and if you look back at some communities it's not uncommon for, for physical punishment of a child and I think is contributing towards the next generation doing the same thing."

Highlighting critical family and environmental factors that put a child at risk for abuse, Patrick (SW) noted a similar experience when he spoke about a mother with domestic issues who had severely beaten her child. "When you do a follow-up of what was the cause … you find that the biological mother is having problems with the father of the child (he) did not support the child … she is also uhm involved in using dagga." Jacky (Psyc) mentioned how family and contextual factors may contribute to maternal stress and thus child abuse: "I

think that can happen in the case of child-rearing or the stress of being a single parent or postal (postnatal) depression; you know those kinds of factors can result in physical abuse." Likewise, Patrick (SW) mentioned how parental stress may lead to child abuse, stating that "some of the parents consume alcohol cause they trying to forget some of the problems they are having".

4.4.2. Socio-economic factors

Other risk factors for child abuse include parental stress due to lack of employment and high costs of child care, with the majority of people in South Africa earning minimal wage. Another contributing factor could be the loss of the breadwinner in the home, who may have died, left the home, been retrenched from work, or fallen ill and been unable to work. These factors leave many families reliant on one person to take care of them financially, or children and grandchildren reliant on one persons' pension grant. This not only puts emotional strain on the parent or caregiver, but also on the children, and may create constant fighting in the home. Some children may even end up dating older men or prostituting themselves to provide for themselves and their families, and are thus at heightened risk of emotional, physical and sexual abuse. Emily (Crim) stated:

> "It varies; there, there's no one single cause, they are many factors that play that come to play uhmm when it comes to child abuse; are being … uhmm not to able to take care of a child, being your social ills, being your social-economic factors."

Emily (Crim) added, "You find that the, the, the perpetrator is a breadwinner uhmm, of course, that case won't materialise, people won't report it because of one's status; two, the person is putting something on the table." In such a case, people who are struggling to take care of their families financially are likely to turn a blind eye to child abuse perpetrated by the breadwinner in the home. Jacky (Psyc) also mentioned how financial issues in the home contribute to child abuse: "It would make it harder for the mother to accept, so even if they know about what's happening to report it … Because if they are dependent on that man, especially if it's financial and emotional." The non-abusing mother could, therefore, minimise awareness of the abuse of her child by her husband or partner, or refuse to believe her child in order to stay in that relationship.

4.4.3. Gender-based violence

Gender-based violence (GBV) is another factor that can contribute to child abuse. In this country, the abuse of women and children is rife. In situations where the man is physically or emotionally abusive to their partner, the children may also be physically, emotionally or sexually abused by that man. The helpless child may find itself in the cross-fire between the caregivers' fights, be neglected by the non-abusive parent, and/or physically or emotionally abused by the abusive parent. Similarly, Jacky (Psyc) indicated how GBV can contribute to child abuse: "Particularly now the awareness of gender-based violence you have to look from a macro level, uhmm girls, in particular, being dominated or being abused and that being very much an attitude that handed down amongst the men in our society." GBV is not only abuse perpetrated by men against women and children; women can be the perpetrators too. For example, Cebo (Psyc) explained how one child was sexually and physically abused by her mother, uncle and grandfather:

> "… due to the fact that she put out that she was a lesbian, so she is still a child, a teenager uhmm they then used uhm some other thing to hit her private parts … and that was due to the fact of her sexuality and they physically abused her and tried to get her and tried to get the … to try and circumcise her, and yeah that was quite traumatic."

As suggested by Belsky's (1993) intergenerational transmission of abuse theory, a parent who was abused themselves might also end up abusing their own child.

4.4.4. Unresolved past traumas

Participants suggested that parents or caregivers who have experienced unresolved past traumas such as complicated bereavement, divorce or abuse or have witnessed violence and abuse are at risk of abusing their own children. Due to the unresolved past traumas, the parent may have difficulties regulating their emotions and have fits of anger, sometimes to the point of being physically or emotionally abusive towards their child. Others may have difficulty forming or maintaining bonds with their children, to the point of neglecting or even sexually abusing them. This may perpetuate the cycle of abuse. Fezeka (Doc) stated how a parent who was abused might end up abusing their child:

> "I think we see them, and perhaps sometimes the parents or the person doing those things to them don't recognise them as abusive or wrong, probably because there are, where they come from its very similar. So, they actually view what was done to them, I don't say sexually abuse is part of this, I probably more qualified to talk about the physical and the emotional abuse."

When such occurs without proper intervention, the intergenerational cycle of abuse is more likely to continue. Patrick (SW) highlighted how a mother with unresolved trauma ended up abusing her child: "When you try to find a history of the mother, the mother is also an orphan… she also grew up in foster parents, you know, she was being abused."

4.5. Protective factors in the socio-ecology

4.5.1. Family and environmental support

One of the most important protective factors when a child has been abused is family and environmental support. The child may feel safe and valued when the family listens to and believes them, and takes the necessary steps to protect them. Also, the child may feel protected and loved when neighbours, community members, teachers and/or the police believe the child, go in search of the perpetrator or provide emotional support. Affirming the value of being believed following the disclosure of abuse, Cebo (Psyc) stated, "I find that one of the most important things is to be believed, so if a child feels they are believed, cause they also deal with some guilt." Likewise, Jacky (Psyc) stated how important it is for a child who has been sexually abused to be believed. She noted, "Ja, she was protected, heard, she was made safe uhmm and for then she was fine." In addition, a strong family support system can buffer the impact of abuse, as indicated by Emily (Crim):

> "Without it, the child won't cope, so a child needs a strong family structure support, they should support the child, not blame the child, not judge the child and of course the child will need even external supporting structures, your teachers, your friends, stuff like that."

Cebo (Psyc) further highlighted the importance of family and environmental support: "I think obviously support from their family, cause family if they support that child then that's amazing … So, support from family, support from community if the community goes and catches the guy that is found very supportive for that client."

4.5.2. Access to services

In addition to family and environmental support, medical, legal, psychological and social services can help the child feel safe and protected. These services may help the child's recovery and contribute to the healing process. With timely intervention, the child is less likely to develop severe physical, behavioural and psychological conditions. Likewise, Jacky (Psyc) highlighted the different types of interventions that an abused child may access. She stated, "I prefer them to go to Thuthuzela where they have medical examinations done, to talk to the social workers so that that role is clear that they are the investigators and I'm the therapist." Emily (Crim) affirmed the value of Thuthuzela: "You know your Thuthuzela centres and stuff like that, you know those are your major role players uhmm ja." This is because the Thuthuzela Rape Crisis Centre has access to psychologists, social workers, legal practitioners, hospital doctors and nurses who work collaboratively in managing cases of child abuse, offering the child medical, legal and psychosocial support following the report or disclosure of abuse. Cebo (Psyc) stressed the importance of professional collaboration, mentioning that "predominantly (she gets clients) referred by the doctor … or a social worker, uhmm sometimes by the courts and sometimes by outsources". Professional collaboration is critical in identifying symptoms of child abuse and management of the case. Likewise, Emily (Crim) stated,

> "When the mother take a closer look, uhmm she realized that damaged has been done then she (the child) was brought to us of course, we uhmm looked at the child as well with a social worker, the social worker took the child to the doctor, the doctor confirmed, hence the PEP pill that we gave that to the child."

Thus, the PEP pill helped to prevent the child from contracting HIV from the perpetrator, following the sexual abuse.

4.5.3. The child's resilience

Having family support, access to and use of services can help build the child's resilience – that is, in spite of the abuse, the child can be a survivor and live a fulfilling and successful life. Some children are resilient by nature, and with minimal support are able to move past the abuse experienced and thrive. This may be the case with children who have had to face much adversity, and have had to fight to survive and achieve their goals. Cebo (Psyc) stated,

"Quite often your very intelligent uhmm already resilient child, quite often presents with strong PTSD symptoms or strong acute stress and then comes out of it very, very strong." Jacky (Psyc) shared similar thoughts:

> "Fortunately, I always look for the child's uhmm I always look for their passion and for her she had a passion for sports … to be able to feel good about your body and be strong to be strong and run fast and all of those things is a really healing thing."

Even when a child is not naturally resilient, psychologists and social workers can work with the child to build resilience. Jacky (Psyc) admitted that she helps her clients to build their ego and resilience. By helping them see that "having goals, that my life is worth something … I'm more than this; that is what we often say to children, that you are more, that this is something that happened to you." Another child who was supported through the child protection institution came out of it as a survivor and used her experience of abuse to make something better of her life. Patrick (SW) mentioned,

> "…through getting support and guidance, showing that you love that person, encouraging the person … now she is a lawyer, we are very proud of this lady … at times we request her to come and motivate these other children who are still in the institution."

4.6. Appropriate evidence-based screening tool

When participants were asked about the screening tools they use for symptoms of sexual violence and child abuse, they all responded that they did not use any screening tools. Rather, they observed the child's physical symptoms and corresponding changes in behaviour for indicators of sexual violence and child abuse. For example, Fezeka (Doc) mentioned that he looks out for any red flags, any abnormalities in the child that may indicate abuse. Likewise, Cebo (Psyc) stated that he does not use any screening tools, but rather receives referrals from doctors, and relies on the intake interview for queries he may have regarding the abuse of the child. Samu (SW) mentioned that a child who has been sexually abused normally becomes promiscuous, which indicates sexualised language or behaviour observed in these children. Patrick (SW) also does not use any screening tools, stating that he uses play therapy for children who find it hard to talk about the abuse they

have experienced, and these children communicate their experiences or feelings through play.

4.7. Conclusion

This chapter presented the findings of this study from the interviews with six research participants. Themes and subthemes were presented and explained. The following chapter will go beyond an explanation to a discussion of the findings relating to the research questions posed, using the betrayal trauma theory and literature in this study.

CHAPTER FIVE: DISCUSSION

5.1. Introduction

This study aimed to explore the symptoms of sexual violence and child abuse through interviews with six research participants, namely, a medical doctor, a criminologist, two psychologists and two social workers. In chapter four, themes and sub-themes were presented and explained. This chapter aims to go beyond an explanation to a discussion of the findings in relation to the research questions posed, using the betrayal trauma theory and literature reviewed in this study. It does so by revisiting the following questions:

1. What are the presenting symptoms of sexual violence and child abuse from a medico-legal and psychosocial perspective?
2. What are the risk factors of child sexual violence and physical abuse from a medico-legal and psychosocial perspective?
3. What are the factors that influence the impact of sexual violence and child abuse from a medico-legal and psychosocial perspective?
4. What is an appropriate evidence-based screening tool to be used to screen for sexual violence and child abuse symptoms?

5.2. Child outcomes

5.2.1. Physical indicators

Physical abuse in children may include, but is not limited to, non-accidental bruises, scars, stitches, strangulation marks and bone fractures. These may stem from the parent using their fists or objects to beat up the child. Similarly, Seth (2015) mentioned that patterns of physical abuse include skin bruising and skeletal fractures at different stages of healing. It is therefore critical that the medical doctor or nurse properly examine the child in order to be able to provide a detailed report when testifying in court during the investigation of the case (Geldenhuys, 2018). However, physical indicators may not always be available, particularly if evidence – such as the collection and storage of the perpetrator's semen or DNA – is lacking and/or the child was not medically examined after the sexual violation occurred. Without physical indicators of abuse, witnesses to testify and circumstantial evidence, the legal case would not hold weight in court. Therefore, the child needs to be

examined within 72 hours of the abuse occurring in order to collect the necessary evidence, such as the doctor's report of the child's genital injuries, and DNA or blood samples of the perpetrator, along with STI results to assist in the investigation of the case (Geldenhuys, 2018). Sadly, the legal system relies heavily on physical evidence to prosecute perpetrators of child abuse. This however, does not mean that where there is a lack of sufficient evidence the child cannot be assisted. To the contrary, the child or surviving adult of child abuse can still access psychosocial support to help them cope and live a fulfilling life despite the trauma they have experienced.

5.2.2. Sudden behavioural, emotional and psychological changes

Abused children often display sudden behavioural, emotional and psychological changes following the abuse. Betrayal trauma theory suggests that abuse perpetrated by a caregiver or someone close to the victim contributes to more adverse physical, emotional, social and mental health outcomes than abuse perpetrated by someone who is not close to them (Edwards et al., 2012). Similarly, mothers in Plummer's study (2006) indicated that they were convinced their children had been sexually abused; 74% as a result of their child's disclosure, 66% after noticing a change in their child's behaviour, and 60% after observing their child's emotional reactions. Children who have been physically abused may display changes in behaviour such as acting out and dressing inappropriately, while others who have been sexually abused may wet their beds or exhibit sexualised behaviour. Fezeka (Doc) spoke about both the behavioural and emotional changes she had observed in her clients. These include children acting out, cutting themselves or feeling suicidal, all of which indicate their emotional turmoil, and risky behaviour such as drugs and alcohol abuse, and promiscuity. Often these children are judged by others as difficult, uncontrollable, angry, rebellious, delinquent, drunkards, junkies or prostitutes. However, as a society we fail to take into consideration what may have happened to them to make them behave in this manner.

Changes in emotional behaviour may include fearfulness, anxiety, anger and dissociation. Jacky (Psyc) stated how some children numb their emotions in response to the abuse: "Ja, so the girls that I talked to, they say I was completely confused, I mean often they is irresponsive to trauma, they is shut down of emotions that I even felt like I left my body and its even shutdown or dissociation to think that I need to tell." This may make it difficult for

children to be aware of what is right or wrong, and to testify in court. Children abused by a family member may subconsciously minimise their awareness of the abuse in order to maintain a relationship with the abusing parent so as to meet their survival needs, such as shelter and food. This is evident in cases reported to child protection services where children deny the abuse and refuse to be separated from their abusing parents. Likewise, Goldsmith et al. (2012) stressed that traumas high in betrayal are associated with severe dissociation, PTSD, depression, anxiety, alexithymia, STIs and chronic pain relative to traumas low in betrayal. This could explain why so many abused children do not disclose or report the abuse. Some numb their emotions and detach from the abuse in the hope of forgetting what happened to them, with some success. Repressing awareness of abuse may help the victim to detach the self from the abusive relationship, but it also increases the risk of revictimisation and other psychological and health outcomes.

Psychological indicators of sexual violence and child abuse may include PTSD, depression or anxiety, and suicidal ideation. However, not all abused children display these behavioural, emotional and psychological indicators. The fact that each child reacts differently to abuse makes it harder to uncover the symptoms of abuse. In addition, changes in behavioural and psychological functioning alone cannot prove abuse in court. Emily (Crim) spoke about how defendants could rule out psychological indicators of abuse and attribute them to other economic factors like poverty. That said, abuse not only affects the child physically, behaviourally, emotionally and psychologically, but also cognitively.

5.2.3. Impaired cognitive functioning

Abuse affects a child's cognitive functioning, which may cause them to lose focus, become disruptive in class, and experience a drop in academic performance. Gagnon et al. (2017, p. 377) highlighted that "executive functioning are cognitive skills that control goal-directed behaviour, such as attention, self-monitoring, remembering and manipulating information in working memory, while inhibiting information unrelated to the task at hand". Cebo (Psyc) indicated that some changes could be observed in the child's executive or cognitive functioning. Similarly, Jacky (Psyc) explained how sexual abuse impacted a client's executive functioning:

> "She was acting out at school she wasn't performing academically, and she was very disruptive in class and she was rebellious so teachers had called the mother in and said we're concerned about your daughter … she shuts down completely and she can't perform scholastically, she has dissociated in her lessons and she gets so anxious that she needs to get up and leave."

Betrayal trauma theory indicates that children and adults who were victims of betrayal trauma may engage in cognitive avoidance such as dissociation and emotional numbing, which may in turn negatively impact their development and utilisation of executive functioning strategies (Gagnon et al., 2017). Some children struggle to focus in class, and may end up repeating grades or dropping out of school. However, not all abused children display these cognitive indicators. Some are able to focus all their attention on school activities and the task at hand, and excel in schoolwork or extra-curricular activities. Very young children who are abused, however, may not have the linguistic and cognitive capacity to verbalise or fully comprehend what happened to them. Speaking about the abuse of a four-year-old, Jacky (Psyc) mentioned that the child did not fully comprehend what had happened to her until she reached adulthood. At the time of the abuse, the child did not have the linguistic and cognitive capacity to fully express what had happened to her, and what the parents had thought was sexual molestation was actually full penetration. Sadly, this child, and many others like her, may find it difficult to concentrate in class and on the task at hand, and struggle with memory and introspection. Without timely and consistent intervention, this impacts the child's academic, psychological and social functioning.

5.2.4 Impaired social functioning

Emily (Crim) spoke about how abuse impairs the child's social functioning, mentioning that a child who was outgoing and social became quiet and timid following the abuse. In contrast, another abused child could become aggressive, fighting with everyone. For example, Samu (SW) explained how the abuse affected her client who was struggling to develop and maintain relationships, and was always fighting with the other children in the home. Another child may blame their non-abusing parent for allowing the abuse to happen or for failing to protect them, such as Jacky's (Psyc) client who was constantly angry with her mother, which affected their relationship. This relates to Jacky's (Psyc) client who was sexually abused by an adolescent uncle living in the home. Likewise, in the Family Systems

Theory, sexual abuse perpetrated by a member of the family is seen as the ultimate betrayal of relational ties and family roles, considering that sexual violence damages the survivor's ability to trust and effectively interact with others (Karakurt & Silver, 2014). Children realise that the caregivers who are supposed to protect them violate them, and these feelings of betrayal are exacerbated when family members fail or are unwilling to protect the child. Likewise, Karakurt and Silver (2014) highlighted that children who grow up in environments where they cannot depend on their caregivers for love and protection will turn inward, thus avoiding expressing their emotions or pain resulting in dismissive or avoidant attachment. This may be seen in children or adult survivors who have trust issues, avoid intimacy and vulnerability, and are extremely self-reliant, sometimes to their own detriment. Abuse not only impacts the child's current social functioning, it also has long-term implications, such as them having trust issues or tolerating abuse from future partners. Similarly, the betrayal trauma theory indicates that the risk of revictimisation is increased because victims are more likely to experience abuse as a normal part of a relationship (Lee et al., 2015). This could explain why some individuals remain in abusive relationships that become violent, feeling powerless to leave.

5.3. Parent intrinsic characteristics

5.3.1. Detached parent

According to Bowlby's attachment theory (1988), certain thoughts and feelings a parent has about their child influences their behaviour and sensitivity towards that child, ultimately putting it at risk of abuse. Lack of emotional control can cause caregivers to feel overwhelmed with anxiety, and to distance themselves from the needy child (Finzi-Dottan & Harel, 2014). Caregiver intrinsic traits that put a child at risk of sexual violence or physical abuse include lack of empathy or inability to regulate emotions. These parents tend to be detached from their children and emotionally withdrawn, having difficulty expressing their feelings. With regards to physical abuse, Cebo (Psyc) mentioned how a detached parent may not be able to control their emotions and this may lead to the parent abusing their child. Similarly, mothers who are described as having anxious attachment tend to be angry or intrusive in their parent-child relationships and are normally inconsistent in their emotions, at times warm and at other times confused or angry (Adam et al., 2004). Whereas mothers described as having avoidant attachment tend to use approaches that protect their children

from a distance; guiding their children by slightly rejecting and discouraging their attachment (Edelstein et al., 2004; Solomon & George, 1996). Jacky (Psyc) mentioned how children with insecure attachment may fall victim to sexual abuse, explaining that these children are already vulnerable and in need of attention, making it hard for them to understand what is appropriate and inappropriate. When these children are abused, they may blame themselves as they may have initially enjoyed the special treatment or attention.

5.3.2. Controlling parent

Mothers described as having avoidant attachment styles are normally less supportive and helpful with their children, and tend to be cold, distant and controlling. These may be parents with unrealistic expectations or who objectify their children. When asked what she believes are the main factors that contribute to child abuse, Cebo (Psyc) mentioned, "I think one of the main things are adults, adults who can't deal with children in the sense of a child who is not leaving up to their expectations of what the child augh to be." This may be reflective of distant caregivers who are unable to regulate their emotions when overwhelmed with anxiety and, therefore, overreact and physically abuse the child in response to what they did or did not do. A parent with unrealistic expectations may not view the child as a person with their own thoughts and feelings, but rather as an object. As stated by Jacky (Psyc), some parents objectify their children and view them as entities rather than human beings with thoughts and feelings. In addition, Jacky (Psyc) mentioned how a client viewed her stepfather who had sexually abused her as a child; the client said her stepfather was controlling, punitive, and harsh towards her and her brother. This shows how a controlling parent can end up sexually or physically abusing their children. The combination of being an extremely insensitive, detached or dissociative caregiver, with low mentalisation or ability to reflect on one's own or other's mental state, triggered by loss or trauma, leads to disorganisation in the child, and abusive behaviour towards the child (Wilkins, 2012). Similarly, the ecological systems framework highlights the characteristics of a parent or guardian that may put a child at risk of abuse as including low self-esteem, poor impulse control, issues with substance abuse, being abused as a child themselves, parental depression or other psychological illness, and negative perceptions of normal child behaviour (Flaherty et al., 2010). However, we need to be cognisant that a number of parents in our society had insecure relationships with their own parents, who may have

been avoidant, anxious or disorganised caregivers. This may impact the way in which they view their own children, the relationships they develop with them, and how they treat them. Therefore, parents are sometimes doing the best they can with what they know. But once they know better, they should try to do better. It is also important to note that not only do the parents' intrinsic characteristics put a child at risk of sexual violence and child abuse, but social and environmental factors also play a huge role.

5.4. Risk factors in the socio-ecology

5.4.1. Family and environmental factors

Socio-ecological factors that put a child at risk include family and environmental, and socio-economic factors, as well as gender-based violence and unresolved past traumas. Therefore, the ecological system framework consists of the wider life in which the child functions, that is the child's worldview, the family background, scholastic functioning, cultural and legal aspects, as well as the economic environment in which the child lives (Preston, 2016). Patrick (SW) provided an example of a child physically abused by the mother, who was having problems with the father not maintaining the child, and both parents were smoking weed. Similarly, family characteristics that place a child at higher risk of abuse include family discord and domestic violence (Finkelhor, 2009), parents abusing drugs and alcohol (Cox et al. 2007), poor family communication and diffused family roles (Scheepers 1994), lower parental economic status and societal isolation (Black et al., 2001), and poor parent-child relationships (Finkelhor & Baron, 1986). Therefore, parenting, youth and children's programmes provided in communities with low socio-economic resources could help bridge the gap between children and their parents. These programmes could also strengthen the relationship between and within families, equip parents with communication and self-sustenance skills, and provide opportunities for members of those communities to support one another.

5.4.2. Socio-economic factors

Environmental factors that place a child at risk for maltreatment include, but are not limited to, social isolation, poverty, unemployment, and single-parent households. Jacky (Psyc) mentioned how having financial issues at home contributed to or maintained child abuse, especially when the mother was financially and emotionally dependent on her partner,

stating that this normally makes it harder for the mom to acknowledge or report the abuse of her child. Likewise, the betrayal trauma theory mentions that some victims of abuse, be it the parents of abused children or children who are abused, subconsciously minimise awareness of the abuse in order to stay in the relationship for survival purposes. In that case, the non-abusing mother could minimise awareness of her child being abused by her husband, or refuse to believe the child in order to stay in the relationship. Likewise, in South Africa, there is a harmful cultural practice of violence against women and children, sexual norms, and cultural silencing when it comes to speaking out against sexual violence and child abuse (Plummer & Njuguna, 2009).

5.4.3. Gender-based violence

In many families and communities in South Africa, men are accorded power over women and children. This results in some men thinking they have the right to beat women and children, and take advantage of them sexually (Richter & Dawes, 2008). Jacky (Psyc) stated how GBV in our society influences child abuse, where men dominate women as something handed down from generation to generation. Similarly, in the patriarchal context, men are assumed to have a biologically driven sexual appetite that demands release, therefore, justifying abuse of children as 'the force of nature' (Townsend & Dawes, 2004). In the South African context, "poverty, patriarchy and gender violence, as well as the socialised obedience, dependency and silence of women and children, create conditions in which abuse can occur, often with few consequences" (Richter & Dawes, 2008, p. 79). Although the impact is slow, there are various movements and hashtags such as #16DaysOfActivism #EndGBV #HearMeToo #MeToo #EndViolenceAgainstWomenAndGirls #BelieveSurvivors, where GBV survivors share their stories to fight against GBV and child abuse in South Africa. Also, of help are the many NGOs and NPOs involved in violence-prevention forums, gender justice, and men-care programmes that invite men and fathers to play an active role in loving and caring for their children.

5.4.4. Unresolved past traumas

Patrick (SW) spoke about a mother with unresolved trauma who ended up abusing her child, mentioning that this mother was an orphan who grew up in a foster home where she was also abused. Intergenerational transmission of abuse suggests that the parents' history of

childhood abuse is associated with the likelihood of them abusing their own children, as postulated by Belsky's (1993) development ecological model. This model highlights that parents who were abused as children have a high chance of continuing the cycle of abuse. Fezeka (Doc) emphasised how a parent who was abused might end up abusing their own child:

> "I think we see them, and perhaps sometimes the parents or the person doing those things to them don't recognise them as abusive or wrong, probably because there are, where they come from its very similar. So, they actually view what was done to them, I don't say sexually abuse is part of this, I probably more qualified to talk about the physical and the emotional abuse."

This is especially evident in the case of physical abuse, or what is called corporal punishment – that is, parents and guardians beating their children, and speaking in aggressive and harsh tones in an effort to 'correct' their 'wrong' behaviours because that is how they themselves were raised. In other cases, parents who had traumatic experiences of their own and were not given the opportunity to find healthy ways to cope may have anger management or trust issues, and an inability to acknowledge and express their emotions appropriately. This may in turn result in the continued cycle of abuse with their children. Likewise, the betrayal trauma theory indicates that child abuse not only impairs the child's current relationships, but also contributes to dysfunctional relationships in adulthood. Thus, without proper intervention, the intergenerational cycle of abuse continues.

5.5. Protective factors in the socio-ecology

5.5.1. Family and environmental support

In addition to being believed, a strong family support system can buffer the impact of abuse, as indicated by Emily (Crim). Cebo (Psyc) also highlighted the importance of family and environmental support, especially if the community takes a stand against the perpetrator. Likewise, Alexander (1992) argued that past family attachment influenced the survivors' experiences of child sexual abuse, which explains the variability in psychological and interpersonal symptomatology of maltreated and non-maltreated children. For example, Shapiro and Lavendosky (1999) found that secure attachment mediated the impact of psychological distress in childhood survivors of child sexual abuse. This is why it is so

important for parents and guardians to form and maintain strong relationships with their children. It will help the child to communicate their upsets directly, to trust others and seek support when needed, and be comfortable with sharing their feelings. This could also explain why it may be easier for some children to disclose the abuse timeously, while others may find it more difficult to do so. What helps to moderate the impact of abuse is that the maltreated child or surviving adult may have formed a secure attachment with a non-abusing parent, supportive peer, partner or sibling, thus enhancing a survivor's subsequent relationships and well-being. Likewise, the ecological systems theory highlights that caregiver support, or support from any significant adult, is associated with less psychological distress of the child, and is important for the adjustment of the child in the long run (Mathews et al., 2013).

5.5.2. Access to services

Jacky (Psyc) stated how access to services can moderate the impact of abuse on the child, mentioning that these services may include medical examinations for children who have been physically or sexually abused, access to social workers who investigate the matter, and counselling from psychologists at the Thuthuzela Rape Crisis Centre. The Thuthuzela centre has psychologists, social workers, legal practitioners, hospital doctors and nurses who work collaboratively in the management of cases of child abuse. Some medical and mental health clinicians, however, have expressed concern about the safety of children following the reporting of suspected abuse, especially considering the scarcity of human and financial resources (Hendricks, 2014). This is justifiable since in South Africa there is a shortage of social workers to fulfil roles in child protection, with one social worker in a population of 3 187 (1:3187) and one policeman serving 336 citizens (1:336) in 2012 (Hendricks, 2014). Similarly, a study that investigated children's knowledge of post-abuse services in two provinces in South Africa showed that only 20% of abuse victims reported the abuse (Meinck et al., 2017). Of those who reported the abuse, 72% received care and support. Of all the children who were abused, 85.6% did not receive help due to not reporting the abuse or a lack of services (Meinck et al., 2018). This is devastating because in our society the lack of or poor service delivery is a real issue. In some areas, hospitals are too far of a distance for communities or short-staffed, making it difficult for some children to access services. In addition, some communities or families may not be aware of the availability of psychological

services or their importance. In most instances, such services are reserved for those who can afford private health care, while government institutions are typically packed, with many people having to wait months or even a year for an appointment with a hospital psychologist. There is, however, an increase in the number of NGOs and NPOs working in vulnerable communities to provide much-needed psycho-social support to early childhood development (ECD) centres, schools, families and community members. That said, with or without access to services, some children have demonstrated resilience in the face of the abuse they have experienced.

5.5.3. The child's resilience

Another protective factor is the child's resilience, as stated by Cebo (Psyc). Similarly, Jacky (Psyc) mentioned that to build ego and resilience requires "a sense of, of having goals that my life is worth something, that my life is worth something, I'm more than this; that is what we often say to children that you are more, that this is something that happened to you". In addition to family background, scholastic functioning, cultural and legal aspects, and the economic environment in which the child lives, the ecological system framework incorporates the child's worldview, which may buffer the impact of sexual violence and child abuse. Resilience is evident in a case mentioned by Patrick (SW), where a client who had been abused received support from the child protection institution and emerged a survivor, going on to become a lawyer who now spends time motivating children in children's homes. Therefore, although sexual violence and child abuse has adverse effects, some children are still resilient, and can come out of their experiences stronger and more determined to make the best of their lives, not only for themselves, but also for their families and communities.

5.6. Indicators that should form part of the child abuse screening tool

Figure 5.1 below presents six features and corresponding points that were identified in the findings from the data and which should form part of the child abuse screening tool. Physical indicators are at the centre, as these are often the first symptoms of sexual violence and physical abuse seen in children. Other key indicators of child abuse identified by participants are sudden behavioural, emotional and psychological changes in children, including changes in social and cognitive functioning. These indicators were identified by medico-legal and psychosocial practitioners with more than three years' experience working

with abused children or surviving adults of child abuse in Pietermaritzburg, KwaZulu-Natal. Although the study focused on a small sample of participants within one province, the findings may be applicable to persons who present with similar symptoms within the South African context. The diagram to screen for symptoms of child abuse, therefore, makes a complex activity accessible for practitioners. It can also help parents and guardians, ECD centres, teachers and the police to take suspicions and reports of abuse more seriously. Furthermore, it can assist in the early identification of symptoms of sexual violence and child abuse, which may in turn lead to the provision of timely interventions.

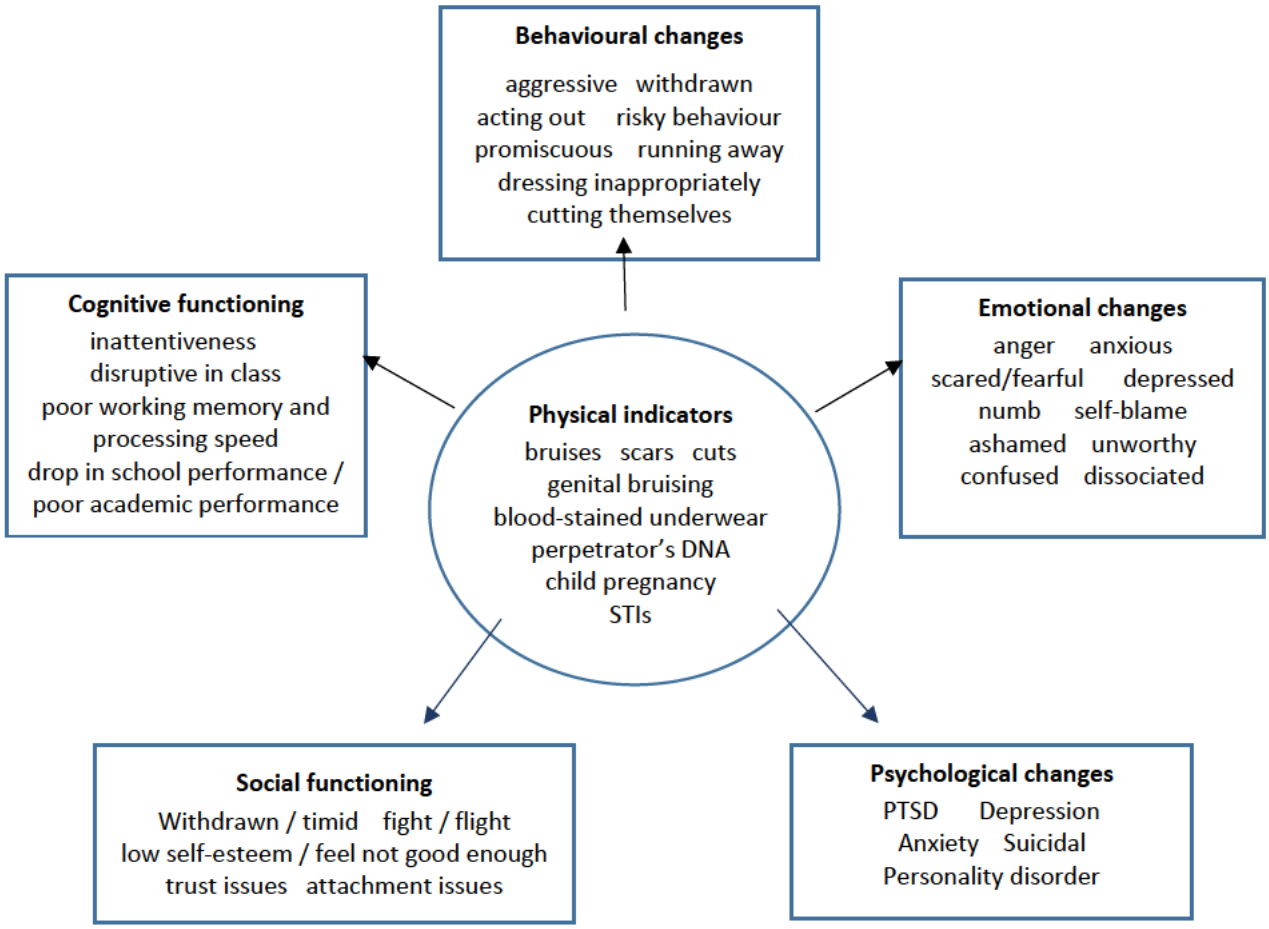

Fig. 5.1: Diagram to screen for child abuse symptoms

5.7. Conclusion

This chapter aimed to go beyond an explanation of the findings, using the betrayal trauma theory and literature reviewed to discuss the findings in relation to the research questions posed. This study found that symptoms of sexual violence and child abuse include physical indicators; sudden behavioural, emotional and psychological changes; and impaired

cognitive and social functioning. Furthermore, risk factors emerged in caregiver intrinsic characteristics and the socio-ecology. The chapter also highlighted those factors that minimise the impact of sexual violence and child abuse. The next chapter will provide a summary of the research findings and the recommendations of the study.

CHAPTER 6: SUMMARY AND CONCLUSION

6.1. Summary of the research process and main findings

6.1.1. Summary of the research process

In the study, the researcher used a qualitative approach to explain sexual violence and child abuse, describe its risk factors, and determine what influences its impact. This allowed the researcher to explore the symptoms of sexual violence and child abuse with a richer, informative and in-depth understanding of the participants' social reality. This study, therefore, used a qualitative approach to uncover symptoms of sexual violence and child abuse from a medical, legal and psychosocial perspective. It applied purposive sampling, using in-depth interviews to collect data from six practitioners, namely, a medical doctor, criminologist, two psychologists, and two social workers who work with abused children in Pietermaritzburg, KwaZulu-Natal. The interviews were recorded, transcribed, and analysed using thematic analysis. Themes and subthemes were presented and explained according to the study's research questions. Four themes were identified with their corresponding subthemes. The first theme is child outcomes, which includes physical indicators; sudden behavioural, emotional and psychological changes; and impaired cognitive and social functioning. The second theme is parent intrinsic characteristics, which involve detached and controlling parenting styles. The third theme is risk factors in the socio-ecology, which include family and environmental factors, socio-economic factors, gender-based violence, and unresolved past traumas. Finally, the fourth theme is protective factors in the socio-ecology, which involves family and environmental support, access to services, and the child's resilience.

6.1.2. Summary of main findings

6.1.2.1. Child outcomes

Indicators of child abuse are linked to a wide range of notable physical symptoms such as bruises, scars, STIs and child pregnancy. Furthermore, indicators include sudden behavioural, emotional and psychological changes. It was said that children who were outgoing and calm suddenly became withdrawn or aggressive. Child abuse also impacts the child's cognitive functioning. Findings indicated that the majority of abused children experienced difficulties paying attention in class, with concentration and staying focused on

the task at hand. Interpersonal trauma impacts children's social functioning. It was said that these children had difficulty forming or maintaining healthy relationships, and tended to be aggressive with others in class or at home.

6.1.2.2. Parent intrinsic characteristics

Caregiving styles that place a child at risk of abuse include detached parents who have avoidant attachment with their children. These are parents who discourage their child's need for attention and affection. It was said that a parent who is detached from their partner and child poses a huge risk to the child, which may present as conduct problems in that child. Furthermore, a child who lacks attention and affection from their caregiver may fall victim to sexual abuse as they are not able to discern between appropriate and inappropriate attention from the perpetrator. Another caregiving style that puts a child at risk of abuse is the parent with anxious attachment. These parents are normally controlling and angry in their parent-child interactions. It was said that controlling parents who objectify their children and have unrealistic expectations of who they ought to be put them at risk of abuse, be it sexual or physical.

6.1.2.3. Risk factors in the socio-ecology

Family and environmental factors that put a child at risk of abuse include family discord. It was said that parents who are constantly fighting over infidelity, money issues or alcohol and drug abuse put their children at risk of abuse, leaving the child caught in the crossfire or used as a punching bag. Another risk factor for the abuse of children is parental stress due to socio-economic factors such as lack or loss of employment, and the high costs of living and childcare, with most people in South Africa earning minimum wage. It was also said that cases where the perpetrator is the breadwinner will usually go unreported, with the non-abusing mother finding it hard to believe the child or to report the case. Gender-based violence is another factor, where the child may be physically, sexually or emotionally abused by the same man who is abusing the mother or may be neglected by the mother. It was said that patriarchy, where men dominate women and children, is an issue handed down from generation to generation and puts children at risk of abuse. It was also said that not conforming to society's norms of sexuality puts children at risk of being abused by their own family members in an attempt to 'correct' the child's sexuality. Furthermore, parents or

caregivers who experienced unresolved traumas such as witnessing or experiencing abuse, complicated loss, or divorce are at risk of abusing their own children. Without appropriate intervention, they risk repeating the cycle of abuse. It was said that parents who physically or emotionally abuse their children may not recognise it as abuse due to how they themselves were raised.

6.1.2.4. Protective factors in the socio-ecology

Inasmuch as there are risk factors in the socio-ecology, there are also protective factors in that influence the impact of sexual violence and child abuse. Family and environmental support are some of the key protective factors when a child has been abused. It was said that children may feel safe and valued when their family listens to and believes them, and takes the necessary steps to protect them from further harm. Having access to services such as medical, legal and psychosocial support may also help the child feel protected and supported. It was said that the Thuthuzela care centre is one of the public places where children have access to doctors, legal practitioners, social workers and psychologists following sexual and/or physical abuse. Having access to family and environmental support, and services may help build the child's resilience. It was said that despite the abuse experienced, the child can emerge as a survivor and live a fulfilling and successful life. Furthermore, some children are resilient by nature, emerging from life's adversities stronger and more determined to achieve their goals.

6.2. Strengths and limitations of the research

This study investigated the symptoms of sexual violence and child abuse to contribute to the information practitioners may need for further intervention programmes. It determined risk factors associated with sexual violence and child abuse from the betrayal trauma approach, by considering the interaction of the victim's physical, psychological and social functioning. This information can be used for the early identification and timely management of cases of sexual violence and child abuse. Previous studies focus on the child's views and experiences of sexual violence and abuse, as well as individual risk and individual protective factors. This study focuses on the experiences of medical, legal and psychosocial practitioners working with abused children; the interpersonal and systemic factors that contribute to child abuse; and the interpersonal and systemic factors that mitigate its impact. This study, therefore,

has generated knowledge that may contribute to the development of a screening tool for sexual violence and child abuse. A screening tool can assist persons working in the medical, legal, mental health, and social services fields to screen for symptoms of sexual violence and child abuse.

One of the limitations of this study was adherence to ethical procedures to recruit participants who are not from government organisations, which restricted the number of recruited participants and excluded professionals with rich experiences from government departments. The public sector is where most people seek services in South Africa due to the free resources for those who cannot afford medical aid or insurance. Therefore, the findings of this study cannot be generalised to the larger population. However, the study was still able to collect rich data from participants working in NGOs, NPOs and the private sector, some of which have several years' experience working in the government sector. In addition, a good number of the general population who cannot afford private services are beneficiaries of the services provided by NGOs and NPOs, and the findings may be applicable to them.

Another limitation is that the use of purposive sampling means the findings of the study cannot be generalised to the larger population, but can be transferred to other cases with similar experiences, such as professionals working with sexual violence and child abuse, parents of abused children, and individuals who were once abused as children. Taking into account the gap in research, the primary objective was to generate knowledge that would contribute to the development of a screening tool for sexual violence and child abuse. However, this was reflected as a secondary objective in the study, whereby the diagram to screen for child abuse symptoms was developed to make a complex activity accessible for practitioners. This diagram could also assist sectors, such as teachers and the police, in taking suspicions and reports of sexual violence and child abuse more seriously.

The researcher did not collect information on the child's cultural context which may have provided background information on the child's victimisation. However, the study had aimed to focus on the experiences of professionals working with sexual violence and child abuse rather than on the experiences of the child. In addition, the study focused on sexual and physical abuse, and not on child emotional abuse and neglect, which have just as many adverse symptoms that are normally under-researched. To address that, the study included

literature on child emotional abuse and neglect in the introduction and the literature review. Therefore, future studies could focus more on the symptoms of child emotional abuse and neglect from a medical, legal and psychosocial perspective.

6.3. Recommendations for future research

Similar to this study, other studies indicate that child victims are either too young to verbalise what happened to them, or are severely injured or too frightened or traumatised to disclose the abuse (Geldenhuys, 2018). For this reason, future research could explore evidence-based screening tools that medical, legal and psychosocial practitioners may use in the South African context to screen for symptoms of sexual violence and child abuse. Furthermore, the literature review indicated that parents' unresolved past traumas put them at risk of abusing their own children, which in turn affects their parental functioning. Likewise, the findings of this study showed that in the majority of cases the parents and relatives were the perpetrators of the abuse. Therefore, future studies could look at family and community programmes that could strengthen parenting styles and interpersonal relationships, thus breaking the cycle of abuse.

The ecological system framework consists of the wider life in which the child functions, including the child's worldview, family background, scholastic functioning, cultural and legal aspects, and economic environment in which the child lives (Preston, 2016). Future studies, therefore, could consider these factors when exploring intervention programmes to prevent and mitigate the impact of sexual violence and child abuse. Similar to this study, the literature review emphasises that family characteristics that place a child at higher risk of abuse include family discord and domestic violence (Finkelhor 2009), parents abusing drugs and alcohol (Cox et al. 2007), poor family communication and diffused family roles (Scheepers 1994), lower parental economic status and societal isolation (Black et al., 2001), and poor parent-child relationships (Finkelhor & Baron, 1986). Future studies could, therefore, explore how to identify high-risk children and families in order to psychosocial support to prevent sexual violence and child abuse.

This study collected data from a medical doctor, criminologist and psychosocial practitioners from NGOs, NPOs and private practice, focusing on a small sample size of six participants to explore their experiences of working with abused children. Future studies could thus

identify symptoms of sexual violence and child abuse by focusing on a large sample size or the experiences of practitioners in the government sector to allow for more generalisability of findings.

In many families and communities in South Africa, men are accorded power over women and children, which is similar to this study's findings. This results in some men believing that they have the right to beat women and children, and take advantage of them sexually (Richter & Dawes, 2008). Therefore, future research could look at different ways in which to challenge gender norms, and possibly explore the factors that contribute to men being present and supportive of their partners and children.

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APPENDIX A

Information Sheet

Good day, I am a University of KwaZulu Natal (UKZN) student doing my Masters of Social Sciences in Counselling Psychology. This interview forms part of my 2018 Research Thesis entitled 'Uncovering symptoms of child abuse and sexual violence: A medico-legal and psychosocial perspective'. My name is Mpumelelo Hadebe (207522276@stu.ukzn.ac.za) and I am the researcher of this project, and my supervisor is Dr. Nontobeko (Nana) Buthelezi (Buthelezin@ukzn.ac.za).

You are invited to consider participating in a study that involves research on sexual violence and child abuse. This study aims to reveal symptoms of sexual violence and child abuse based on your experience in working with abused children and adults who were abused as children. This study will assist persons working in the medical, legal, mental health and social services to screen for symptoms of sexual violence and child abuse and therefore intervene as early as possible to offer care and support. The study is expected to enroll approximately six professional practitioners- a medical doctor, a forensic nurse, legal practitioner, paediatrician, psychologists, and a social worker. Each participant will talk about their experiences of working with sexual violence and child abuse, giving a narrative account of these through a +/-30 minute telephonic interview.

Participation in this study is voluntary, and you could withdraw from it at any stage without incurring any penalties.

Your participation will be confidential, your real name and place of work will not be mentioned in the study. No identifying information of your clients will be mentioned in the study, to ensure their anonymity. You will be responding in your individual capacity, without representing your organisation or institution. With your consent, the interview discussion will be audio-recorded to facilitate the transcription and analysis of data. If you feel distressed due to your participation in the study, UKZN Child and Family Centre will be your referral point.

Storage of transcripts and audio-recorded information will remain in locked storage for five years, after which it will be shredded. The findings obtained in the data may be used in the presentation of student case conferences and journal publications. A handout summary of the research findings will be made available to you at the end of the study. You will also have access to a Thesis available to all members of the public and will be invited for a debriefing session of findings after the study has been completed.

This study has been ethically reviewed and approved by the UKZN Humanities and Social Sciences Research Ethics Committee (approval number HSS/0895/018M).

In the event where you want clarity of the research or have any concerns, feel free to contact me on 076 4806409, email 207522276@stu.ukzn.ac.za or my supervisor on 033 260 5670, email Buthelezin@ukzn.ac.za.

Thank you

Mpumelelo Hadebe
Discipline of Psychology, School of Applied Human Sciences
University of KwaZulu-Natal Pietermaritzburg

APPENDIX B

Informed consent to participate in a research study entitled: Uncovering symptoms of child abuse and sexual violence froma medico-legal and psychosocial perspective.

DECLARATION

I _____ (full name) hereby conform that I understand the contents of this document and the nature of the research project, and I consent to participate in the research project.

In addition, I hereby provide consent to be audio-recorded in the interview to facilitate the transcription and analysis of data

YES	NO

I understand that my participation in this study is voluntary and that I have the right to withdraw from the study at any stage should I wish to do so.

I declare that my participation in this study is confidential and that no identifiable information about myself and the names of clients I have worked with will be provided in the study.

If I have any queries or concerns about my participation in the study I may contact:

The Humanities and Social Sciences Research Ethics Committee

Professor Dipane Hlalele (Chair)

Westville Campus

Tel: + 27 (0)31 260 3587/8350/4557

Email: HSSREC@ukzn.ac.za

_____ _____

Signature of Participant Date

APPENDIX C

Interview Schedule: Uncovering symptoms of child abuse and sexual violence: A medico-legal and psychosocial perspective

Interview question guide:

1. Introduction, overview of research, and consent

2. Tell me about your occupation, what do you do?
   a. How did you decide on this career?
   b. What did you study at tertiary?
   c. How long have you been in this field?

3. You have worked with sexual violence and abused children in your career. What is child abuse according to your understanding?
   a. In your experience of working with abused children and adults who were abused as children, what are the main causes?
   b. Who are the common victims?
   c. Who are the perpetrators?

4. Can you please recall approximately three experiences you have of working with sexual violence and child abuse cases?
   a. How old was the client when they came to see you?
   b. What was the method of referral?
   c. Who reported on the incident?
   d. What was the situation around the incident?
   e. What were the self-reported symptoms?
   f. What were the presenting symptoms that you observed on the client?
   g. What were the symptoms reported by the parent, guardian or accompanying person?
   h. In your opinion,how did the incident affect the client's physical health, home life, academic life, social life, and self-image?

5. According to your experience, what are the factors that influence sexual violence and child abuse?

6. What do you think are the identifying symptoms of child abuse in particular?

7. What do you think are the identifying symptoms of child sexual violence in boys and girls?

8. What are some of the distinct features you have observed in children who have experienced sexual violence and other forms of child abuse?

9. Is there any other thing you want to tell me that you feel is relevant to this topic?
10. Conclusion, you will receive feedback of the findings via your email, thank you for your participation.

APPENDIX D

Ethics certificate from HSSREC

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

19 June 2020

Ms Mpumeleleo Sthembile Hadebe 207522276
School of Applied Human Sciences
Pietermaritzburg Campus

Dear Ms Hadebe,

Protocol reference number : HSS/0895/018M
Project title: Uncovering symptoms of child abuse and sexual violence: A medico-legal and psychosocial perspective

Approval Notification – Expedited Application

With regards to your response received on 05 February 2020 to our letter of 12 October 2019, the application was reviewed by the Humanities and Social Sciences Research Ethics Committee (HSSREC) and the protocol has been granted FULL APPROVAL with the following condition:

- No participants from the Public Sector will be involved in the study.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number. PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

This approval is valid until 23 June 2021.
To ensure uninterrupted approval of this study beyond the approval expiry date, a progress report must be submitted to the Research Office on the appropriate form 2 - 3 months before the expiry date. A close-out report to be submitted when study is finished.

All research conducted during the COVID-19 period must adhere to the national and UKZN guidelines.

HSSREC is registered with the South African National Research Ethics Council (REC-040414-040).

Yours sincerely,

[redacted]

Professor Dipane Hlalele (Chair)

/ms

Humanities & Social Sciences Research Ethics Committee
UKZN Research Ethics Office Westville Campus, Govan Mbeki Building
Postal Address: Private Bag X54001, Durban 4000
Tel: +27 31 260 8350 / 4557 / 3587
Website: http://research.ukzn.ac.za/Research-Ethics/

APPENDIX E

Referral letter from the Child and Family Centre

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

29 May 2018

To whom it may concern

This letter serves to provide the assurance that should any research participant interviewed by Ms Mpumelelo Hadebe (Psychology masters student) require psychological assistance as a result of any distress arising from the research project titled: ***"Uncovering symptoms of child abuse and sexual violence: A medico-legal and psychosocial perspective"***, the service will be provided by Psychology Masters students and/or Intern Psychologists at the Child and Family Centre, University of KwaZulu-Natal, Pietermaritzburg Campus. It is acknowledged that Ms Hadebe's project is under the supervision of Dr Nontobeko Buthelezi. The reduced rate per session is R200.

Yours sincerely,

[redacted]

Dr Phindile L. Mayaba
Director: Child and Family Centre
University of KwaZulu-Natal
Pietermaritzburg Campus

CHILD AND FAMILY CENTRE

School of Applied Human Sciences
Discipline of Psychology
Postal Address: Private Bag X01, Scottsville, Pietermaritzburg 3209, South Africa
Telephone: +27 (0)33 260 5166/6368 **Email:** mayabap@ukzn.ac.za **Website:** psychology.ukzn.ac.za
Founding Campuses: Edgewood Howard College Medical School Pietermaritzburg Westville

APPENDIX F

Turnitin Report

MS Hadebe Dissertation- Uncovering symptoms of child abuse and sexual violence: A medico-legal and psychosocial perspective

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