Identifying psycho-social risk factors for children of mothers who were sexually abused during childhood

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Mini-dissertation submitted in partial fulfilment of the requirements for the degree Magister of *Social Work in Forensic Practice* at the Potchefstroom Campus of the North-West University

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LANGUAGE EDITING CERTIFICATION

This is to certify that the English language editing of this dissertation by Ms S. Appelgryn was done by Ms G. de Larch.

Ms G. de Larch has completed a Honours in English, has taught English at a secondary and tertiary level and has been an editor of theses, dissertations and journal articles for over 15 years.

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STATEMENT

I, **Sandri Appelgryn,** hereby state that the manuscript entitled

"**Identifying psycho-social risk factors for children of mothers who were sexually abused during childhood"**

is my own work.

…… ……

S. Appelgryn Date

SUMMARY

Title: Identifying psycho-social risk factors for children of mothers who were sexually abused in childhood

Key words: Children, childhood, risk factors, mothers, psycho-social, risk, sexual abuse

With this research the researcher aims to explore and describe the psycho-social risk factors for children of mothers with a history of childhood sexual abuse in order to gain a better understanding of the extent to which a mother can place her child at risk of also being abused. Insight into this question will enable social workers and other family practitioners with the ability to conduct more accurate assessments and consequently design effective intervention strategies that are focused on alleviating risk to children.

This study reveals that participants experience significant challenges in respect of their relationships with their intimate partners. Trust issues and self-blame are but a few factors identified that impact on the quality of the intimate partner relationship and consequently threatens the stability of the family unit. Several risk factors relating to this theme have been identified that could impact on a child's safety and welfare.

According to the study, a mother with a history of childhood sexual abuse also has a higher tendency to experience difficulties in her role as a parent. A lack of confidence in parenting abilities and difficulty forming and maintaining secure attachments with her children (specifically female children) serve as significant factors increasing the likelihood of such a mother's children being at risk of child abuse and neglect.

The effect childhood sexual abuse has on a mother has been proven to also impact extensively on her mental and physical health. Due to significant challenges maintaining stability in her overall well-being, several risks have been identified for the children of such a mother, which includes potential child neglect and abuse, as well as an increased risk of being placed in alternative care.

In this study it became evident that social support serves as a protective factor, minimising the risk of a mother placing her child at risk of child abuse and neglect.

This study also revealed that the impact of childhood sexual abuse on various aspects of the mother's overall functioning can be reduced if the mother is engaged in individual therapy, group therapy, couples therapy, parental groups and attachment therapy focusing on the parent-child relationship.

OPSOMMING

Titel: Identifisering van psigo-sosiale risiko faktore vir kinders van moeders wie seksueel misbruik is tydens hulle kinderlewe

Sleutelwoorde: Kinders, kinderlewe, risiko faktore, moeders, psigo-sosiale, risiko, seksuele misbruik

Met hierdie navorsing poog die navorser om die psigo-sosiale risiko faktore te eksploreer en te beskryf vir kinders van moeders met ‘n geskiedenis van seksuele misbruik tydens hulle kinderlewe ten einde ‘n beter begrip te verkry van die mate tot wat ‘n moeder haar kind in ‘n risiko kan plaas om ook misbruik te word. Insig tot hierdie vraag sal maatskaplike werkers en ander gesinspraktisyns bemagtig met die vermoë om meer akkurate assesserings te voltooi en gevolglik meer effektiewe intervensie strategieë te implimenteer wat fokus om risikos vir kinders te verlig.

Hierdie studie toon dat die deelnemers daadwerklike uitdagings ervaar ten opsigte van hulle verhoudings met hulle intieme metgeselle. Kwessies rondom vertroue en selfblaam is slegs ‘n paar faktore wat geidentifiseer is wat impak maak op die kwaliteit van die intimiteit in die verhouding met ‘n metgesel en bedreig gevolglik die stabiliteit van die familie eenheid. Verskeie risiko faktore wat met hierdie tema geassosieer word is geidentifiseer wat ‘n inpak mag hê op die veiligheid en welsyn van ‘n kind.

Volgens die studie, het ‘n moeder met ‘n geskiedenis van seksuele misbruik in haar kinderlewe, ‘n hoër geneigdheid om probleme te ervaar in haar rol as ‘n ouer. ‘n Tekort aan selfvertroue in ouerskap vermoëns sowel as die uitdaging om sekuur bindings met haar kinders (veral vroulike kinders) te vorm en te handhaaf, dien as belangrike faktore wat die moonlikheid verhoog vir sulke moeders om hulle kinders bloot te stel aan kindermisbruik en –verwaarlosing.

Daar is bewys dat die effek wat seksuele misbruik in die kinderlewe van ‘n moeder het, ook ‘n daadwerklike impak het op haar verstandelike en fisiese gesondheid. As gevolg van belangrike uitdagings om stabiliteit in haar algemende welsyn te handhaaf, is verskeie risikos geidentifiseer vir die kinders van so ‘n moeder, wat insluit potensiële kinderverwaarlosing en –misbruik, sowel as die verhoogde risiko dat hulle in alternatiewe sorg geplaas kan word.

Vanuit hierdie studie is dit duidelik dat sosiale ondersteuningsnetwerke as beskermende faktore dien wat die risiko verminder vir ‘n moeder om haar kind in gevaar te stel van kindermishandeling en –verwaarlosing. Die studie het ook onthul dat die impak van seksuele misbruik tydens kinderlewe, verminder kan word as die moeder deelneem aan individuele terapie, groep terapie, terapie vir beide metgeselle, ouer groepe en bindings terapie wat fokus op die ouer-kind verhouding.

FOREWORD

The article format was chosen in accordance with regulations A.11.2.5 for the degree MA (Social Work in Forensic Practice). The article will comply with the requirements of the journal, *Social Work/Maatskaplike Werk.*

INSTRUCTIONS TO THE AUTHORS

Social Work/Maatskaplike Werk

The journal publishes articles, book reviews and commentary on articles already published from the field of Social Work. Contributions may be written in English or Afrikaans. All contributions will be critically reviewed by at least two referees on whose advice contributions will be accepted or rejected by the editorial committee. All refereeing is strictly confidential. Manuscripts may be returned to the authors if extensive revision is required or if the style of presentation does not conform to the Journal practice. Articles of less than 2 000 words or more than 10 000 words are normally not considered for publication. The article must be in Times Roman, font size 12 and in double spacing. When word-for-word quotations, facts or arguments from other sources are cited, the surname(s), year of publication and the page number(s) must appear in parenthesis in the text, e.g. "…" (Berger, 1976:12).

More details about sources referred to in the text should appear at the end of the manuscript under the caption "Reference". The sources must be arranged alphabetically according to the surnames of the authors. In terms of SANSO-014, the Journal is classified as an approved research journal for the purpose of subsidy by the State.

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SECTION A

IDENTIFYING PSYCHO-SOCIAL RISK FACTORS FOR CHILDREN OF MOTHERS WHO WERE SEXUALLY ABUSED IN CHILDHOOD

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Dr. A.A. Roux, Supervisor: North-West University, Potchefstroom Campus.

Prof C.C. Wessels: Co-study leader: North-West University, Potchefstroom Campus.

1. INTRODUCTION

Although child sexual abuse is a global problem (Johnson, 2004:462; Pereda, *et al*. 2009:332), South Africa has the highest incidence of reported cases of child sexual abuse in the world (Artz & Smythe, 2007:13). It is estimated that 1 in 3 children in South Africa will be abused at some time during their childhood (Dunn, 2008:37).

During 2010/2011, 63 603 sexual offences were reported at the South African Police Service (SAPS) and 28 128 of these cases included children younger than 18 years (South Africa, 2013). It must be noted that only the cases that were reported are being reflected by the statistics. October (2015:14) refers to the statistics that were announced by the South African Police Service for 2014/2015 and points out that 53 617 sexual offences were investigated by the South African Police Service during the aforementioned period. The true extent of sexual abuse is, however, underestimated by far, due to South Africa being known for its culture of under reporting sexual abuse cases (UNICEF, 2012:1).

Given the occurrence of child sexual abuse in South Africa and the extent of its impact, it is critical that research address the implications of childhood sexual abuse not only for those who have been victimised, but also for others who may be secondarily affected by it. As female survivors of childhood sexual abuse reach adulthood, many have children of their own and the possibility that these children may be exposed to the negative consequences of their mothers' childhood sexual abuse has to be considered. This study aims to identify psycho-social risk factors for children of mothers with a history of childhood sexual abuse. By obtaining

information from such mothers, social workers and other family practitioners, the extent to which a mother can potentially place her child at risk of being abused can be better understood.

2. PROBLEM STATEMENT

The long-term effects of child sexual abuse can, according to Spies (2006b:62), be so pervasive that it is sometimes hard to pinpoint how the sexual abuse affects the person's life as an adult. The abuse can have an effect on various levels of the survivor's life, such as their self-esteem, intimate relationships, sexuality, parenting role, mental health and their work life (DiLillo, 2003; Goodrich, 2005; Robberts, *et al.,* 2004:526).

The World Health Organisation notes that in order to develop effective prevention strategies, interventions must simultaneously address risk factors on all levels (World Health Organisation, 2006). Research over the past two decades has mainly investigated the possible effects of childhood sexual abuse upon various aspects of women's adult functioning, which may include their physical and mental health, interpersonal relationships, family life and parenting. Cavanaugh *et al.* (2015:508) refer to only four studies known which have specifically investigated the impact of childhood sexual abuse on parenting – Armsworth & Stronk (1999) Burkett (1991), Roller (2011) and Wright *et al.* (2012).

These studies highlight the significant and lasting impact childhood sexual abuse has on the survivors' functioning as adults. The impact childhood sexual abuse has on their parenting experiences reveals a multitude of ways childhood sexual abuse affects survivors' thoughts, feelings, and behaviours regarding parenting. It is evident from the available research that mothers with a history of childhood sexual abuse report several difficulties they associate with their role as a mother. Cavanaugh e*t al.* (2015:519) indicate that there are no parenting interventions specifically for mothers with histories of childhood sexual abuse that are experiencing difficulties with fulfilling their parenting role. Further research on this matter is therefore necessary in order to understand the risks posed to the offspring of mothers with a history of childhood sexual abuse. This will enable the development and implementation of more accurate and effective interventions.

When focusing on available research, it is apparent that studies aimed at the mental health outcome of survivors of childhood sexual abuse dominate the research field. Abundant evidence has been collected to point out the increased risk a mother with a history of childhood sexual abuse is at to develop mental health disorders such as Post Traumatic Stress Disorder, suicidality, depression, anxiety, low self-esteem, summarisation, dissociation, obsessive compulsive disorders, phobias, paranoid ideation, substance abuse, eating disorders, and personality disorders (Roberts *et al.,* 2004:539).

Childhood sexual abuse has been found to increase the victim's level of depression in both clinical and community samples (Mapp, 2006:1295). However, due to the wide range of problems, Bulik *et al.* (2001:445) has argued that there is no specific childhood sexual abuse syndrome which contributes to the challenge of offering effective interventions to survivors of childhood sexual abuse.

Concern is raised when considering these findings due to the evidence that suggests that mothers who are depressed have higher odds of negative interactions with their children, including spanking the child, yelling at the child, and feeling aggravated with the child. Parental depressive symptoms are therefore of particular interest because of both their prevalence and their potential as marker for at-risk children (Lyons-Ruth *et al.*, 2002:217).

Ruscio (2001:371) points out that sexual abuse survivors are more likely than non-abused mothers to hold specific parenting attitudes that may compromise effective parenting abilities. Such attitudes include low confidence in parenting abilities (Schuetze & Eiden, 2005:654), role reversal with children (Burkett, 1991422) and excessive concerns about child safety (Kreklewetz & Piotrowski, 1998:1306). In addition, according to Banyard *et al.* (2003:1295) mothers with a history of sexual abuse in childhood are more likely to use physical methods of discipline than mothers who were not sexually abused as children.

Ruscio (2001:369) identifies several negative consequences for the parenting practices of mothers that have been exposed to sexual abuse during their childhood years. These negative consequences particularly influence their ability to provide their children with appropriate structure, consistent discipline, and clear behavioural expectations. A history of sexual abuse may exacerbate the stresses of parenting,

reduce available energy for parenting activities, and weaken important social supports. This results in making the tasks of child-rearing particularly challenging. Sexual abuse was therefore expected to have an indirect negative influence on parenting behaviour through its association with these “dysfunctional” parenting attitudes (Ruscio, 2001:373).

The literature indicates that internal working models that developed as a result of a mother’s own early care-giving relationships experienced as a child become cognitive templates that guide relationships with her own children. It has been found that female survivors of sexual abuse have more negative views of themselves as a parent than male survivors of sexual abuse (Banyard *et al.,* 2003:33). These adult survivors are often uncertain of normative child development and therefore may have unrealistic expectations of their children (Cross, 2001:567).

A research study conducted by Schuetze and Eiden (2005:655) indicates that a history of childhood sexual abuse can also predict current partner violence, which is negatively related to parenting behaviours, in turn associated with increased antisocial behaviour in children. According to Coid *et al.* (2001:254) women presenting a history of sexual or physical abuse are three and a half times more likely to experience partner violence as adults. Taking this finding into consideration clarifies why mothers with a history of childhood sexual abuse are also more likely to be reported to Child Protective Services and become the subject of an investigation as an adult (DiLillo & Damashek, 2003:324). Research based in the South African context relating to this matter could not be found to inform this research study.

Trickett *et al.* (2011:468-471) summarise and support these research findings as they found in their study that the offspring born of mothers with a history of childhood sexual abuse were at increased risk for child maltreatment and overall maldevelopment. The impact of the cyclical nature of generational patterns of abuse, neglect and family dysfunction is also highlighted. In addition, a large percentage of sexually abused females are considered to be at a markedly increased risk for perpetuating the next generational cycle of maltreatment and parental dysfunction as they become mothers.

Holm (2010:1) points out that the consequences of childhood sexual abuse can affect individuals on a physical, phychological and social level and can have far-

reaching implications for the overall functioning of the survivor. These findings are supported by Maleka (2010:3) who suggests that childhood sexual abuse survivors might not only have to deal with the shame, fear and the victimisation brought on by their childhood sexual abuse, but might struggle with almost every area of their functioning, which can include parenting.

From the above, the following research question arises:

What are the psycho-social risk factors for children of mothers with a history of childhood sexual abuse?

3. AIM OF THE RESEARCH STUDY

The aim of this study is to explore and describe the psycho-social risk factors for children of mothers with a history of childhood sexual abuse.

4. CENTRAL THEORETICAL ARGUMENT

It is believed that identifying and consequently understanding the psycho-social risk factors for children of mothers with a history of childhood sexual abuse may assist the social worker and family practitioner working in the field of forensic social work and child protection to gain a better understanding of the extent to which a mother can place her child at risk of also being abused.

5. RESEARCH METHODOLOGY

According to Fouché and Schurink (2011:323) research methodology is a process that involves the application of a variety of standardised methods and techniques in the pursuit of knowledge. The researcher of this study followed the qualitative research approach (Botma *et al.,* 2010:42–43). According to Rubin and Babbie (2008:62), qualitative research methods attempt to dig into the deeper meanings of particular human experiences and are intended to "generate theoretically richer observations that are not easily reduced to numbers".

5.1 Literature Review

Klopper (2008:64) states that the literature review in a qualitative study should be presented in such a way that it provides a theoretical context for the study. There is limited literature based on the South African context available on the topic concerning the psycho-social risk factors for children of mothers with a history of

childhood sexual abuse. International resources were therefore utilised to serve as a theoretical framework and to contextualise the study (Delport et *al.* 2011:97–303).

A literature review took place for the purpose of compiling the research proposal with the primary aim of contributing to a clearer understanding of the nature and meaning of the identified research problem. Literature was reviewed throughout the research process in order to refine themes such as childhood sexual abuse, psycho-social risks and parent-child relationships. A literature control was also conducted after data collection had taken place (Botma *et al.,* 2010:196).

The researcher consulted books, journals and dissertations to obtain information with respect to the subject. The Ferdinand Postma Library of the North-West University (Potchefstroom) was mainly used as resource to access literature and information. The Library website was utilised to access articles published in magazines and journals. Databases used include: Social Work Abstracts, Social Science Abstracts, EBSCHO host WEB, NEXUS, SABINET and Google Scholar.

5.2 Research Design

According to Creswell (2013:49), the research design is the plan according to which the research will be conducted and includes every aspect of a proposed research study, from conceptualisation of the problem to the dissemination of findings (Grinnell, 2001:231). Research design is a set of guidelines and instructions on how to reach a goal set by the researcher. It also indicates how the researcher intends to conduct the study, what type of data is required, how it will be collected and how it will be analysed in order to answer the research question. Babbie and Mouton (2001:647) refer to a research design as the blueprint of how one intends to conduct research.

The researcher used an explorative-descriptive design to understand the psycho-social risk factors for children of mothers who were sexually abused in childhood. According to Botma *et al.* (2010:110) descriptive “designs are used when little is known about a topic”. As indicated earlier, there is little to no research available on the psycho-social risk factors for children of mothers who were sexually abused during childhood in South Africa, hence the relevance of the descriptive design tool.

As well as descriptive design, as indicated above, the researcher employed a qualitative research method for this study. According to Botma *et al.* (2010:196) one

of the main reasons for conducting a qualitative study is that the study is exploratory. The researcher focuses on “listening to participants and build an understanding based on what is heard.” Creswell (2013:49) states that qualitative research starts with assumptions that are made from interpreted and theoretical frameworks which highlight a social problem and investigate the meaning an individual or group attach to it.

5.3 Research Context

The research study was conducted with participants residing in the West Rand district, which is located in the west of the Gauteng province and gives name to the urban western part of the Witwatersrand. This area was settled by Europeans after a gold-bearing reef was discovered in 1886 and sparked the Gold Rush that gave rise to the establishment of Johannesburg.

The West Rand district extends for 4066km^2 in area with a population of 744 149 and a density of 182 people per km^2. The West Rand District Municipality is due west of Johannesburg and comprises Mogale City (Krugersdorp and Magaliesburg), Merafong City in the far west (Carleton, Fochville and Khutsong), Randfontein and Westonaria. The areas are economically linked through the gold mining industry. It is bordered by Bojanala Platinum to the north-west, City of Tshwane to the north-east, City of Johannesburg to the east, Sedibeng to the south-east and Dr Kenneth Kaunda to the south-west.

The West Rand district is situated relatively close to the hub of economic activity in Gauteng and is transversed by major national roads, namely the N12 and N14. Its main economic contribution lies primarily within the mining sector. Areas such as Krugersdorp fulfil a residential function for many people working in Johannesburg.

The researcher has experience in working for a non-governmental organisation practicing in generic social work in this area. She has come to observe several cases of children reported to welfare organisations who have mothers with a childhood history of sexual abuse. It became more apparent while interviewing these mothers that their history of sexual abuse is likely to have an impact on their parenting abilities. It also appears that these mothers share similar background histories in respect of their childhood experiences as well as comparable disrupted relationships with their primary care givers as children. The researcher was

therefore motivated to study the risks involved for children of mothers with a history of childhood sexual abuse.

5.4 Participants

For the purpose of conducting this study, the researcher made use of purposive sampling. Strydom and Delport (2011a:390) describe purposive sampling as based entirely on the judgement of the researcher. This implies that the sample is composed of elements which contain the most characteristic, representative and typical attributes of the population.

Strydom (2011:224) describes a sample as compromising elements or a subset of the population considered for actual inclusion in the study. A 'population' is a term that sets boundaries on the study units. It also refers to individuals in the universe of the study who possess specific characteristics (Strydom, 2011:224). Included in this study as research subjects were mothers with a history of childhood sexual abuse who were known to non-governmental welfare organisations focusing on child protection and assisting women and children in need based in the West Rand district.

The sample size of this specific research study was determined by data saturation. Monette *et al.* (2005:242) explain that data saturation occurs when the researcher becomes aware that he or she has "heard the theme repeatedly" and no longer obtains any new information.

5.4.1 Inclusion criteria

Botma *et al.* (2010:201) and Maree (2007:79) emphasise that the clear formulation of inclusion criteria is of serious importance when selecting participants. Respondents meeting the following inclusion criteria were included in the research study:

- Mothers with a history of childhood sexual abuse who are known to the non-governmental welfare organisations of The Cradle of Hope and Teddy Bear Clinic who focus on child protection and assisting women and children in need. These organisations are based in the West Rand district.

- Clients on the case load of a social worker in private practice who met the inclusion criteria and provided their informed consent were also included in the study.
- Mothers who are fluent in Afrikaans and English. Because of the sensitivity of the research it was decided not to use the services of a translator.
- Mothers who have a childhood history of sexual abuse.
- Mothers with children younger than eighteen.
- Mothers who gave written consent to be part of the research and who also gave written consent that the interview could be tape recorded, were part of the research.

5.4.2 Exclusion criteria

Mothers with no history of childhood sexual abuse were excluded.

5.5 Research Method

According to Botma *et al. (*2010:199), the research method refers to the process of data gathering, data analysis and ensuring rigor in research.

5.5.1 Data collection

Data collection was conducted in two phases. **Phase one** included completing semi-structured interviews with mothers known to The Cradle of Hope who were sexually abused as children. A social worker in private practice also identified participants on her case load who consented to be included in the study and who met the inclusion criteria. Semi-structured interviews were also conducted with these participants.

Phase two included the analysis of official documents/files from the Teddy Bear Clinic of mothers who were sexually abused during childhood. Official documents are those that are compiled and maintained on a continuous basis by organisations such as government institutions. The accessibility of official documents is often a problem due to the legislation on the confidentiality of information which is an aspect that qualitative researchers should always keep in mind (Strydom & Delport, 2011:379).

5.5.1.1 Phase one: Semi-structured one-on-one interviews

During this phase, as a primary method, data was collected through one of the predominant methods in qualitative research according to De Poy and Gilson (2008:108), namely one-on-one semi-structured interviews. Greeff (2011:342) describes an interview as a powerful way to acquire insights into the participants' experiences.

According to Botma *et al. (*2010:206) a semi-structured interview suggests a conversation and captures the attitude of the interaction. Semi-structured interviews were conducted with research participants until data saturation occurred. Data saturation occurred to the point where a sense of closure was attained because new data yields redundant information (Botma *et al.,* 2010:290). Upon reaching this point during this research study, the researcher withdrew and concluded data gathering.

The interviews were guided by a semi-structured open-ended interview schedule ***(Please refer to Annexure 4)*** to enable flexibility and free-flowing discussions. Interviews were organised around areas of particular interest, while still allowing for considerable flexibility in scope and depth. With the semi-structured interview the researcher used six predetermined open questions on the interview schedule. The interviews were guided by this interview schedule and not dictated by it (Greeff, 2011:348). The main aim with the semi-structured interviews was to obtain information from the research participants in order to gain insight into the psycho-social risk factors involved for children of mothers with a history of childhood sexual abuse.

The interview schedule was evaluated by four experts in research and forensic social work of the Social Work Division of the North-West University of the Potchefstroom Campus to ensure quality control (Botma *et al*., 2010:137). The questions were also evaluated by two mothers who did not form part of the study. This was necessary in order to determine whether the questions were clear and whether it would render the desired results of an elaborate description of psycho-social risk factors for children of mothers who were sexually abused during childhood. After evaluation it was clear that the questions were stated in a conversational manner in words familiar to the participants.

Audiotape recordings were made of each interview with the informed written consent of the participants**.** According to Monette *et al*. (2005:79) the main task is to record the responses of the participants. Recording the interviews gave the researcher the opportunity to fully focus her attention on the participants during the interviews (Rubin & Babbie, 2008:457). Extensive field notes were made directly after each interview (Greeff, 2005:298). According to Flick (2002:168) field notes are a standard medium for collecting data when conducting qualitative research.

Due to the sensitive nature of the interview, research participants were interviewed in the researcher's office where privacy could be assured. This allowed the required environment, ensuring the confidentiality of the participants as well as creating a comfortable space for the participants to disclose very intimate information to the researcher.

5.5.1.2 Phase two: Document analysis

The researcher **used document analyses** as method to analyse the data. Ritchie and Lewis (2003:35) explain that documentary analysis involves the study of existing documents in order to understand their content. These documents can include personal documents such as letters, diaries, confessions, suicide notes and autobiographies. This method of data gathering is relatively less expensive than conducting a comprehensive survey (Monette *et al.,* 2005:195).

Document analysis as research method consists of coding the data, categorising the data into main and sub-categories, labelling these categories, integrating the categories into themes and integrating all the data (Botma *et al.,* 2010:222; Strydom & Delport, 2011:380). When using this method of data analysis, the researcher identifies core meanings and consistencies in the data (Patton, 2002:453). It is important that the selection of data used in document analysis is consistently and rigidly applied so that other researchers will consistently get the same results (Botma, *et al.,* 2010:222). The researcher conducted the document analysis with files belonging to the Teddy Bear Clinic in Krugersdorp, West Rand.

5.5.2 Role of the researcher

- Approval from the Health Research Ethical Committee of the Faculty Health Sciences of the North-West University to conduct this study in the Social Work Forensic Practice project was obtained (***Please refer to Annexure 1).***
- Written permission to conduct the research was obtained from the managers of the non-governmental welfare organisation, The Cradle of Hope, and the Teddy Bear Clinic for the purpose of conducting interviews with clients on their caseloads who met the inclusion criteria (***Please refer to Annexure 2).***
- Informed written consent was obtained from the participants to be part of the research (***Please refer to Annexure 3).***
- The interviews with the participants were conducted in the researcher's office, offering the necessary privacy and confidentiality.
- The place and time of each interview was scheduled with the participants well in advance.
- The researcher conducted the semi-structured interviews with each participant individually. The interview with each social worker lasted approximately 60-90 minutes.
- Permission was obtained from the participants for tape-recording the interviews.
- The data was collected, recorded and transcribed.

5.5.3 Data analysis

5.5.3.1 Data analysis of interviews

Data analysis begins by re-evaluating the purpose of the study as the depth and intensity of analysis is determined by the purpose (Botma *et al.*, 2010:220). It is advised that data analysis is almost always conducted alongside gathering data. Waiting until all the data is collected before starting with transcribing and analysing the interviews is warned against. All the audio tape recorded interviews were transcribed verbatim. Preliminary coding was used that enabled the researcher to return to participants to clarify any uncertainties.

Themes derived from the questions posed to participants during the semi-structured interviews were used to group raw data. The researcher made use of Creswell's

(2009:184) qualitative analysis approach. Creswell (2009:184) incorporated the approach of Tesch (1990) into three steps: collection of qualitative data, analysis of themes and reporting the themes. Botma *et al.* (2010:213) and Schurink *et al.* (2011:402) identified specific guidelines when analysing data, which was applied to the current research.

This included:

- The initial research was kept in mind.
- All data obtained from the interviews with participants was transcribed by a typist who signed an agreement of confidentiality (***Please refer to Annexure 5).***
- The correctness of transcripts was ensured by a social worker as co-coder. The researcher also verified the correctness.
- During transcription, enough space was left on both the left and right margins that allowed the researcher to make notes during analysis.
- No translation was needed during the data analysis.
- Topics were coded.

The processing and interpretation of the qualitative data was done by hand and themes and sub-themes were identified.

5.5.3.2 Document analysis

The content document analysis was used for the purpose of this study (Strydom & Delport, 2011b:380). Written permission was obtained from the Teddy Bear Clinic prior to commencing with this research. Upon intake, this organisation always obtains consent from clients to use the information recorded during interventions with them for research purposes. Additional permission from clients to access their data files was therefore not requested.

The following steps were followed (Rapley in Strydom and Delport, 2011b:381):

- The initial research question was formulated.
- A research diary was opened.
- Sources of material were identified and an archive was generated.
- The texts were transcribed in some detail.

- Texts and documents were critically read.
- To maintain confidentiality, the researcher assigned a number to each participant's document beforehand, such as document A**,** document B, etc., instead of using their names.
- A comprehensive and systematic coding scheme was developed.
- Analysis by regularity and variability in the data was completed and tentative findings were formed.
- Credibility, validity and reliability were checked by means of case analysis. Findings were compared to previous work.
- Findings were written up.

Fifty-eight client files were analysed in order to identify clients who met the inclusion criteria. Only five files met the inclusion criteria and were found to be applicable for the purpose of the study.

5.5.4 Procedures

The following procedures were followed by the researcher in the research study:

- The research protocol was submitted to the Health Research Ethics Committee (HREC) of the Faculty of Health Sciences of the North-West University for approval to conduct this study in the Social Work Forensic Practice.
- The proposed study commenced after approval from the HREC was obtained **(Please refer to Annexure 1).**
- The researcher wrote letters to the managing directors of The Cradle of Hope as and the Teddy Bear Clinic situated in the West-Rand area to request permission to conduct the research after explaining the aim of the research and all the ethical aspects regarding the research. A social worker in private practice was also approached with a request for assistance in identifying suitable candidates on her caseload and four mothers decided that they wanted to be part of the research.
- After permission was granted from The Cradle of Hope, the manager as gatekeeper, allowed the researcher to has access to the contact details of participants.

- The social worker in private practice also provided the researcher with the contact details of the candidates she identified as meeting the inclusion criteria and who were willing to be part of the research study.
- The participants were individually informed by the researcher regarding the aim of the study, the benefits and risks of taking part in the study as well as the ethical aspects regarding the research. This ensured that the participants made informed choices on whether to continue taking part.
- Sufficient time (about a week) was given to the participants to consider the details on the consent form before they decided to be part of the research.
- Upon meeting with the participants, the researcher again explained the aim of the research. Prior to commencing with the interviews, written informed consent was requested and obtained from the participants to be part of the research, as well as for the interviews to be audio recorded.
- Interviews were conducted in the researcher's private office. The interview with each participant lasted approximately 60–90 minutes.
- All tape-recorded materials and completed interview reports were safely stored in a locked cabinet in the researcher's office, which no one apart from the researcher had access to. These reports were password protected and tape recordings were destroyed following transcription.
- The researcher wrote detailed reports after each interview.
- The report was completed by the researcher in the form of a mini-dissertation with recommendations regarding psycho-social risk factors for children of mothers who were sexually abused during childhood.

5.6 Ethical Aspects

A researcher is legally responsible towards the research participants in the study as well as towards the discipline of the study (Strydom, 2011:113–129). A research proposal was submitted for consideration by the Health Research Ethics Committee (HREC) of the Faculty of Health Sciences of North-West University. Written permission was obtained from the ethics committee for the research project in Forensic Social Work Practice (***Please refer to Annexure 1).*** No interviews were conducted with participants before receiving written consent from the HREC.

For the purpose of this study the prominent ethical aspects discussed below were focused on.

5.6.1 Risks/Discomfort and precautions

Avoidance of harm is essential to fulfil fundamental social work ethics. Research participants can potentially be uncomfortable psychologically during a study when revisiting past traumatic incidents. Researchers must remain aware of the "subtle dangers and guard against them" (Rubin & Babbie, 2008:71).

During the research study, the participants were required to revisit childhood memories of sexual abuse they were exposed to. Taking into consideration the nature of the study, it was envisaged that participants might experience some degree of emotional discomfort and distress during the process of interviewing.

In order to further minimise the risk of emotional discomfort to the participants, they were properly briefed with regards to their right to freely withdraw from the research study without prejudice. Participants were also advised to direct any questions pertaining to the research study to the researcher or alternatively to Ms Carolien van Zyl at the Health Research Ethics Committee (HREC) of the Faculty of Health Sciences of North-West University in Potchefstroom. The benefits outweighed the risks in this study.

5.6.2 Violation of privacy, anonymity and confidentiality

Due to the sensitive nature of the subject of this research, the research participants were assured of confidentiality. The privacy and confidentiality of all the participants were safeguarded at all times during the study. All data was reported anonymously during the semi-structured interviews to protect the identity of the participants. A coding system was used to differentiate between participants instead of using the names of the participants, they were allocated numbers. Interviews were conducted with each participant individually in a quiet office space chosen by the researcher, offering the required privacy. The researcher ensured that raw data was kept locked in a fireproof cabinet in the researcher's office. The researcher's personal computer used to record research data was password protected to ensure security.

All video-recorded materials and completed interview schedules were safely stored in a locked cabinet in the researcher's office, which no one had access to, and

thereafter, it was stored in a storeroom at the Social Work division of the North-West University, Potchefstroom Campus, prohibiting all people, including the researcher and study leader, from having access to the material for five years. Participants were assured of confidentiality and anonymity prior to conducting the interviews. They were also provided with a written informed consent form.

5.6.3 Debriefing

The participants were taken through a directed and reflective process which had the potential to affect the participants on an emotional level. Participants of the study were therefore offered the opportunity to be referred to an independent registered counsellor for the purpose of receiving debriefing should it be required following participation in the research study. No participant requested any debriefing sessions following the interviews conducted.

5.6.4 Voluntary participation

Patton (2002:407) states that the importance of the information to be collected and the reason for the importance should be communicated to participants. Participants were made fully aware that their participation was voluntary and that they were free to withdraw from the study at any point.

According to Rubin and Babbie (2008:71) participation by participants should always be of a voluntary nature. The researcher therefore took great care to ensure that potential participants were aware of the fact that they were free to withdraw consent and discontinue participation at any point, without any repercussions. The voluntary nature of participating in the research study was communicated to the potential research participants upon first telephonic contact between the researcher and the participants.

Clients from The Cradle of Hope were comfortable and willing to give informed written consent to participate in the research study. This is likely to be due to the voluntary nature of their membership to the organisation which does not use the services of designated social workers.

Apart from the experience at The Cradle of Hope, the researcher found this aspect of the research study particularly challenging. Mothers on the caseloads of social workers from non-governmental child welfare organisations did not want to

participate in this research study. The reason for this is not specifically clear and could be explored with further research.

5.6.5 Obtaining written informed consent

Written informed consent ensures the full knowledge and co-operation of participants, while also resolving, or at least relieving, any possible tension, aggression resistance or insecurity in the participants (Strydom, 2011:118). Great care was taken to inform participants of the nature of the study prior to obtaining their written informed consent. Participants were provided with a written informed consent form by the researcher upon initial contact and allowed approximately seven days to decide about whether they are willing to participate in the study voluntarily **(*Please refer to Annexure 3).***

All other information relevant to the research project, such as the procedures followed during the investigation, possible risks and discomforts, as well as possible benefits associated with the research study, was discussed with the participants by the researcher prior to gaining their written informed consent.

5.6.6 Tape recording and note taking

Tape recording as well as note taking was explained to the participants. Voluntary informed consent was confirmed on the tape recorder and participants were reminded that they were free to withdraw from the study at any time (Greeff, 2005:295). The tape recorder was placed out of sight of the participant during the interview in order to minimise the risk of the participant feeling nervous.

5.6.7 Actions and competence of the researcher

When sensitive research is undertaken, the researcher and field workers must be qualified and equipped to undertake the research. There rests an ethical obligation on researchers to ensure that they are competent and adequately skilled to undertake the intended investigation (Strydom, 2011:124).

The researcher of this study is a qualified social worker with 11 years of experience in the field of social work. The researcher is also registered with the South African Council for Social Service Professions with registration number: 10-23367, a requirement for any researcher undertaking this kind of research (Babbie, 2014:68). The researcher has experience in interviewing not only in social work practice, but

during a module in the Master's degree as well as in research projects by other researchers. She continued to keep abreast of knowledge pertaining to appropriate interview techniques from pertinent literature and a one day course in order to refine her interviewing skills. As a registered social worker, the researcher has to obey the code of ethics and rules for the social workers of the South African Council for Social Service Professions.

5.6.8 Compensation

According to Strydom (2011:122) compensation should not be viewed by research participants as the only incentive to take part in a study. Participants that engaged in this particular study did not directly benefit from it as no remuneration was offered. There was no cost to participants as a result of their participation in this study.

It is, however, considered reasonable to compensate participants for costs incurred such as time spent away from work or transportation costs (Strydom, 2011:121). The researcher therefore took into consideration the possibility of reimbursing any participants who might have had traveling expenses due to participating in the study. No participant had any expenses incurred due to the research.

5.6.9 Benefits and risks of the study

This study made a contribution to the limited research available in South Africa on identifying psycho-social risk factors for children of mothers who were sexually abused during childhood. It provided insight for social workers working in the field of forensic social work by gaining a better understanding of the extent to which a mother can place her child at risk of also being sexually abused. The social worker consequently developed insight into the mother's ability to protect her child from being at risk of sexual abuse. Prevention programmes can be developed accordingly. The benefit to participants taking part in this study was that they were being offered an opportunity to discuss their experiences and to vent their associations and feelings of being exposed to sexual abuse during childhood.

Risk "equates to arm of injury and implies it is something detrimental that will occur in the future" (Botma *et al.,* 2010:22). Emotional harm may occur due to self-disclosure of participants regarding their childhood sexual abuse. The participants were informed about the opportunity of working through their trauma by means of

debriefing sessions by an appropriate therapist (Strydom, 2011:122). Throughout the research study, risks were diminished by evaluating the participant's emotional well-being through the answers they gave. The benefits outweighed the risks, not only for the participants but also for the social work profession to gain a better understanding of the extent to which a mother can place her child at risk of being abused. Social workers will consequently also develop insight into the mother's ability to protect her child from being at risk of sexual abuse specifically.

5.6.10 Release and publication of the findings

The findings of the study will be introduced to the reading public in written form by means of a dissertation as well as an article in an accredited journal. The managers of the two organisations will be informed when this occurs, as suggested appropriated by Mnisi (2012:8).

6. TERMINOLOGY

6.1 Children

The Criminal Law (Sexual Offences and Related Matters) Amendment Act, 2007 (Act No. 32 of 2007) defines a child as a person under the age of 18 years, or with reference to section 15 and 16, a person 12 years or older but under the age of 16 years, and "children" has a corresponding meaning.

'Childhood' is the time for children to be in school and at play, to grow strong and confident with the love and encouragement of their family and an extended community of caring adults. It is a precious time in which children should live free from fear, safe from violence and protected from abuse and exploitation. As such, childhood means much more than just the space between birth and the attainment of adulthood. It refers to the state and condition of a child's life, to the quality of those years (UNICEF, 2015).

6.2 Factor

According to Oxford Dictionaries (2015a) a factor can be defined as "a circumstance, fact, or influence that contributes to a result". For the purpose of this study, the researcher will refer to factors as circumstances that might have an influence on children of mothers who were sexually abused during childhood.

6.3 Mother

A mother is defined by the Collins English Dictionary (2015) as: “a female who has given birth to offspring”. A mother is also described as a female substituting in the function of a mother.

6.4 Psycho-Social

According to the Merriam-Webster Dictionary (2015) psycho-social can be described as involving both psychological and social aspects. The New Dictionary of Social Work (1995:50) defines psycho-social problems as multiple and complex transactions pertaining to the social functioning of individuals or the social and organisational functioning of larger social systems that are affected by, among others, personality disorders or mental illnesses, inadequate role performance and life transitions involving developmental changes, crises, as well as communication and relationship difficulties.

In this research the researcher wanted to explore both the psychological as well as the social risk factors for children of mothers who were sexually abused during childhood, hence psycho-social risk factors.

6.5 Risk

A risk, according to the Oxford Dictionary (2015b) is a situation involving exposure to anger or the possibility that something unpleasant or unwelcome will happen. For the purpose of this study the word risk will be used to describe the possibility that children of mothers who were sexually abused during childhood may be abused.

6.6 Sexual Abuse

The Children’s Act, (Act No. 38 of 2005) defines sexual abuse as:

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

- procuring or allowing a child to be procured for commercial sexual exploitation or in any way participating or assisting in the commercial sexual exploitation of a child."

Zoldbrod (2015:4) refers to overt sexual abuse as the "intentional participation of the child in sexual activities which are developmentally inappropriate and for which the child cannot give informed consent and, in adolescents, rape". It is also defined as: "practices intended to give sexual gratification to an adult or any other person of higher age in a position of power or authority and might occur either in an intra-familial or extra-familial setting" (Gomes *et al.,* 2014:255).

7. TRUSTWORTHINESS

There are four aspects for trustworthiness that are relevant to both quantitative and qualitative studies: (a) truth value, (b) applicability, (c) consistency, and (d) neutrality (Guba in Botma *et al.,* 2010:232). These are the four epistemological standards for trustworthiness.

In qualitative research there are four strategies that could be applied to the epistemological standards to ensure trustworthiness namely, credibility, dependability, transferability and conformability. These strategies could also be used as strategies throughout the research process to increase the worth of qualitative projects (Shurink *et al*., 2011:419:421). Graneheim and Lundman (2003:110) state that "in qualitative research, trustworthiness of interpretations deals with establishing arguments for the most probable interpretations". Trustworthiness will increase if the findings are presented in a way that allows the reader to look for alternative interpretations.

Table 1: Standards, Strategies and Applied Criteria to Ensure Trustworthiness

Epistemological Standards	Strategies	Application
Truth Value	According to McMillan (2011:277), credibility is determined by the extent to which data analysis and conclusions are trustworthy.	The researcher will leave an audit trail in order to establish credibility. This will enable another researcher to check the pathway of decisions made in the data analysis.
Consistency	Reliability is described as what is being studied actually occurring in the setting that was studied (McMillan, 2011:278).	Data was captured by means of verbatim audio recordings.
Applicability	Applicability refers to the transferability of one set of findings to another context and is the alternative to external validity or generalisable ability (Shurink *et al.,* 2011:420).	To facilitate transferability, the researcher gave a clear and distinct description of culture and context, selection and characteristics of participants, data collection and process of analysis. A rich and vigorous presentation of the findings, together with appropriate quotations, also enhanced transferability (Graneheim & Lundman, 2003:110).
Neutrality	**Confirmability used as a** strategy refers to enquiry about whether the results of the research study are confirmed by another study (Schurink *et al.,* 2011:419).	Comprehensive field notes were taken by the researcher and made available for auditing. Literature control was completed.

8. LIMITATIONS OF THE STUDY

8.1 Difficulty in Identifying Suitable Candidates on the Caseloads of Social Workers Employed by Welfare Organisations

This study originally aimed to include women with a childhood history of sexual abuse on the caseloads of designated social workers from Child Welfare Organisation and the Dutch Reform Church (NG Welsyn) in the West Rand district. Attempts to recruit and include clients known to these organisations were unsuccessful for the reasons discussed below.

8.1.1 Non-disclosure of history of childhood sexual abuse by client known to a social worker

Approximately seven designated social workers from the two welfare organisations were initially approached with the request to identify mothers on their caseloads with histories of childhood sexual abuse. Only three social workers were able to identify clients on their caseloads who met the inclusion criteria. In total, only three potential participants were identified. It has to be considered that the clients do not voluntarily disclose their histories of childhood sexual abuse to the designated social workers.

Considering the nature of the designated social worker's function to protect children, the childhood history of the mother figure might not necessarily be the first priority for investigation. It consequently likely receives less attention from the designated social worker, resulting in them not necessarily being aware of the mother's background history of childhood sexual abuse. Recruiting potential participants from the caseloads of the welfare organisation for the research project therefore proved very challenging.

The same tendency became apparent during the data analysis process. It was evident that mothers do not necessarily disclose their histories of childhood sexual abuse voluntarily during the intake and assessment process. Only 4% of the client files analysed by the researcher were found to be of clients suitable to meet the inclusion criteria. This percentage is considered very low.

In addition, it was evident that limited information was recorded on the files of clients who met the inclusion criteria. Information relating to the sexual abuse histories of the clients was found to be limited to one word sentences such as: "Divorced" or "Domestic violence". This offered restricted information relating to the circumstances associated with the client's interpersonal and social problems.

The challenges in respect of identifying a client's history of childhood sexual abuse, was also reported following a study conducted by Breckenridge & Davidson (2002). In this study it became apparent that the counsellors only became aware of the history of the mother's childhood sexual abuse when the mother had taken the responsibility of disclosing her history to the counsellor. A significant factor identified was that in many cases the counsellors did not specifically enquire about the participants' history of childhood sexual abuse and assumed that they had none. The tendency of clinicians, social workers and family practitioners to overlook the

childhood sexual abuse history of the client could, potentially, influence their assessment and intervention process.

Relying on clients to reveal their childhood histories of sexual abuse can result in inaccurate assessments as it might only be those mothers who have reached some degree of trauma integration, some degree of ease with speaking about their abuse and those who have already received effective trauma therapy who might choose to self-disclose (Breckenridge & Davidson, 2002:25). A large amount of information is therefore lacking from the assessment process.

8.2 Gaining Informed Consent from Participants

The researcher was provided with several names of women who were sexually abused as a child but because of the nature of this research the majority of these women did not want to participate in the research study. The reaction of one potential participant was: *"Ek wil nie weer die verlede oopgrawe nie"* (I don't want to dig up the past). According to Spies (2006:81) moving on means affirming the strengths the survivor of childhood sexual abuse has developed through a healing process.

Resistance to participate in the research study was also noted among potential participants known by The Cradle of Hope. The mediator (social worker known to the women by means of service delivery to them) informed the researcher that she approached approximately eight women currently living in the facility. Only one woman who is currently a resident at The Cracle of Hope was willing to consent to participating in the study. The majority of the participants identified by the mediator from The Cradle of Hope were women who are known to the organisation but not current residents.

8.3 Self-Reporting

This research study obtained data by means of semi-structured interviews conducted with participants. The participants were therefore expected to provide self-reports with respect to the questions posed to them during the interviews.

Previous research has demonstrated the lack of validity of self-reports in terms of risk factors compared to documented reports. Widom and Shepard (1996:413) point out that the effects of social desirability bias may result in underreporting, especially

when the self-report is not anonymous. In addition, in the absence of corroborating data, this technique is problematic because participants may either purposely or unintentionally provide inaccurate accounts of childhood sexual abuse. The classification of participants as abused or not abused is inexact and to some degree a subjective process. How did the sexual abuse during your childhood affect your relationship with your spouse/partner?

9. DISCUSSION OF RESEARCH RESULTS

This study's results will be discussed according to:

- themes followed during the semi-structured interviews with the participants numbered as participant 1 to participant 10; and
- data received through an analysis of five documents numbered as document A to E. Results are compared to the literature on the subject.

Six main themes with sub-themes were distinguished and used to focus on the aim of the study as explained in Table 5.

9.1 Profile of Participants

Semi-structured interviews were conducted with ten participants who met the inclusion criteria set for the purpose of this study. The participants were referred to as Participant 1, 2, etc.

9.1.1 Age of participants

Table 2: Age and Gender

Participants	Age	Sex
Participant 1	30–40	Female
Participant 2	40–50	Female
Participant 3	40–50	Female
Participant 4	20–30	Female
Participant 5	30–40	Female
Participant 6	30–40	Female
Participant 7	40–50	Female
Participant 8	20–30	Female

Participant 9	40–50	Female
Participant 10	20–30	Female

All ten participants were female, three participants were between the ages of 20–30, three participants were between the ages of 30–40 and four participants were between 40–50 years of age. Most of the participants still have children in the house.

9.1.2 Gender and number of children of participants

Table 3: Gender of participants' children

Participant	**Gender of Children**	
	Female	**Male**
Participant 1	2	
Participant 2	1	1
Participant 3		2
Participant 4	1	
Participant 5	1	1
Participant 6	1	1
Participant 7	2	
Participant 8		1
Participant 9		2
Participant 10	1	

None of the participants have more than two children and nine of the children were girls. From the interviews conducted with the participants it became evident that the participants share a common fear that their daughters will also be sexually abused. According to Spies (2006a:74) adult survivors such as the mothers may have a desire to protect their own children against any situation in which abus could take pace..

9.1.3 Marital status of participants and family composition

Table 4: Marital Status of Participants and Family Composition

Participant	**Marital Status**	**Family Composition**
Participant 1	Married	Step-family, second marriage
Participant 2	Married	First marriage
Participant 3	Married	Step-family, second marriage

Participant 4	Divorced	Single mother
Participant 5	Divorced	Single mother
Participant 6	Married	First marriage
Participant 7	Married	First marriage
Participant 8	Divorced	Single mother
Participant 9	Married	First marriage
Participant 10	Unmarried	Single mother

The majority of the participants are single mothers or mothers who form part of a step-family. Four mothers were in their first marriage. According to Lotter (2006:87) several factors can contribute to the adult survivor's experience of their marital relationships as "uncomfortable, unsuccessful and even needing a resolution in the form of divorce".

9.1.4 Profile of the documents

Table 5: Documents

Document Number	Marital Status of Mother
Document A	Divorced
Document B	Single
Document C	Unknown
Document D	Unknown
Document E	Married

Two documents have no information regarding the marital status of the mother. From the documents that have information, one participant was married, one divorced and one single.

9.2 Themes and Sub-Themes Obtained From the Interviews

Semi-structured interviews were used, guided by an interview schedule of preset questions to gather the data. After the completion of the interviews, the researcher identified five main themes, some of the themes having their own sub-themes.

The themes and sub-themes can be summarised as follows:

Table 6: Question Themes and Subthemes

Theme No.	Theme Name	Sub-themes	Risk Identified for the Child
1	Sexual abuse during childhood affecting the relationship of the	1.1 Sexual problems in intimate relationships	a. Incest between father and daughter

	survivor with spouse/partner	1.2 Shame and intimate partner conflict 1.3 Breakdown of family unit and becoming part of a step-family 1.4 Lack of trust in intimate partner concerning children's safety 1.5 Re-victimisation	b. Sexual abuse of children c. Becoming part of a re-organised family d. Domestic violence e. Parental alienation f. Sexual allegations in divorce
2	Sexual abuse during childhood affecting the relationship of the parent-child relationship	2.1 The level of maternal support the mother experienced as a child 2.2. Lack of trust in parenting abilities 2.3 Overprotecting children 2.4 Difficulty attaching with female children from birth 2.5 Difficulty maintaining bond with children due to being emotionally absent 2.6 Less worried over male children being at risk of sexual abuse 2.7 Mother-child role reversal 2.8 Parenting style 2.9 Excessive concern that daughter can be sexually abused	a. Attachment disorder b. Intergenerational effect of sexual abuse on parenting abilities c. Overprotective mother influencing the social development of the child d. Male children at risk of sexual abuse
3	Sexual abuse during childhood affecting the overall mental and physical health of the survivor	3.1 Compromised mental health: • Post-traumatic stress syndrome (PTSD) • Acute Stress Disorder • Dissociative Disorder • Mood Disorders 3.2 Self-esteem and locus of control 3.3 Suicidal tendencies and suicide 3.4 Maternal anger 3.5 Factors influencing the impact of child sexual abuse on a survivor 3.6 Compromised physical health 3.7 Substance abuse	a. Child neglect b. Child abuse c. Children being at risk of placement in alternative care d. Incest between siblings

4	Sexual abuse during childhood affecting the social life of the survivor	4.1 Lack of social support network	a. Lack of respite for the mother leading to potential child abuse and/or neglect
5	Measures that can be taken to empower mothers with a history of childhood sexual abuse	5.1 Individual therapy 5.2 Group therapy 5.3 Couples therapy 5.4 Parental guidance in parenting groups 5.5 Attachment therapy	

9.2.1 Theme 1: Sexual abuse during childhood affecting the relationship with the spouse/partner

According to Spies (2006b:62) the long-term effects of childhood sexual abuse can be so pervasive that it is sometimes hard to pinpoint exactly how the abuse can affect a survivor. Research in the field indicates that childhood sexual abuse may have significant negative implications for multiple aspects of the survivor's adult life. Childhood sexual abuse survivors are particularly at risk of developing insecure attachment representations, which are associated with relational problems, including couple dissatisfaction (Berthelot *et al.,* 2013:441. The researcher asked the participants how did the sexual abuse during their childhood affect their relationship with their spouse/partner? From the research study conducted with the research participants, the following sub-themes relating to their intimate relationships will be discussed.

9.2.1.1 Sub-themes

9.2.1.1.1 Sub-theme 1: Sexual problems in intimate relationships

According to Dube e*t al.* (2005:430) the long-term consequences of childhood sexual abuse includes survivors experiencing significant intimate relationship problems. These findings are supported by earlier research conducted by DiLillo (2001:574) as well as previous research by Godbout *et al.* (2009:380) and Maniglio

(2009:654) that also point to heightened problems in intimiate relationships of survivors with a history of childhood sexual abuse.

Hill *et al.* (2001:107) identify the dynamics of the relationship between childhood sexual abuse survivors and their subsequent partners as having characteristics of instability and poor quality. Problems with sexuality have been highlighted by Leonard and Follette (2002:385). In addition, evidence further suggests that the romantic relationships of the childhood sexual abuse survivor are often characterised by a relationship dynamic in which traumatic patterns are re-enacted (Maltas, 1996:361).

Zoldbrod (2015:3) refers to the critical importance of a person being able to engage in sexual encounters in order to have a vital romantic relationship. Data obtained from the interviews with the participants confirmed that they experience considerable challenges in respect of the sexual dimension of their relationships with their intimate partners.

The majority of the participants referred to experiencing a fear of being hurt by their partner during sexual interactions. One participant stated: "*Ek is bang hy maak my seer. Ek is bang hy verkrag my*" (I'm scared he hurts me. I'm scared he rapes me). Maltz (2013:3) has found vaginal pain or orgasmic difficulties being reported by women with histories of childhood sexual abuse. It would, however, appear as if this fear also manifests on a psychological level as the following statements were recorded: "*Ek is bang ek is nie goed genoeg nie"* (I'm scared I'm not good enough) and *"Ek voel ek is nie mooi genoeg vir my man nie"* (I feel that I'm not pretty enough for my husband/man).

The most common sexual symptoms that have been identified in victims of childhood sexual abuse include avoiding, fearing or lacking interest in sex and it is viewed as an obligation. This was reflected by a statement from a participant who said: *"Ek haat seks. Dit grief my. Dit is erg vir my man want met tye het ek dit al weggesteek maar met tye kan 'n mens dit nie wegsteek nie. Die trauma wat voorkom kan ek partykeer beheer maar partykeer kan ek net nie dan sal ek in trane uitbars en vir hom sê stop dit net"* (I hate sex. It grieves me. It is terrible for my husband because at times I've hidden it, but at other times one just can't hide it. The trauma that happens I can sometimes control, but other times I'll just burst into tears

and tell him to stop). This participant continued to say: *"Partykeer sal ek net om hom gelukkig te hou sê kom ons doen dit net gou dat dit net verby kom. En dan sê hy nee dan wil hy nie en onttrek van my. Dis ook nie wat ek wil hê nie"* (Sometimes, just to keep him happy, I'll tell him, come let's do it quickly and get it over with. Then he'll reply no and withdraw from me. This is also not what I want). In a study done by Lotter in 2003 regardig the effect of child sexual abuse (Lotter, 2006:92) most of the sexually abused women expressed a lost of interest in sexual activities after they got married

Maltz (2013:3) identified negative feelings such as anger, disgust and guilt which are experienced by victims of childhood sexual abuse upon receiving touch. In addition, the victim experiences difficulty in becoming aroused or feeling sensation. Feeling distant or not present during sex and experiencing intrusive or disturbing sexual thoughts and images are also known to be symptoms that can be identified in victims of childhood sexual abuse. This was confirmed by several participants who described engaging in sexual intercourse whilst focusing their thoughts elsewhere. One participant said: "*Ek lê net en wag vir hom om klaar te maak. Dit voel nie of ek daar is nie. Ek dink hy kom dit partykeer agter*" (I just lie there and wait for him to finish. It feels like I'm not there. Sometimes I think he is aware of it). Another participant stated: *"Ek sny uit"* (I disappear somewhere else). Some women engage in compulsive or inappropriate sexual behaviour. This was reflected by at least four participants with one participant describing her behaviour as follows: *"Ek het baie kêrels gehad. Daar was baie seks maar geen liefde*" (I had a lot of boyfriends. There was a lot of sex but no love).

From the data obtained from the participants, it also became evident that some viewed their position in their intimate relationships as submissive. Statements such as: *"Ek doen dit maar vir sy genot"* (I just do it for his pleasure) and *"Ek gee maar toe as hy dit wil hê"* (I just give in when he wants it), were recorded. A participant stated: "*Dit het gevoel hy dwing my, dan hou hy aan en aan en dan sal ek sê doen dit net! Maar om 'n ding te doen teen jou sin maak seer"* (It felt as if he was forcing me, and he kept on on and on and on and then I'll say, just do it! But to do something against your will hurts). Another participant shared her views by saying: "*My liggaam is my man s'n*" (My body belongs to my husband).

A general view amongst the participants is that their experiences of childhood sexual abuse have had a significant impact on their ability to enjoy normal, healthy sexual relationships with their intimate partners. A general concern is shared by the participants that this can potentially destroy their current relationships. A participant said: "*Die Here het vir my 'n baie geduldige man gegee wat dit aanbetref maar 'n man se geduld kan ook net so lank hou*" (The Lord gave me a very patient man as far as that's concerned, but a man's patience can only last so long). One participant confirmed that her problems relating to her difficulties in being sexually active with a man has contributed directly to her first failed marriage.

From the data obtained it becomes evident that the level of trust between the participant and her intimate partner contributes significantly to her ability to engage in sexual activities with him: *"Ek vertrou hom, tussen my en my man is dit 'n liefdesdaad en nie 'n verkragtingsaak nie"* (I trust him. Between me and him it's an act of love and not an act of rape). Another participant contributed by stating: "*My man het my baie ondersteun, dit het baie gehelp om beter te word"* (My husband gave me a lot of support; it helped a lot in the healing process). A lack of trust has been identified by the majority of the participants as one of the factors that influences their sexual relationships.

A general opinion amongst the participants was that a man can't be trusted. In a study done by Lotter (2006:91) the women in the study indicated that "they could not easily trust their partners, and always felt vulnerable and exploited in their presence". They will constantly test their partners in order to establish if they can be trusted. According to Spies (2006b:66–67) adult survivors of childhood sexual abuse bring into adulthood all their confusing messages arising from the abuse they experienced about the relationship between sex and love, and trust and betrayal.

9.2.1.1.2 Sub-theme 2: Shame and intimate partner conflict

Whilst exploring with participants the effect that childhood sexual abuse has had on their relationship with their spouse or intimate partner, the participants' answers reflected that they experience a high level of shame associated with their childhood sexual abuse. According to Spies (2006b:56) survivors of childhood sexual abuse often experience intense feelings of shame and guilt because they feel that they were responsible for the sexual abuse. The majority of the participants explained

that they have experienced low self-esteem at some point in their relationships with their intimate partners.

Although none of the participants pointed out a direct link between their feelings of shame and conflict with their intimate partners, the majority of the group reported experiencing conflict with their intimate partners. A fact pointed out by some of the participants was that the nature of the conflict between them and their intimate partners were very often verbal, which did not necessarily escalate to physical abuse. A participant stated: "*Ek en my man het baie baklei; erg baklei op 'n verbale vlak. Die kinders het dit beslis gehoor"* (My husband and I fought a lot; fought badly on a verbal level. The children definitely heard it).

In addition, data obtained from the document analysis reflects problems in the intimate partner relationships of three individuals but omits to specify whether the conflict resulted in physical or verbal abuse. In a study conducted by Kim *et al.* (2009:10), it was indicated that shame significantly mediated the association between childhood sexual abuse and intimate partner conflict expressed as women's verbal aggression towards their partners.

According to the results of this study it is evident that women with a history of childhood sexual abuse were more likely to experience shame, which in turn, was associated with their verbal conflict in intimate relationships. It has, however, been pointed out in the study that further research is required in order to fully investigate the role of shame in the intimate partner and family conflicts of women with a history of childhood sexual abuse.

Shame as a contributing factor to child maltreatment by a mother with a history of sexual abuse has, however, not been confirmed in the study conducted by Kim e*t al. (*2009:11). It is considered that other emotions, such as anger, are more influential in predicting the association between childhood sexual abuse and later child maltreatment (DiLillo, 2000:775)

In addition, from research conducted it is evident that an abusive childhood may predispose an individual to exhibit aggression in later life and may put an individual at increased risk of being drawn to violent partners (Dixon *et al.,* 2005:47). According to Coid e*t al.* (2001:450) women who were sexually or physically abused as children are 3.5 times more likely to experience partner violence as adults. A

survivor of childhood trauma is more at risk for abusive or traumatic relationships in adulthood (Hyu *et al.,* 2014:10). It was found that persons who have a history of childhood trauma may attempt to address the emotional distress caused by associations with past traumatic events by organising their interpersonal relationships in a way that allows them some degree of perceived control. It is further indicated that: "they attempt to develop a sense of mastery by being the initiator of the potentially traumatic interactions" (Hyu *et al.,* 2014:10). This can result in the survivor stepping into the role of the aggressor initiating the intimate partner conflict.

Taking into consideration these findings, concern is raised over the ability of the survivor of childhood sexual abuse to maintain a meaningful interpersonal relationship that will contribute to creating a conductive environment for children to be cared for and raised in.

9.2.1.1.3 Sub-theme 3: Breakdown of family unit and becoming part of a step-family

Most of the time, difficulties in family life lie at the heart of sexual abuse of young children and according to Richter *et al.* (2007:457) children born outside of the traditional family systems may not experience the same nurturing and protection as that accorded to children born within these societal structures. Findings from a study conducted by Roberts *et al.* (2004:539) indicate that childhood sexual abuse survivors are more likely to form part of non-traditional families such as being a single mother or living in a step-family.

This was true for seven of the ten participants. Only three participants confirmed being in first-time marriage relationships with their husbands. Of the remaining participants, four were single mothers and three formed part of a step-family. Several participants reported that their intimate partners had started romantic affairs that significantly contributed to the final break-up in the relationship. One participant shared the following view: "*Ek is getroud maar toe werk dit nie want ek was gekondisioneer in die gewoonte van misbruik. Ek het my man se gewoonte vergelyk met die persoon wat my misbruik het en altyd gevoel my man is nie goed genoeg nie. Dit het gelei tot baie erge huwelikskonflik*" (I was married but then it didn't work because I was conditioned to the habit of abuse. I compared my husband's habit

with the person who abused me and always felt that my husband wasn't good enough. This led to very serious marital conflict).

Another respondent who is currently married to her second husband explained: *"Ons het baie en sommer oor enigiets baklei. Dit het al baie gevoel of ons huwelik nie gaan hou nie"* (We fought a lot and over any thing. It always felt as if our marriage wasn't going to last). She added: "*My man het nie my gevoelens verstaan nie. Hy't nie al hierdie goeters verstaan nie en ek kon dit nie met hom bespreek nie. Ek kon dit net uithaal op hom. So dan raak mens maar eensaam"* (My husband did not understand my feelings. He didn't understand all these things and I couldn't discuss it with him. All I could do was take it out on him. So then one becomes lonely). Another participant stated: *"Na my egskeiding het my standaarde aansienlik verhoog, ek is nou vir vyf jaar al single"* (After my divorce my standards have increased dramatically; I've been single for five years already).

Roberts *et al*. (2004:539) found that when a mother with a history of childhood sexual abuse with symptoms of poor psychological well-being and low maternal enjoyment became a part of a re-organised family, these symptoms could be exacerbated in the step-family system. The level of household crowding is considered the key factor for explaining the pattern of results in complex step-families. This is linked to the invasion of personal space in overcrowding conditions, which the victim of childhood sexual abuse can associate with the violation of personal space associated with sexual offences committed against her. Traumatic memories can therefore be reactivated under such conditions.

Data obtained from Documents B, C, D and E reflected non-traditional family systems, which included a single mother with no previous history of being married, two mothers who formed part of a step-family system and a divorced single mother. This information corresponds with literature indicating that mothers with a history of childhood sexual abuse are more likely to form part of a non-traditional family system (Richter *et al.,* 2007:457–458; Spies, 2006a:74–75).

From data obtained from the interviews conducted, it became evident that some participants experience their current, non-threatening intimate relationships as contributing to their ability to deal with the trauma they associate with their childhood sexual abuse. Earlier studies have found that interpersonal relationships have the

potential to moderate and mediate the long-term distress displayed by the childhood sexual abuse survivor (Runtz & Schallow, 1997:223; Whiffen, *et al.,* 1999:942).

More recent research findings continue to highlight the mediating effect the family environment has on the link between childhood sexual abuse and the emotional distress of the survivor (Whiffen & MacIntosh, 2005:29). This is important knowledge when considering a treatment plan for a survivor of childhood sexual abuse and has formed the foundation for the rationale suggested by Nadan and Nasim (2013:8) – that establishing a context for witnessing in couples therapy with childhood sexual abuse survivors can contribute to their healing process.

According to the Kerry Rape and Sexual Abuse Centre (2013:4) any loving relationship need the ongoing support and understanding of both partners. However, to be the partner of a survivor of childhood sexual abuse takes extra understanding and patience. One participant explained: *"Ons verhouding het heeltemal verander. Die vertroue wat hy in my gestel het en my gewys het hy sal my en my kinders nie seer maak nie. En dit is die belangrikste ding wat kon gebeur het."* (Our relationship changed completely. He instilled a sense of confidence in me that he would not hurt me or my children. And that is the most important thing that could have happened).

9.2.1.1.4 Sub-theme 4: Lack of trust in intimate partner concerning children's safety

A common concern amongst the participants was entrusting intimate partners with the safety of their children. One participant stated that she does not trust her husband alone with her daughters. Whilst referring to her husband, she explained: *"Ek het altyd gewonder of ek my kind blootstel aan 'n pedofiel?"* (I always wondered whether I was exposing my child to a paedophile). Another participant stated: *"Ek kyk altyd agterdogtig na my man en wonder"* (I always look at my husband suspiciously and wonder).

Mothers with a history of childhood sexual abuse may be particularly prone to excessive concerns that their child can be sexually abused by someone such as their intimate partner. This is corroborated by earlier research conducted by Cross (2001:572). Interviews with incest victims revealed themes of great concern about

children's safety. It is evident from the research that they experience great difficulty trusting others, including their own husbands with their children.

A woman who was sexually abused as a child by her father or stepfather will fear that her partner will sexually abuse her daughter too. The sexually abused child fosters anger towards her mother, herself and the father or stepfather. These feelings can become generalised and incorporated into the basic personality structure of the sexually abused child. Being given the opportunity to appropriately vent the anger is a primary goal of most of the therapeutic interventions (Killian & Brakarsh, 2007:371–372). If feelings of anger are not properly handled during therapeutic interventions, it can potentially affect the woman's relationship with her partner and also have a potential negative effect on the parent-child relationship between her children and their father.

During the analysis of Document C, it became evident that the mother of the alleged abused child suspects her ex-husband of being the perpetrator. Despite limited information provided in the client file, it was evident that the father of the child had no form of contact at the time. It has to be taken into consideration that unsubstantiated allegations of sexual abuse against the father could potentially have a detrimental effect on the attachment relationship he shares with his children.

9.2.1.1.5 Sub-theme 5: Re-victimisation

According to results obtained from a study conducted by Tapia (2014:70) a history of child sexual victimisation serves as a significant risk factor for future sexual assault. Self-blame that resulted from their initial abusive experience may increase the likelihood of a later sexual assault due to distorted perceptions of their physical body and/or sexuality, which may increase the risk of being victimised through specific cognitions and behaviours. These findings are consistent with earlier research that confirmed that the association of childhood sexual abuse with re-victimisation was directly mediated by self-blame and post-traumatic stress disorder (Spies, 2006c:56; Miller e*t al.,* 2007:134). Noll *et al.* (2003:1468) found that a victim of childhood sexual abuse who has not fully integrated the trauma or who has otherwise minimised or denied it in total, may be prone to making inaccurate or uninformed decisions regarding potential danger when experiencing avoidant symptoms.

During the semi-structured interviews conducted, some participants referred to life choices they made that placed them in situations in which they fell victim to re-victimisation. One participant remembered making a conscious decision to join an occult group that encouraged sexual activities among the group members. She stated: *"Daar was ook seksuele rituele waaraan ek deelgeneem het"* (There were also sexual rituals in which I took part). Another participant recalled her experiences as a very young mother, engaging in sexual activities with different men over a period of time. She explained that she was obsessed with sex and that her sexual interactions usually took place whilst she was also using drugs. She recalled: "*Ek was nie altyd tydens seks met mans bewus van wat ek doen nie"* (I wasn't always aware of what I was doing while having sex with men).

From the document analysis, there was no information was available for the purpose of identifying mothers who have been re-victimised. It has to be considered that this information does not necessarily get reported to the social workers or intake officers voluntarily and consequently does not get recorded.

9.2.1.2 Risks identified

9.2.1.2.1 Risk 1: Incest between father and daughter

Sexual abuse within families has in recent years become a significant issue of concern worldwide (Ferguson, 2004:22; UNICEF, 2012:1; Zastrow, 2010:193). Zoldbrod (2015:4) defines incest as overt sexual abuse perpetrated by a family member. According to Gomes *et al.* (2014:258) biological paternal incest seems to be the most frequent form of incest, which has more serious consequences for the victim.

These findings support earlier research that indicates that incest between father and daughter is more abundant than information about any other forms of incest. Available figures indicate that 70–80% of reported incest cases occur between daughters and their biologiacal fathers or step-fathers (Spies, 2006b:5). Rice and Harris (2002:335) offer one explanation for incestuous relationships between fathers and their daughters by referring to the scarcity of a sexual partner for the father. Intra-familial child abusers define a distorted family relationship in which daughters are selected as sexual partners.

Taking into consideration the tendency of survivors of childhood sexual abuse to have challenges in respect of fulfilling their role as sexual partner in the intimate relationship, consideration has to be given to the level of risk this poses to their children to become victims of intrafamilial sexual abuse. The intimacy that should take place in the intimate partner relationship is absent and a violation of inter-generative boundaries occurs. Instead, the intimacy can potentially shift to the parent-child relationship. High frequency of abuse episodes, the duration of the abuse, the child's low age and unstable family context and dynamics which can include physical and psychological violence in the domestic setting, are all factors considered to exacerbate the trauma experienced by the victim and also aggravate the consequences (Gomes, 2014:258)

Harter *et al.* (1988:7) concludes that children's symptoms are more severe when sexual abuse is by parent figures such as their biological parents or step-parents. These research findings have been confirmed by later studies with corresponding results (Cyr e*t al.,* 2002:970; Celbis e*t al.,* 2006:39; Magalhaes *et al.,* 2009:455). It has also been found that sexual abuse involving penetrative sex, the level of aggression it is accompanied with the number of abusers, and/or duration of time over which it occurs are also factors impacting on the severity of the abuse (Schloredt & Heiman, 2003:281).

Sexual abuse that occurs in incestuous relationships between parents and children is a very challenging problem due to the particular characteristics of the intrafamilial abusive situations and specifically of sexual abuse perpetrated by the father. Incest between father and daughter moves in a certain pattern, such as: first the engagement phase to the sexual interaction phase, then to secrecy, to disclosure and often to suppression (Crosson-Tower, 2005:153).

In addition, evidence suggests that there is a significant delay between the alleged abuse and performing the forensic medical evaluation which compromises evidence and other sample collection (Magalhaes *et al.,* 2009:458). In a study conducted by Gomes (2014:258) it was noted that less physically intrusive practices were recorded in incestuous relationships, with absence of injuries in 61% of the cases. The opportunity for medical intervention and consequent child protection is therefore likely to be limited as the symptoms, signs and evidence of sexual abuse within an incestuous child-parent relationship are less visible to an outsider.

9.2.1.2.2 Risk 2: Divorce or parental separation and becoming part of a re-organised family

Roberts e*t al.* (2004:539) indicates that it is more likely that women with a history of childhood sexual abuse will become part of a reorganised family. Should it happen that the marital relationship breaks down completely, to the point where divorce or separation is unavoidable, the effect this life-changing event might have on the children concerned has to be considered.

Ängarne-Lindberg (2014:2) however, points out that the majority of children manage to adapt to the changed circumstances following parental divorce and that this has to do with resilience. The difficult circumstances surrounding the divorce and other negative events are seen to be the contributing factors of negative consequences rather than the separation itself (Rhoades, 2008:1943; Nunes-Costa *et al.,* 2009:393).

Children who have experienced high conflict parental divorce may experience higher levels of psychological distress, feelings of loss, abandonment, and ideations that their lives will be more difficult due to their parent's divorce (Laumann-Billings & Emery, 2000:685). Taking into consideration the challenges a mother with a history of childhood sexual abuse is facing in relation to her relationship with her intimate partner/husband that includes problems with sexuality and trust, the risk of separation and divorce remains substantially high without therapeutic intervention. The circumstances around the divorce and the impact of the event on the psychological development, physiological stress responses, physical health and psychopathology in children have to be taken into consideration.

9.2.1.2.3 Risk 3: Domestic violence

From available research findings it is evident that a mother's history of abuse may predispose her to exhibit aggression as an adult and also increases her risk to be drawn to violent partners and to become involved in abusive relationships. This raises concern over the high likeliness of domestic violence occurring in the household of the mother. Domestic violence by the intimate partner is a stressor on its own and when children are part of this, the risk for psychological problems of children increases (Graham-Bermann & Howell, 2011:172).

It was found that children exposed to domestic violence appear to be more prone to physical aggression and have higher levels of general behavioural problems when rated by parents and teachers (Sternburg *et al.,* 2006:865). Studies have also found that children exposed to domestic violence experience a range negative outcomes, including increased internalising and externalising behaviours (Evans *et al.,* 2008:9; Moylan, 2010:59).

It has to be considered that due to the high likeliness of women with a history of childhood sexual abuse becoming involved in abusive relationships, a direct risk is posed to the welfare and safety of her children. Kitzmann *et al.* (2003:349) offers evidence that relates to predicting poor developmental outcomes for children that are exposed to domestic violence in the houshold, particularly in the preschool years. This raises additional concern over the developmental needs of children of mothers with a history of childhood sexual abuse.

9.2.1.2.4 Risk 4: Parental alienation

Studies on father involvement repeatedly show that school-aged children whose fathers were minimally present or absent from their lives had difficulties across behavioural, cognitive and academic achievement, social, moral and emotional domains (McLanahan *et al.*, 2013:339).

In comparison, research shows that the quality of parent-child relationships characterised by parental acceptance and rejection serves as a very important predictor of psychological functioning and development for both children and adults universally (Khaleque & Rohner, 2002:61). Research has found significant benefits for children across domains which are associated with higher levels of positive paternal involvement (Kelly, 2012:50; King 2002:644; Sandler *et al.,* 2012:83).

Although none of the participants admitted to purposefully alienating their children from their fathers, due to their concerns and suspicions, the possibility must be taken into account that they could be alienating their children on an unconscious level as naïve alienators. Darnall (1998:325) defines a naïve alienator as a parent who is passive about the relationship with the other parent and occasionally says or does something to alienate or reinforce alienation. Taking into consideration the challenge mothers with a history of childhood sexual abuse experience in trusting

any person, including the father of their children, most likely have a direct impact on the parent-child relationship between the father and the child.

From the information obtained from the participants, they present high resistance to the idea that their infant or pre-school daughters should be assisted with general hygiene routines such as changing diapers or bathing, by their fathers. It is, however these routines that could contribute to the quality of the parent-child relationship. Additional research will be helpful to further explore this hypothesis.

9.2.1.2.5 Risk 5: Sexual allegations in divorce

Blush and Ross (1987:1) refer to the phenomenon of sexual allegations being made during divorce proceedings by one of the parents in respect of the children concerned, as the SAID syndrome. This acronym describes the particular phenomenon which occurs when sexual abuse allegations are made within a pre- or post-divorce context. It is believed that when sexual allegations occur during the divorce proceedings, a different set of dynamics and variables are present.

Evidence of the SAID syndrome was found during analysis of document C. The mother of the child concerned suspected that her husband whom she was in the process of divorcing was committing sexual offences against their daughter. No evidence was found by the social worker assessing the child to give weight to the allegations made by the mother**.**

Very little evidence was found in the literature pointing out a possible link between a mother's history of childhood sexual abuse and the likeliness that this could cause her to make allegations of sexual abuse in respect of her children during divorce proceedings. The mother's challenges in terms of trusting her partner with the safety of her children and the high likeliness of the family unit she forms part of breaking down, raises concern over the possibility that these factors could within the ideal circumstances increase the chances of SAID syndrome.

9.2.2 Theme 2: Sexual abuse during childhood affecting the parent-child relationship

Findings from a study conducted by Roberts *et al.* (2004:538) indicate that a history of childhood sexual abuse of a mother has long term repercussions for her parenting abilities, which have consequences for her children with respect to the

parent-child relationship and child adjustment. Schuetze *et al.* (2005:653) provide evidence that the effects of childhood sexual abuse on parenting are indirect. Women with a history of childhood sexual abuse are more likely to experience both depression and partner violence as adults. It is argued that these experiences have an impact on parenting outcomes such as the attitudes mothers have of themselves and the disciplinary strategies they utilise.

Burkett (1991:1433), however, asserts that a history of childhood sexual abuse does not necessarily result in dysfunctional parenting. Banyard (1997:1104) supports this view, emphasising that although a history of childhood sexual abuse is associated with some dimensions of negative parenting, not all survivors demonstrated negative parenting behaviours.

Follow-up research conducted by Barnyard (2003:347) points out that the trauma history of a person is only a small component of a larger matrix of factors that determine parenting and the outcomes for children. The research findings suggests that creating new social support networks and developing self-care skills is important for reducing the negative pscychological consequences of childhood sexual abuse.

The following sub-themes were identified from the research study concerned, which relate directly to the respondents' relationship with their children.

9.2.2.1 Sub-themes

9.2.2.1.1 Sub-theme 1: The level of maternal support the sexually abused mother experienced as a child

Elliott and Carnes (2001:35) identify maternal support to be the most crucial factor influencing a child's recovery from childhood sexual abuse. A study by Morrison and Clavenna-Villaroy (1998:33) found that adolescent girls who perceived their mothers to be supportive when they disclosed sexual abuse, had higher self-concept and fewer symptoms of depression compared to adolescents whose mothers were perceived to be non-supportive at that time.

It became evident from the information obtained from the participants that not one of them experienced sufficient levels of maternal support during the time of their childhood sexual abuse or following their disclosures. The general perception amongst the participants was that this had a significant impact on them. Two

participants experienced extreme reactions from their mothers upon disclosing their sexual abuse.

One participant stated: *"My ma het 'n verskriklike groot reaksie gehad. Ek het gevoel ek moes eerder stil gebly het"* (My mother had a very big reaction. I felt I should rather have stayed quiet). Another participant reflected this reaction by saying: *"My ma was baie geskok en het met my baklei"* (My mother was very shocked and fought with me). Three participants remembered being accused of being responsible for the abuse by their mothers: *"My ma het my blameer daarvoor dat ek haar huwelik opgebreek het"* (My mother blamed me for breaking up her marriage), one participant said. According to another participant: "*Nadat ek my ma vertel het, het sy my ook daarvan beskuldig dat ek met my pa seksueel aktief is"* (After I told my mother, she also accused me of being sexually active with my father).

One participant referred to her mother who refuses to belief her disclosure of sexual abuse at the age of thirteen years old: "*Ek het vir my ma 'n brief geskryf en toe het sy die brief gelees, opgefrommel en gesê jy praat nooit weer daarvan nie en vergeet dit, asseblief, ek vra jou mooi"* (I wrote my mother a letter and then she read it, rolled it into a ball and said, you will never speak about this again and you will forget it, please, I'm asking you nicely). This respondent was re-victimised by a stranger at the age of fourteen. After disclosing to a social worker, it was reported to a minister of the church. She remembered: *"Ek kry toe 'n oproep die middag van my ma af. Sy sê toe die dominee wil ons sien en toe ons daar instap toe sit die maatskaplike werker by die dominee. Ek is toe uit die vertrek uit en hulle drie het toe besluit ek jok oor die situasie en dit is soort van aandag soek wat ek wou gehad het"* (I received a call from my mother that afternoon. She said the minister wants to see us and when I walked in the social worker was sitting with the minister. I was told to leave the room and the three of them decided I was lying about the situation and that I was looking for attention).

Mothers being emotionally unavailable were also identified with four participants referring to their mothers as absent due to alcoholism and/or substance abuse. A participant remembered: *"My ma was my anker toe ek klein was, sy was my alles. Ek het aan haar geklou maar as sy gedrink het, was sy weg"* (My mother was my anchor when I was small; she was my everything. I clung to her, but when she

drank, she wasn't there). A recurring theme is that the participants felt hesitant to discuss any issues relating to sexual matters with their mothers. According to Eliott and Carnes (2001:16) a substantial part of non-offending mothers disbelieved their children's allegations of sexual abuse and responded with rejection and blame. In comparison, Humphreys (1992:31) found that the mothers in her study who had a maternal history of sexual assault had no trouble believing their child's disclosure.

According to Gogela (2013:25) and Spies (2006a:62) for many women who were sexually abused it is difficult to handle a disclosure of sexual abuse involving their children. Feelings of guilt and painful memories will surface after a disclosure. In research done by Gogela (2013:35) she recommends that parenting programmes should be conducted to equip parents on how to handle the child's disclosure of sexual abuse.

It was also recorded by some of the participants that their mothers did not reach out to them in order to offer sex education on any level. The protective role of parental support upon disclosure of sexual abuse is highlighted by Godbout *et al.* (2014:324). It was found that the child's perception of the parent's availability and willingness to intervene in traumatic situations, such as childhood sexual abuse, may have a significant impact on the subsequent development of secure adult attachment and positive psychological adjustment.

The majority of the participants believed that their mothers were also victims of sexual abuse although not one participant was able to confirm their suspicions. A participant said: "*Ek vermoed my ma en haar susters is ook deur my oupa gemollesteer. My ma hoereer, haar suster is 'n lesbeen en die ander suster is behep met kinders. Sy het my een keer gemollesteer"* (I suspect my mother and her sisters were also molested by my grandfather. My mother is a prostitute, her sister is a lesbian and the other sister is obsessed with children. She molested me once).

From the data obtained, participants were of the view that their mothers were aware of the sexual abuse taking place but did not take any action to minimise the risk of it reoccurring. "*My ma het niks gedoen om my weg te hou van my oupa af nie"* (My mother did nothing to keep me away from my grandfather), one participant said. During the interview with one participant, the impact of maternal support was highlighted. This participant was gang-raped by unknown men on two separate

occasions as an adult. Despite being re-victimised twice, the central theme of her nightmares is of her step-father raping her and how she is trying to convince her mother of it. She said: "*Ek kry nagmerries, dan is ek weer bewus dat hy my verkrag het en hoe ek my ma probeer oortuig dat hy skuldig is*" (I have nightmares, then I'm aware that he is raping me and how I'm trying to convince my mother that he's guilty).

No information relating to maternal support was obtained during the document analysis. This is likely due to the fact that the focus of client files which have been analysed were primarily on the alleged, abused child. No indication was found that the mother's experience of her own sexual abuse was explored during the intake process.

9.2.2.1.2 Sub-theme 2: Lack of trust and reduced confidence in parenting abilities

A general view reflected by the participants was that they lost their trust in people and potential helpers in light of the reactions they received from their mothers following their disclosures of sexual abuse to them. According to Pollio *et al.* (2011:268) to optimally support a child's recovery from sexual abuse, "it is important to assess parent's responses, their support resources, and their personal histories of abuse and/or trauma".

There is a common assumption that internal working models of parenting are influenced by childhood experiences and are mostly reflected in interactions with one's own children (Roberts, 2004:526). A theme that transpired from the data obtained from the participants is that the majority of the group fostered negative views of themselves as mothers. A participant said: "*As ma dink ek, ek is 'n slegte ma omdat ek die heeltyd sit met hierdie goed in my gedagtes en ek moet nog steeds voorgee ek is 'n mamma wat okey is"* (As mother, I think I'm a bad mother because I'm always thinking about this stuff and at the same time I must pretend I'm a mommy who is ok). Another participant explained: "*Ek het op Moedersdag vir my man gesê ek dink ek is 'n baie slegte ma. Ek doen nie alles wat 'n ma kan doen vir haar kinders nie. Ek dink dit is die depressie wat 'n rol gespeel het meer as die verkragtings"* (I told my husband on Mother's Day that I think I'm a very bad mother. I don't do everything that a mother can do for her children. I think it's the depression that has played more of a role than the rapes).

Barnyard *et al.* (2003:345) found that traumatic experiences in both childhood and adulthood were related to problems in parenting children. More negative parenting outcomes both in terms of self-reported parenting behaviours and perceptions of oneself as a parent were recorded in the study conducted. Information obtained from the participants points to them being very sensitive to the opinions that others might have about their parenting abilities. One participant stated: "*My man was baie krities. Hy sou vir my gesê het doen dit so of nee moenie dit doen nie. Hy sou gesê het, haar winde is nog nie uit nie en hy sou oorgevat het en dan het ek terug gestaan*" (My husband was very critical. He would say do it like this, no, don't do it that. He would say, you're not trying hard enough and then he would take over and I would stand back).

Armsworth and Stronk (1999:305) found that all mothers perceived some effects of their childhood sexual abuse as influential in relation to the perceptions of their own parenting and their parenting practices. It was, however, found that significant issues in childhood, for example physical abuse and extreme neglect, were equally significant in influencing their own perceived parenting abilities.

This is mainly explained by attachment theory that highlights the role of early experiences of parents in the development of their own caregiving responses to their children. Their interactions and relationships with their own offspring is guided by internal working models that develop from the caregiving relationships they experienced as children (George & Solomon, 1999:667). The lack of trust mothers display in their own parenting abilities can therefore be understood if it is argued that these perceptions of themselves are based on adverse childhood experiences associated with the relationships with their primary care givers.

9.2.2.1.3 Sub-theme 3: Overprotecting children

Successful parenting involves emotional demands under any circumstances. Survivors of childhood sexual abuse may have an additional desire to protect their children against any possible situation in which sexual abuse could take place (Spies, 2006a:74). Overprotecting is an exaggeration of the healthy desire of sexual abuse survivors to keep their own children safe (Bass & Davis in Spies, 2006a:74).

A question was asked to the participants "*How do you ensure your child's safety in your absence*?" The answers of the participants were as follows:

"*Ek laat nie my kinders alleen loop nie. Ek sal eerder tien keer ry en gelukkig nou vir selfone. Ek "Whatsapp" hulle baie en hulle vir my*" (I don't let my children walk anywhere. I'd rather drive ten times, and thankfully there are now cellphones. I 'Whatsapp' them a lot and they message me a lot).

"Ek hou my kind terug in sekere aspekte. Ek maak seker dat sy nie uitlokkend aantrek nie. Sy mag ook glad nie op Facebook kom nie" (I hold my child back in certain aspects. I make sure that she isn't dressed provocatively. She may also not use Facebook at all).

"My kinders weet hulle slaap nie by maatjies oor nie." (My children know they're not allowed to sleep over at friends' houses).

"Ons hou nie groot partytjies met baie mense by ons huis nie. Dis juis sulke omstandighede wat gemaak het dat my oom 'n "gap" gekry het. My pa-hulle het so lekker gekuier dat hulle nie gekyk het waar is ons nie. Ek wil nie sulke geleenthede skep waar my kinders kan seer kry nie." (We don't have big parties with a lot of people at our house. It was just such an event at which my uncle found a 'gap'. My parents were having such a good time that they didn't look where where were. I don't want to create opportunities where my children can be hurt).

"Ek sal my kinders net by my ma los, niemand anders nie!" (I will only leave my children with my mother, no one else!).

"Ek sal my kind by niemand los of vertrou nie". (I will never leave my child with anyone or trust them with anyone).

All the participants reported experiencing a strong need to protect their children. This was particularly true for participants with female children. No significant evidence was found during the document analysis that pointed to mothers with a history of childhood sexual abuse overprotecting their children.

9.2.2.1.4 Sub-theme 4: Difficulty attaching with female children from birth

One consequence of child maltreatment in general and neglect specifically is the development of an insecure attachment between child and parent (Erickson & Egeland, 2011:111). The long-term interpersonal correlates of childhood sexual abuse may engender insecure or disorganised attachment among victims (Alexander, 2000:835). These attachment styles are then carried into adulthood in

the form of poor functioning in important interpersonal contexts which includes the victims' relationship with their own children. Insecurely attached mothers are therefore said to experience "anxieties and distortions" in the parenting role.

The data obtained from the participants made it evident that mothers with a history of childhood sexual abuse, experience significant difficulty forming a healthy attachment with their female babies. A participant explained: *"Die dag toe ek geboorte gegee het aan my dogter, was die swaarste dag van my lewe. Ek het gehuil. Ek het reguit gesê ek wil haar nie hê nie. Nie omdat ek nie lief is vir haar nie maar omdat ek deur sulke dinge gegaan het, was ek bang my dogter gaan ook daardeur gaan."* (The day I gave birth to my daughter was the most difficult day of my life. I cried. I said I didn't want her. Not because I don't love her, but because of the things I went through I was scared she would go through as well). Another participant said: "*Ek het drie dae gehuil toe ek hoor dit is 'n dogtertjie wat ek verwag. Ek wou 'n seuntjie gehad het. Ek het gedink die Here straf my, hy wil kyk kan ek dit anders hanteer as wat my ma dit hanteer het*" (I cried for three days after I heard I'm expecting a girl. I wanted a boy. I thought the Lord was punishing me, trying to see if I would handle it differently than my mother did).

A general impression obtained from the participants was that they were not excited or interested in meeting their new female baby after birth. One participant stated: "*Die sister het my gedwing om die baba te voed vyf ure na haar geboorte. Ek was bang om 'n band met haar te vorm want ek was bang sy gaan met my wees soos ek met my ma was."* (The nurse forced me to feed the baby five hours after her birth. I was scared to form a bond with her because I was scared she was going to be with me like I was with my mother). This participant was referring to childhood experiences involving her mother having sex with men in her presence and exposing her as a young child to intimate partner violence. She described her mother as an alcoholic and not experiencing any form of attachment to her mother as a child or adult.

In research done by the Minnesota Longitudinal Study of High Risk Parents and Children, they came to the conclusion that how a parent cares for their children is strongly influenced by the care the parent received in their own childhood (Erickson & Egeland, 2011:108). These findings support previous research that suggests that victims of intra-familial sexual abuse may have inadequate opportunities to observe

and learn from healthy, effective parenting models (Armsworth & Stronk, 1999:305; George & Solomon, 1999:667).

A general theme that became evident among the participants was that they did not experience difficulties in caring for their young babies. It was on an emotional level that there is mutual agreement that they experienced great difficulties to form attachments with their daughters. One participant stated: "*Om 'n emotionele band met 'n kind te bou vat jare se werk. Ek het eers op twaalf jarige ouderdom met haar gebind*" (To form an emotional attachment with a child takes years of work. I first formed an attachment with her when she was 12 years old). Similar reports were made by research participants of a study conducted by Cavanaugh *et al.* (2015:519) and it was found that difficulties bonding with children are a particularly challenging parental task a mother with a history of childhood sexual abuse has to conquer.

9.2.2.1.5 Sub-theme 5: Difficulty maintaining bond with children due to being emotionally absent

The impact of neglect on children's development is as damaging as any other more overt types of abuse (Erickson & Egeland, 2011:110). Five participants reported feeling guilty over their tendency to emotionally disconnect from their children. One participant stated: "*Ek kon glad nie met my kinders speel nie. Ek het nie vreugde in my nie. Nooit vreugde in my gehad nie. My man het altyd oorgevat. Ek was baie keer as hy nie daar was nie, half afwesig. Ek was 'n afwesige ma."* (I couldn't play with my children at all. I don't have joy in me. I've never had joy in me. My husband always took over. Many times, when he wasn't there, I was half absent. I was an absent mother). Another participant said: "*Ek was 'n buitestaander in ons gesin. Ek wou nie deel wees van gesinsaktiwiteite nie, ek sou eerder wou lê en lees. Ek wou eenkant wees*." (I was a bystander in our family. I didn't want to take part in family activities, but rather wanted to read. I wanted to be alone). Children who experienced psychologically unavailable parenting in the first two years of life continued to have problems throughout their elementary school years (Erickson & Egeland, 2011:108–110).

9.2.2.1.6 Sub-theme 6: Less worried about male children being at risk of sexual abuse

A common perception was identified among the participants that male children are less at risk of being sexually abused than female children. In a study conducted by Dube e*t al.* (2005:436) it was found that the experience of childhood sexual abuse was common among both men and women. It was further confirmed that the long-term impact on health and social problems were similar for both genders.

One participant stated: "*Ek het geweet my man sou nie iets met die seuns doen nie. Mans verkrag nie eintlik seuns nie. Ek was minder bekommerd oor die seuns as oor die dogters gewees.*" (I knew my husband would do nothing with the boys. Men don't really rape boys. I was less worried about the boys than the girls). Another view shared by a participant is as follows: "*Seuns is beter in staat om hulle self te beskerm. Seuns kan terug baklei."* (Boys are better able to protect themselves. Boys can fight back).

9.2.2.1.7 Sub-theme 7: Mother-child role reversal

Men and women who become parents enter a new phase of their lives. It is considered that fulfilling a parental role is one of the most difficult and demanding endeavours anyone can undertake (Spies, 2006a:74; Strong *et al.,* 1998:382). As the nature of parenting is multifaceted, the impact of having a history of sexual abuse on a variety of parenting skills and behaviour of the mother has to be considered.

According to Spies (2006a:74), adult survivors of sexual abuse often grew up in dysfunctional families and therefore do not have the benefit of healthy role models in their lives. This raises concern considering the increased risk for children when considering that difficulties in the family life lie at the heart of the sexual abuse of young children (Richter *et al.,* 2007:457).

A theme that strongly emerges is that of mother-child role reversal. This phenomenon refers to mothers with a history of childhood sexual abuse who become overly dependent on their children to meet their own emotional needs. In a study conducted by Alexander e*t al.* (2000:835) it was found that mothers with a history of childhood sexual abuse relied more heavily on their children for emotional support than mothers without a history of childhood sexual abuse. This poses a risk

to children's development when they are subjected to this sort of interaction in the relationships they share with their mothers (Chase 1999). Due to the emotional pressure experienced, a child might take on a more mature appearance than their peers, which is potentially problematic considering their developmental phase.

Limited evidence was obtained from the participants to indicate that they are experiencing role-reversal in their relationships with their children. It has to be taken into consideration that this limitation stems from the lack of opportunity to observe the interaction between the participants and their children and the information mainly being based on self-report.

From the interviews conducted with the participants, however, it became evident that the majority of the participants view their relationships with their children as very close. These participants have, however, also indicated their initial difficulty to form attachments with their female children, raising a question with respect to the nature of the close relationship between the participants and their children.

From the data obtained from the participants it was evident that they tend to have less rigid boundaries relating to privacy in their homes. Sex education with their children also seems to take place less formally with a very open approach to discussing sexually-related matters with their children. A participant informed the researcher of the following: "*Ek is baie openlik met my kinders oor seks."* (I am very open with my children about sex)*. She also explained: "My seun kom sit by my in die badkamer, ons het 'n oop deur beleid in die huis.*" (My son comes and sits with me in the bathroom; we have an open-door policy in the house).

9.2.2.1.8 Sub-theme 8: Parenting style

Ruscio (2001:372) suggests that by identifying individuals's parenting styles, the psychosocial adjustment for their children can be predicted. It has been found that mother's with a history of childhood sexual abuse are more likely to present increased permissive child-rearing practices and decreased authoritative practices. A permissive parenting style is described as parents affirming their children's desires but actively avoiding shaping their child's behaviour through parental direction. They allow their children to regulate their own activities without controlling them according to their own standards of conduct (Ruscio, 2001:372).

It is argued that mothers with a history of childhood sexual abuse may find it more challenging to offer their children guidance on socialisation due to their lack of ability to provide their children with structure, clear behavioural expectations and consistent discipline. It is further suggested that as these mothers have experienced the pain of being subjected to an adult's power, they might avoid punitive parenting altogether. This can include withholding criticism and ignoring their children's misbehaviour. It is argued that these mothers lack confidence in their abilities to set limites on their children's behaviour and would therefore encourage their childen to be autonomous rather than parent-directed (Ruscio, 2001:381).

Research suggests that a history of maternal childhood sexual abuse can predict the use of physical violence and harsh parenting as a tactic for dealing with parent-child conflicts. According to DiLillo and Damashek (2003:327) it can be considered that mothers with a history of childhood sexual abuse may find it challenging to set firm hierarchical boundaries in place with their children, but that once they actually do, they may resort to rather harsh or punitive methods of disciplinary practices.

This ambivilance in the parenting style of mothers with a history of childhood sexual abuse raises concern as this again is considered a high risk for children developing attachment disorders. Unsecured attachment styles are especially evident in parent-child relationships characterised by parents displaying inconsistent and ambivalant parenting skills**. (*Please refer to risk 1).***

9.2.2.1.9 Sub-theme 9: Excessive concern that own daughter can be sexually victimised

According to Spies (2006a:74), adult survivors of childhood sexual abuse may have a desire to protect their own children against any possible situation in which abuse could take place especially their daughters. According to Berliner (2011:220) girls are at a higher risk of being sexually abused than boys but if they have lived without one of their natural parents, have a mother who is unavailable or have an unhappy family life, both boys and girls are at risk of being sexually victimised or abused.

Excessive concern over the possibility that their own daughters can be sexually abused was reflected in the following statements made by the participants:

"My grootste vrees sal waar word as my kind seer moet kry." (My biggest fear will be realised if my child is hurt).

"My boetie het 'n kondoom opgeblaas en my kind daarmee laat speel. Dit het my verskriklik ontstel. Wat as so iets met haar moet gebeur?" (My brother blew up a condom and let my child play with it. It upset me terribly. What if something like that happens to her?)

"Sy het haar bed begin natmaak en ek het gevra of iemand daar met haar gepeuter het." (She wet her bed and I asked her whether someone had interfered with her).

"Ek het vir my kind gesê, jy vertrou geen man nie, jy vertrou nie eers vir mamma nie!" (I told my child, don't trust any man, don't even trust mommy!)

"*Ek was baie erg gewees. Ek was baie oorbeskermende teenoor my kinders. Ek was baie streng gewees."* (I was terrible. I was very overprotective towards my children. I was very strict).

9.2.2.2 Risks identified

9.2.2.2.1 Risk 1: Attachment disorder

Attachment, according to Brooks (2008:55–56), is the affectional tie established between one person and another person or a child and a caregiver in the first several years of life. It profoundly influences every component of the human condition – mind, body, emotions, relationships and values. Attachment is not something that parents do to their children rather it is something that children and parents create together, in an ongoing, reciprocal relationship. A secure attachment with a responsive caretaker/parent provides a "secure base" for the infant or child to explore their environment: "Secure attachment facilitates a sense of trust and helps the young child achieve autonomy" (Hart *et al.,* 2011:133*).*

According to Ericson & Egeland (2011:113) how a parent cares for their children is strongly influenced by the care the parent received in their own childhood. A parent can't change their history but what is most important is how a parent thinks now about their own history, facing the experiences that were painful and choosing what to not repeat.

In a study conducted by Lyons-Ruth and Block (1996) the attachment styles of infants of mothers who had experienced abuse, neglect or other violence, were examined. Infants whose mothers had been exposed to childhood trauma were significantly more likely to display a disorganised attachment style, in comparison to

the other insecurely attached infants (Erickson & Egeland, 2011:111). A maternal history of childhood sexual abuse had the strongest relationship to decreased maternal involvement with infants and restricted maternal affect. These results are in general accord with a recent study indicating that decreased parental support is a specific predictor of avoidant attachment (Briere, *et al.* 2012:314).

Taking into consideration the information obtained from the participants as well as the research findings, it raises concern in respect of mothers with histories of childhood sexual abuse experiencing unique challenges relating to their ability to form healthy attachments with their children, especially female children. Kagan (2004:8–11) explain the importance of attachment as follows:

> Attachment forms the foundation of a child's future relationships, social learning and expectations. The strength of a child's attachment shapes his or her emotional regulatory system and fosters exploration and mastery, feelings of self-confidence, empathy, language development, reasoning processes and the ability to manage and resolve conflicts. The consistency of care, empathy and commitment of a parent allows the child to progress steadily through developmental stages, steadily building vital skills of self-regulation, understanding and competence.

It has to be considered that a mother with a history of childhood sexual abuse with reduced confidence in her parenting abilities may find it especially challenging forming a healthy attachment with her child, especially when the child is female and the mother has excessive concern over the possibility that she can also become a victim of sexual abuse. This can then result in attachment disorder in the child, manifesting in behaviour difficulties in the child.

In addition, single parent status, harsh punishment, low parental involvement, and child-reported depression in early adolescence predicted steeper decreases in the quality of the attachment relationship with a primary care giver from ages 11–14 (Scott *et al.,* 2013:804). This, in turn, is believed to predict greater depression and conduct disorder symptoms in later adolescence.

These factors are of concern, taking into consideration the themes identified in this research study pointing to the challenges experienced by a mother with a history of childhood sexual abuse. These challenges include difficulties in the relationships

with her intimate partner, challenges in the parent-child relationship as well as problems with overall mental and physical health.

9.2.2.2.2 Risk 2: Intergenerational effect of sexual abuse on parenting abilities

In a study conducted by Voth and Tutty (1999:37) the daughters of incest survivors perceive their mothers to be: “emotionally immature, angry, needy and passive and that they did not act to protect their daughters or enforce household rules.” According to the findings of the study, these daughters reported that they often felt like “bad” children in light of their mother’s outbursts of anger. These daughters also reported lacking good parenting skills and that they are repeating some of their own negative childhood experiences with their own children, who are the third generation.

McClosky and Baily (2000:1032) offer an alternative explanation to the intergenerational sexual abuse of children by referring to a proportion of mothers who maintain contact with the family in which they were originally abused, therefore exposing their daughters to the same risks. The general consensus from the literature is that individuals with a history of abuse in childhood are at increased risk of maltreating their own children (Egeland *et al.,* 2002:230; McCloskey & Bailey, 2000:1029). Parental risk factors include anxiety, depression, poor self-esteem, emotional problems, substance abuse and mental illness. Egeland e*t al.* (2002:229) identified poor interpersonal skills as another risk factor.

In a study conducted by Dixon *et al. (*2005:17) three risk factors are pointed out that significantly increase the risk of intergenerational abuse of children: Being a parent under twenty-one years old, having a history of mental illness or depression and residing with a violent adult. Taking into consideration the tendency of mothers with a history of childhood sexual abuse to suffer from mental health problems, including depression, and to have a high tendency to be drawn to partners with the potential to be violent, the risk of the child being abused increases significantly.

In addition, an underlying factor associated with abusive interactions between a mother and a child is the mother’s inability to form healthy adult relationships that offer both general support as well as support for parenting and child protection

(Berlin, 2011:174). Social isolation and the mother's aggressive response bias have been found to act as mediators between physical abuse and child maltreatment.

9.2.2.2.3 Risk 3: Overprotective mother influencing the social development of her children

Sexually abused children tend to be less socially competent than non-abused children and according to Berliner (2011:226) sexually abused youngsters tend to be less trusting of those in their immediate environment. This would explain the tendency of the mother with a history of childhood sexual abuse to overprotect her children. An overly-restrictive stance in parenting is considered harmful to children because they require a certain amount of mobility and freedom appropriate to their age in order to develop the autonomy and independence necessary for their healthy adjustment to life. This overprotective style of parenting can also inhibit a child's ability to separate from their mother for the purpose of exploring their immediate environment. This can have an impact on the child's ability to gain self-esteem and become more independent from their mother.

9.2.2.2.4 Risk 4: Mother-child attachment style impacting on the sexually abused child's therapeutic process and support

In a study conducted by Aspelmeier *et al.* (2007:563) results suggested that attachment security in peer and parent relationships protects against the negative effects of childhood sexual abuse. It can therefore be considered that securely attached children who have been exposed to sexual offences will be less at risk of the trauma-related symptoms of childhood sexual abuse than children who do not have secure attachments with significant people in their lives, such as their mothers. Children exposed to childhood sexual abuse that do not have secure attachments with their mothers are therefore considered to be at a higher risk of developing adverse reactions in relation to the negative consequences of childhood sexual abuse.

9.2.2.2.5 Risk 5: Male children at risk of sexual abuse

In this research the majority of the respondents did not verbalise concerns about their sons being at risk of sexual abuse because their perceptions were that it is mostly the girls who are victims of sexual abuse. In a study conducted by Dube e*t al.* (2005:436), it is evident that both boys and girls can be victims of sexual abuse.

The misconception still persists that only girls are sexually abused and boys are less prone to sexual abuse, and if involved in such cases, are more likely to be abused by female offenders (Buchanan, 2015:28). Father-son incest is thought to be even more underdiagnosed than the other types of sexual abuse, due to the fact that it aggregates several social taboos into one single problem: incest, homosexuality and paedophilia (Rind, 2001:347).

The risk of male children being at risk of sexual abuse has to be taken into account considering the general perception that they are less vulnerable than girls. It is highly likely that boys can in fact be placed in high-risk situations due to the mother's false believe that her male child is not at risk of being sexually abused. This creates the ideal opportunity for sex offenders to take advantage of the opportunity to have access to male children without raising any suspicion among their parents or the community.

9.2.3 Theme 3: Sexual abuse during childhood affecting the overall mental and physical health of the survivor

According to Spies (2006c:57) sexual activity, self-mutilation, suicide attempts and dysfunctional patterns can frequently be defined as intentionally self-destructive behaviour on the part of sexually abused children who feel guilty for the sexual abuse and who therefore try to punish themselves through self-degrading activities.

Hyu *et al. (*2014:10) point out that childhood sexual abuse seems to have contrasting interpersonal patterns such as dominant and submissive attitude simultaneously. It has been found that persons who experience sexual abuse in childhood display characteristics of domineering and controlling personalities. At the same time, they are overly accommodating, self-sacrificing and present intrusive/needy interpersonal patterns. These findings reflect the ambivalent feelings victims of childhood sexual abuse have toward others.

Evidence can also be found in numerous studies that sexual abuse in childhood has serious and longstanding psychological consequences for the survivor. It is documented that depression, suicidal tendencies, sexual dysfunction, self-mutilation, chronic anxiety, post-traumatic stress disorder, dissociation, memory impairment and somatisation are included in the long-term psychological correlates of childhood sexual abuse (Tapia, 2014:64).

The participants were asked an open-ended question relating to the impact their history of childhood sexual abuse has had on their overall mental and physical health. Various problems were identified and discussed. The problems participants identified, can be divided under the following sub-themes discussed below.

9.2.3.1 Sub-themes

9.2.3.1.1 Sub-theme 1: Mental disorders

In studies conducted by Bebbington *et al.* (2011:33) and Lotter (2006:91–93) a strong association of psychosis with childhood sexual abuse was found, especially when it involved non-consensual sexual intercourse before the age of sixteen. It is stated clearly in Zoldbrod (2015:4) that symptoms following childhood sexual abuse are more severe when the abuse is inflicted by a parent figure, when it involves penetrative sex, when it is accompanied by aggression, when there are more than one abuser and/or when it continues over an extended period. For the purpose of this study, these factors will be taken into account when identifying the occurrence of symptoms of mental health disorders among the participants.

Post-traumatic stress disorder highlights the presence of a traumatic event such as the sexual abuse of a child (Faller, 2007:221–224). Clinicians have developed awareness that post-traumatic stress disorder (PTSD) victims may have "experienced developmental interference or episodic or persistent symptomatology throughout their lives" (Faller, 2007:223). Symptoms include intrusive re-experiencing, such as flashbacks and nightmares, avoidance of situations or people associated with the event, and hyper arousal, such as alert scanning of their environment or jumpiness. The symptoms can last more than a month and may be of short duration (less than three months), chronic (more than three months), or have a delayed onset (Faller, 2007:29).

All the participants reported experiencing at least two of these symptoms since they were sexually abused as children for more than three months. Taking into consideration that all the participants are adults, this indicates that their symptoms have lasted more than three months, which can then be considered an indicator for post-traumatic stress disorder. It appears from the data obtained from the participants that an unrelated trauma can reactivate the trauma associated with their childhood sexual abuse. One participant explained: "*My man was ge-retrench en*

finansieël het dit met ons begin sleg gaan. Alles wat ek al my hele lewe uitgeblik het, het toe net opgespring. Ek het 'n oordosis pille gedrink en was baie naby aan die dood." (My husband was retrenched and things started to go very badly for us financially. Everything that I'd repressed my whole life suddenly re-emerged. I overdosed on pills and almost died).

A distinction between post-traumatic stress disorder and acute stress disorder is made by the DSM-IV classification (Coleman & Hagell, 2007:97). Children and adolescents may present with signs such as depressed mood, poor or excessive sleep, change in appetite, weight changes (usually loss), self-harm thoughts, poor concentration, lost of interest for previously enjoyable activities and/or fatigue and negative cognitions. One participant who can relate to these signs explained that she experienced severe depression during one episode in her life. She recalled: "*Ek het erge depressie gehad en was in en uit die hospital. Die psigiaters het my pille aangepas en dit maak mens nog meer deurmekaar en partymaal maak dit jou nog siek ook. Daar was weke wat en net omgeslaap het wat ek nie 'n ma vir my kinders kon wees nie."* (I had serious depression and I was hospitalised. The psychiatrists adjusted my medication, which only makes one more confused, and sometimes it makes you sick as well. I spent weeks sleeping where I could not be a mother to my children). Another participant stated: *"My sussie sê dat ek een aand op haar bed gaan sit het en vir haar vertel het wat my pa doen. Sy het toe vir die kinderhuis vertel. Ek kan dit nie onthou nie. Ek was sewe jaar oud."* (My sister says that one night I came and sat on her bed and told her what my father was doing. She told the adoption home. I can't remember it. I was seven years old).

The DSM-V (2014:1) characterises dissociative disorders by "a disruption of and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, and behaviour". None of the participants disclosed having been diagnosed with dissociative disorder before. One participant, however, explained how she has an "out of body" experience when engaging in any form of sexual activity with her husband. At least seven participants reported feeling emotionally detached during sexual activities. Feeling emotionally absent was also an experience the participants associated with certain aspects of their parenting experiences.

Mental disorders were not mentioned in the documents. Only two participants were known to mental health specialists like psychiatrists and psychologists at the time of the interviews. It therefore has to be considered that once formal assessments take place, symptoms of dissociative disorder might be identified among the participants. The researcher realises that dissociative symptoms might be present among the participants, but undiagnosed.

Due to the time elapsed between the traumatic events the participants' experienced and when the research interviews were conducted, it may be possible that the participants could have experienced such symptoms at the time but that the memories of it have become less prominent.

The existence of a post-childhood sexual abuse syndrome with an identifiable symptom profile can not be confirmed (Bulik *et al.,* 2001:448). Childhood sexual abuse is considered as a non-specific risk factor for increased likeliness that the survivor might develop psychiatric and substance use problems. It is stressed that it cannot be confirmed that certain patterns of abuse lead to psychiatric syndromes later in life.

9.2.3.1.2 Sub-theme 2: Self-esteem and locus of control

Adult survivors of childhood sexual abuse may experience a sense of powerlessness in adulthood, believing that they have no right to make decisions about personal boundaries (Spies, 2006c:63). Many abused children receive messages about their worthlessness, directly or indirectly, which they carry into adulthood (Ferguson, 2004:152; Spies, 2006b:63). Mapp (2006:1295) defines locus of control as: "a person's belief as to where the power to control their life is located: within themselves or external to their wishes and actions." In a study conducted by Porter and Long (1999) it has been found that a victim's locus of control can predict the severity of the impact of childhood sexual abuse.

The general view of the participants is that they had no control over the childhood sexual abuse they were subjected to. One participant stated: "*Niemand kan jou help nie."* (No one can help you). This participant also reported feeling often very frustrated as an adult due to still experiencing external forces controlling her life.

Another participant referred to adverse experiences she has had in her failed marriage. She commented: "*Dis asof jy nie daaroor beheer het nie.*" (It's as if you

don’t have control over it). She explained that she experienced her family unit dissolve without her having control over the process.

9.2.3.1.3 Sub-theme 3: Suicidal tendencies and suicide

The association between childhood sexual abuse and suicidality is well-documented. It is evident that survivors show a significant risk for suicide due to childhood sexual abuse being associated with psychiatric disturbance (Coleman & Hagell, 2007:98). A strong association between psychosis and childhood sexual abuse, particularly when it involves penetration, was found in a study conducted by Bebbington (2011:33).

In a study conducted by Spokas *et al.* (2009:3) the findings suggest that childhood sexual abuse may have a direct effect on suicidal ideation. Hopelessness was found to be a significant mediator between CSA and suicidal ideation. In addition, findings from a study conducted by Bagge *et al.* (2013:1) confirmed that it is only survival instinct and coping mechanisms which fully mediate the relation between hopelessness and suicide attempt.

From the data obtained from the participants, it is evident that they experience cycles of depression and reported that they feel particularly suicidal during these cycles. One participant stated: “*Ek word vir die afgelope vier jaar elk elke jaar teen Februarie opgeneem. Dit gaan dan net sleg met my want ek gaan dan in hierdie diep depressie in en dan het ek al hierdie selfmoordneigings.”* (Every year for the last four years I’m admitted to hospital. Then I don’t do well and I go into a deep depression and I have these suicidal tendencies).

One participant explained how she was rescued on several occasions by her daughter. She stated: “*Ek het die ergste goed gedoen wat ‘n impak op my dogters se lewens gehad het. Ek het ‘n oordosis pille geneem en toe geval. My dogter het van buite af gesien hoe ek in ‘n plas bloed lê en moes die venster breek om in te kom. Dit was vir haar baie traumaties.*” (I’ve done the worst things that impacted my daughters’ lives. I overdosed on pills and fell. From outside the house my daughter saw me lying in a puddle of blood and had to break the window to get into the house. It was very traumatic for her).

Another participant referred to her daughter who does not trust her and who has difficulty forgiving her following her suicide attempts. She acknowledged that these episodes must have been very traumatic for her daughter.

Very limited information was obtained from the document analysis in respect of the history of the mother relating to suicidal thoughts and feelings or attempts. It was only evident in Document A that the mother of the child concerned attempted suicide. No indication pertaining to the circumstances associated with her attempted suicide was recorded or whether she received any treatment afterwards. It is therefore unclear as to whether the attempted suicide had any direct relation to the mother's history of childhood sexual abuse.

9.2.3.1.4 Sub-theme 4: Maternal anger

It is important to note that to many survivors of trauma, anger is a logical and even adaptive response to abuse. It fosters resilience, protects self-worth and imparts a sense of mastery and control over one's environment. It has, however, been found that appropriate expression of anger is one of the most common emotional difficulties experienced by a person with a history of childhood sexual abuse. With the potential to activate aggression, it can pose a risk factor to the children of the survivor of childhood sexual abuse (DiLillo, 2000:768–775).

Trauma-related anger and aggression have been conceptualised as context-inappropriate survival responses that occur in the face of a perceived threat (DiLillo *et al.*, 2000:775). According to this view, "survival mode" functioning among sexually-traumatised women may be expressed as interpersonal aggression in an attempt to alleviate a perceived threat. Repeated abuse, particularly of an incestuous nature, plays a very important role as it can severely impair survivors' sense of self-worth, leaving them with an all-encompassing and lasting sense of helplessness. In subsequent interpersonal relationships, these chronic feelings of powerlessness are thought to manifest in an increased sensitivity to issues of control.

One participant demonstrated the anger she experience by referring to incidents involving her children's daily bathtime routines. She stated: "*Ek was baie gefrustreerd met my kinders. Ek was baie ongeduldig. As hulle gebad het, het ek gevra hulle moet uitklim. Ek sal aan hulle hare geruk het en gesê het: 'Klim uit!'"* (I

was very frustrated with my children. I was very impatient. When I bathed them, I used to ask them to get out. I would pull them by their hair and shout at them to get out).

Limited information was obtained from the document analysis in respect of maternal anger experienced by mothers with a history of childhood sexual abuse. In document C, reference was, however, made to the fact that the children were removed from the care of the biological mother due to “child abuse”. It is highly likely that this is an indication of maternal anger manifesting in the form of child abuse.

It is important to note that maternal anger mediates the relationship between childhood sexual abuse and “the potential for physically abusing their children” (DiLillo *et al.,* 2000:775). It can therefore be assumed that maternal anger is a very important risk factor that needs to be identified during any assessment or intervention process involving children of mothers with a history of childhood sexual abuse.

A mother who presents poor emotional regulation has stress management difficulties and long-term anger, is at riks of having her emotional equilibrium easily disrupted by a child’s needs, demands or misbehaviour is likely to resort to physical discipline in order to regain interpersonal control. It is further argued that mothers with a history of childhood sexual abuse is more likely to resolve parent-child conflict through applying physical discipline due to being less skilled on a number of parenting dimensions (DiLillo, 2003:324).

9.2.3.1.5 Sub-theme 5: Factors influencing the impact of childhood sexual abuse on a survivor

Some survivors of childhood sexual abuse have been found to not develop the adverse effects which have been noted in research. Several studies including Trickett *et al*. (2001:1017) have found that the effect of the abuse appears to be more severe in situations where the perpetrator was the father or father figure in the family, where penetration took place and in cases where the abuse continued for extended periods. The child’s age, coping strategies and the support received by parents and peers are also factors that have been identified as having an impact on the effect of the abuse.

From the interviews conducted with the participants, it has become evident that the participants who reported sexual abuse by a father figure, reported more complaints relating to their mental health functioning as well as confirmed continuing challenges with over-medicating or addiction. One participant explained her ongoing challenges in dealing with her incestuous relationship with her father. She stated: "*Ek sukkel om hierdie goed te prosseseer. Ek weet dit het gebeur maar ek onderdruk dit.*" (I struggle to process this stuff. I know it happened but I suppress it). Another participant explained: *"Ek het nie 'n dogter-pa verhouding met my pa gehad nie. Hy was 'n swakeling in elke opsig as pa. Hy was afwesig. En hier kom hierdie man en hy word my alles wat ek mis. Hy was soos 'n pa vir my."* (I didn't have a father-daughter relationship with my father. He was weak in every aspect as a father. And here comes this man who becomes everything that I'm missing. He was like a father for me). This participant explained how this man became a father figure in her life and sexually abused her from the age of fourteen years until she was twenty-one years old. This participant reported several suicide attempts.

Another factor influencing the impact of childhood sexual abuse on a survivor is the level of support received when disclosing the sexual abuse to her mother. This theme clearly also impacted on several sectors of the participant's lives. Please refer to sub-theme *9.2.2.1.1 The level of maternal support the sexually abused mother experienced as a child.*

Additional biological, psychological, or social factors, especially the negative family circumstances in which many sexually abused children are raised in, which may include domestic violence, other forms of maltreatment or substance abuse, should also be considered as factors contributing to the negative outcomes for survivors of childhood sexual abuse (Schmidt & Humfress, 1997:204).

Multiple types of abuse increase the risk of the survivor developing greater symptoms of depression, suicidality, low self-esteem, substance abuse, sexual difficulties, and delinquent behaviour (Arata *et al.,* 2005:47). Clemmons *et al. (*2003:762) found similar results between multiple forms of abuse and poorer psycho-social adjustment among college students.

9.2.3.1.6 Sub-theme 6: Compromised physical health

According to Irish *et al.* (2010:457) childhood sexual abuse is systematically related to higher rates of subsequent physical health symptoms, including general health, GI, gynaecologic, pain and cardiopulmonary symptoms, and obesity. These findings support previous research conducted by Thompson *et al.* (2002:1117) who found a link between the experiences of childhood sexual abuse and adverse physical health effects, which include poor perceptions of physical health. Children who have been sexually abused may be at increased risk for medical difficulties (Pollio *et al.,* 2011:267).

One participant reported waking up and experiencing spasms through her body. She believes that it is a symptom of her post-traumatic stress syndrome. A general health complaint shared by all the participants are a feeling of constant physically exhausted. Another physical factor one participant complained about was irregular menstrual cycles and recurring vaginal infections.

A participant explained how her general health has impacted on her ability to maintain a healthy bond with her children who are both male. She stated: *"My gesondheid het ons verhoudings beinvloed. Die seuns sou eerder na pa toe gaan met kwellings en klagtes want mamma het weer kopseer"* (My health influenced our relationships. The boys would rather go to daddy with issues and complaints because mommy had a headache again). Feelings of guilt have been reported by this participant. *"Die skuldgevoel slaan my want ek was nie altyd daar as hulle iets wou weet of as hulle hulp nodig gehad het nie. Mamma het al ewig nie lekker gevoel nie."* (This feeling of guilt hits me because I wasn't always there when they wanted to know something or if they needed my help. Mommy was always feeling unwell).

Another participant explained how she constantly has to rely on immune boosters to enable her to function at her optimum level. She reported experiencing continuous flu symptoms which she then treats with increased vitamin supplements. She complained about constant fatique which then limits her ability to fulfil her maternal duties towards her children.

An interesting contribution made by one of the participants was her report of her experiences being admitted to a psychiatric hospital with total burnout. According to

her, this was the first opportunity she got to access therapeutic services which addressed her experiences of sexual abuse during her childhood.

9.2.3.1.7 Sub-theme 7: Substance abuse

A familial risk factor for co-occurance of child abuse and childhood sexual abuse is substance abuse, which could potentially result in severe disciplinary practices and child abuse (Bermann & Howell: 2011:171). Parents, especially mothers, abusing substances have become a major problem in South Africa (Barth *et al.,* 2011:36). Many sexual offences are committed in families where parents, and especially mothers, abuse substances (Ncanywa, 2014:28). Women who are addicted to drugs report higher levels of self-blame for having been abused (Dufour & Nadeau, 2014:669). They also feel more stigmatised.

According to Noll e*t al.* (2003:1466) women with a history of childhood sexual abuse often numb symptoms of abuse with alcohol and drug use, which can serve to impair judgement and defensive strategies. Galaif *et al.* (2001:486) found that substance abuse is a common coping mechanism for women who have been unable to resolve trauma associated with childhood sexual abuse. Abusing substances in order to induce sleep is a common habit amongst the participants. A particular trend was identified amongst the participants to specifically increase their intake of mood stabilising and anti-depressant medicine.

A participant explained: "*Ek wil net slaap en as ek nie kan slaap nie dan drink ek pille om te slaap. Ek sal sommer tien Adcadols drink. Twee Adcadols doen niks aan my nie. Ek dink dit is omdat ek op sulke sterk medikasie is by die psigiater. Ek sal sommer 'n Xanor ekstra drink. As ek voel die dag ek kan nie cope nie, dan sal ek 'n Xanor die oggend drink en net die dag omslaap."* (I just want to sleep and if I can't sleep, then I drink pills to help me sleep. I'll just drink ten Adcadols. Two Adcadols do nothing to me. I think it's because the psychiatrist has me on such strong medication. I will also just drink an extra Xanor. If I feel I can't cope that day, I'll drink a Xanor in the morning and sleep the day away).

She added: *"As ek voel die dag dit gaan regtig nie goed nie dan sal ek vir my man sê ek gaan 'n hele Leponex drink. Dan weet hy my reaksies gaan stadiger wees. Dit is dan asof ek daardie gevoel van angs en goed heeltemal wen. Dit maak my baie rustig. Te rustig. Dit tas my spraak aan. Dit affekteer my hele menswees."* (If I feel

that the day is really not good then I'll tell my husband I'm going to drink a whole Leponex. Then he knows my reactions are going to be slower. It's then as if I then beat that feeling of anxiety and stuff. It makes me very calm. Too calm. It affects my speech. It affects my whole being). Another participant remembered: *"Ek het baie pille gedrink. Baie kalmeerpille en hoofpynpille. Ek het pille in plaas van drank gedrink. Vir baie lank in my lewe was my lewe slaap"* (I drank a lot of pills. A lot of sedatives and headache tablets. I drank tablets instead of alcohol. For a very long time, my life was just sleep).

Information obtained from Documents C and E indicates that tendencies of alcohol abuse were evident in these cases. Despite very limited information available, evidence in Document E confirms that the mother of the child concerned had previously been an in-patient at an alcohol and drug rehabilitation centre.

9.2.3.2 Risks identified

Petterson and Albers (2001:1172) point out the link between maternal mental health problems, diminished parental functioning and poor developmental outcomes for children. The identified risks are discussed below.

9.2.3.2.1 Risk 1: Child abuse

It has been found that mothers with a history of childhood sexual abuse tend to have a more negative view of themselves as a parent and are more likely to use physical methods of discipline than mothers who do not have a history of childhood abuse (Graham-Bermann & Howell, 2011:171). According to a study conducted by Mapp (2006:1306) the experience of sexual abuse in childhood alone, however, does not indicate whether a victim will potentially physically abuse her children. It is indicated that it is rather the victim's ability to resolve the trauma associated with the abuse that needs to be taken into consideration.

It is pointed out in this research that it is the level of depression and the victim's locus of control that will directly influence the risk of abuse by the mother. It is therefore argued that gaining information relating to these two factors will not only assist mothers with a history of childhood sexual abuse to resolve the trauma, but will also to assist in "lowering the risk of future child physical abuse".

Taking into consideration the findings of increased substance use amongst female victims of sexual abuse during childhood, it has to be taken into consideration that children raised by mothers who use substances excessively are almost three times more likely to be abused (Child Welfare League of America [CWLA], 2001:2). Children living in families with alcohol-abusing parents present an increased risk of a variety of other adverse childhood experiences, including being abused or neglected, witnessing domestic violence, and being exposed to drug-abusing, mentally ill, suicidal, or criminal household members (Anda e*t al.,* 2002:1001).

Hien *et al.* (2010:106) emphasise the research findings by indicating that substance-using mothers are more likely to be punitive toward their children than those without substance use disorders. They also refer to research findings indicating that substance-using mothers have been found to rely on more severe disciplinary practices. Mothers addicted to substances have also been found to be high on authoritarian involvement, with the implication that they exclude outside influences in their mothering roles in an attempt to control the child and the child's environment. In addition, DiLillo *et al.* (2000:774) found that maternal anger is a mediator in the relationship between childhood sexual abuse and the potential for victims physically abusing their children.

9.2.3.2.2 Risk 2: Child neglect

Taking into consideration that substance abuse is a common coping mechanism for women who have been unable to resolve trauma associated with childhood sexual abuse, the risk of child neglect has to be considered. It is reported that children of mothers who are addicted to alcohol or other drugs are four times more likely to be neglected (Child Welfare League of America [CWLA], 2001:2). This was reflected by a participant remembering her own childhood: "*My ma was 'n alkoholis. Sy het boyfriends gehad wat haar aangerand het en sy het voor my met hulle seks gehad. Ek dink sy is ook deur my oupa gemollesteer. Al die tekens was daar. Ons het toe geen band gehad nie en ek het alle bande met haar verbreek."* (My mother was an alcoholic. She had boyfriends who assaulted her and she had sex with them in front of me. I think she was also abused by my grandfather. All the signs were there. We had no connection then and I've broken all contact with her).

According to Douglas (2000:425) mothers with a history of childhood sexual abuse report higher levels of discomfort with the intimate aspects of parenting, such as changing diapers. It is believed that this can lead to increased neglect of their children and emotional unavailability. The risk of neglecting children's emotional needs therefore also has to be considered. One participant explained: "*Ek het gefaal daar. Ek het verskriklik gesukkel met dit. Ek het nie met hulle geraas of so nie maar ek het so in my eie wêreld weggekruip. Ek weet nie hoe om vir jou te sê nie. Hulle sou met my praat en speel maar dan is ek nie waar hulle is nie. Dan is ek op 'n ander plek. Dan sou hulle sê Mamma, Mamma, Ma!"* (I failed there. I struggled with that hugely. I didn't shout at them or anything like that but I hid away in my own world. I don't know how to tell you. They would speak to me and play but I wasn't where they were. Then I'm in another place. And they would say Mommy, Mommy, Mom!).

Neglecting children's general care needs have also been identified as a risk factor. A participant recalls a memory that entails her waking up one morning after a drug- and alcohol-fuelled party: "*Ek het een oggend wakker geword na ons die vorige aand goed geparty het. My dogtertjie het op die grond gesit en met haar eie poef speel."* (I woke up one morning after we'd partied the night before. My little girl sat on the ground, playing with her own excrement). The participant acknowledged the risks to her children's safety by stating: "*Met dwelms raak jy goed aan die slaap. Jy weet nie van jou kinders nie."* (With drugs you sleep deeply. You don't even know about your children). The participant's children were one and two years old at the time she was referring to in the interview.

An alcoholic mother's difficulty in caring for her children may be exacerbated by the coexistence of affective, personality, and thought disorders (Anda 2002:1007). The essential role of a mother is traditionally considered as the primary caretaker. When a mother is abusing alcohol, which diminishes her capacity to care for her children and to deal with household problems, household dysfunction follows.

Child neglect poses a serious risk to the child's future adjustment (Oshri e*t al.*, 2012:253). Direct paths were identified between experiences of neglect and negative home environment and alcohol or drug abuse and dependence symptoms in adolescents. In addition, multiple risk factors for exposure to HIV and sexually-transmitted diseases were identified among adolescents undergoing treatment for

substance abuse. This risk was linked to risky sexual behaviour which was also found to be associated with substance abuse problems identified in adolescents with a history of childhood neglect.

9.2.3.2.3 Risk 3: Children at risk of being placed in alternative care

According to the U.S. Department of Health and Human Services (1999:36) children from substance-abusing families are more likely to be placed in foster care and are more likely to remain in care longer than maltreated children from non-substance abusing families. Taking into consideration the high risk of abuse and neglect to the children of mothers with a history of childhood sexual abuse who engage in substance abuse, it is highly likely that they will be reported to a child protection agency and potentially removed from the care of their mother.

Only one participant, however, reported having had her children separated from her for a short period due to a private arrangement she has put in place. It would appear that further research is required in this respect to determine the likeliness of children having been removed from the care of mothers with histories of childhood sexual abuse.

In analysing Document C, evidence was obtained that the children concerned were removed from the care of their mother due to child abuse. Mothers known to welfare organisations whose children have been removed from their care have been found very resistant to participating in the research study. It has to be considered, however, that it is these mothers who will particularly benefit from intervention programmes, should they be willing to voluntarily participate. No research on this matter was found to have been conducted in the South African context yet.

9.2.3.2.4 Risk 4: Incest between siblings

Although father and daughter incest is the most frequently discussed and reported form of incest, sibling incest is believed to be the most widespread form of incest (Spies, 2006b:6–7). Crosson-Tower (2005:168) estimates that sibling incest is five times more common than parent-child incest. According to Spies (2006b:7), children will not necessarily experience intense trauma through sibling incest, but the meaning and actions that adults attach to it by means of their reactions can create or add to the trauma.

Researchers such as Crosson-Tower (2005:171–172) and Spies (2006b:8) have observed that some of the problems these siblings experienced are similar to the problems these siblings experienced in the father-daughter incest. Lack of adequate parental supervision has been identified as an important factor providing young perpetrators with ongoing opportunities to offend and protects the secret, leaving the victim vulnerable to continuing abuse (Caffaro & Conn-Caffaro, 2005). It is further pointed out by Ballantine (2012:60) that family practitioners often fail to identify sibling incest as they tend to focus on the more salient family dynamics with only superficial examination of the sibling relationship.

From the data obtained during the analysis of Document A and E, it was evident that the alleged sexual abuse recorded in the client files involved the siblings of the children concerned. In Document A, reference was made to biological siblings engaging in sexual acts with each other and in Document E reference was made to the step-brother of the child concerned as the alleged perpetrator committing a sexual offence.

9.2.4 Theme 4: Sexual abuse during childhood affecting the social life of the survivor

Extensive evidence suggests that childhood abuse can lead to difficulty with intimate relationships later in life and the formation of a secure attachment (Roche *et al.* 1999:203; Joanne & Davis, 2001:68; Hankin, 2005:667). Regarding interpersonal relationships, childhood trauma can disrupt the development of attachment to others and reflective awareness of self and others (Withers, 2013:502). According to a study conducted by Hyu *et al*. (2014:10) childhood sexual abuse seems to have contrasting interpersonal patterns such as dominant and submissive attitudes simultaneously. It was found that persons who had experienced sexual abuse in childhood displayed characteristics of domineering and controlling personalities. At the same time they are overly accommodating, self-sacrificing and present intrusive/needy interpersonal patterns. These findings reflect the ambivalent feelings victims of childhood sexual abuse have toward others.

For the purpose of this research study, participants' views relating to the impact their histories of childhood sexual abuse has had on their social life, has been explored. The identified themes are discussed below.

9.2.4.1 Sub-themes

9.2.4.1.1 Sub-theme 1: Lack of social support network

Social support is defined as: “the quantity and quality of available resources to the parent in times of need” (Mapp, 2006:1296). According to a study conducted by Mulsow e*t al.* (2002:953) a lack of social support has been found to be a predictor of parental stress. It has been suggested that a positive social support network can help alleviate the impact of other stressors.

Predicting the victimisation of children is possible when taking into consideration the childhood history of mothers who were subjected to childhood physical abuse but not neglected as children (Berlin, 2011:172). Findings suggested that this association was mediated by mothers’ social isolation and aggressive response biases.

Ruscio (2001:382) found that social support satisfaction was positively related to authoritative parenting which is considered the “optimal” style of parenting. Secure adults find it relatively easy to get close to others, they feel comfortable depending on others and don’t worry about being abandoned or having someone get too close to them (Strong *et al.,* 1998:121–122). Sexual abuse affects every aspect of the survivor’s life, including the survivor’s social life. Women who were abused during childhood are at risk of developing inadequately supportive friendships, romantic partnerships and social networks (Berlin, 2011:168).

Before a survivor of sexual abuse can trust anyone, they need to know that they are accepted as a person of worth and that they have to make peace with their guilt feelings and develop their self-worth (Lotter, 2006:94). There is no recipe to be followed during the therapeutic process and because control had been taken away from the survivor during the sexual abuse, they need to feel in control of their own lives (Lotter, 2006:95). Before this happens they can’t expect to have social network support.

During an interview with one of the participants, she said: *“Ek stel nie belang daarin om vriendinne te hê nie. Ek laat nie mense naby my toe nie.”* (I’m not interested in having friends. I don’t allow people near me). Another participant stated: “*Ek het nie naby vriende nie. As ek alleen is, is ek veilig. Ek soek privaatheid en veiligheid.”* (I don’t have close friends. When I’m alone, I’m safe). There is a higher risk of abuse

occurring in families who are socialy isolated with little social support available to them. In contrast, parents such as mothers who have access to a positive social support network have been found to be more positive in their interactions with their children (Daro, 2011:24–25).

In light of the research findings, it has to be considered that their lack of intimate relationships and social support systems could potentially decrease their ability to support and protect their own children. Engaging such women in therapeutic interventions which will improve and enhance their interpersonal skills can therefore be considered as an effective intervention strategy.

9.2.4.1.2 Sub-theme 2: Lack of respite for the mother

A participant explained that she will not consider leaving her four month old baby daughter in the care of anybody without her being present. She stated very clearly: "*Ek vertrou niemand by my kind nie."* (I trust no one with my child). The same participant however acknowledged how she very often feels tired and irritable and needs a break from her baby. She said: "*Ek kort 'n break maar ek sien nie kans om haar onder my oë te laat uitgaan nie."* (I need a break, but I can't have her anywhere I can't see her).

Upon exploring with this participant the methods she applies when not feeling able to cope with her baby, she replied: "*Ek sit haar neer en loop weg van haar af. Ek gaan terug na haar toe wanneer ek asem geskep het."* (I put her down and walk away from her. I return to her when I've been to get some air). She confirmed that this meant leaving her baby crying and unattended until she feels in control again. This participant was observed by the researcher getting increasingly annoyed with her baby who remained unsettled for the duration of the interview.

9.2.4.2 Risk identified

9.2.4.2.1 Risk 1: Child abuse and child neglect

Lack of sufficient opportunity for respite has been identified as a risk for children of mothers with a history of childhood sexual abuse (Erickson & Egeland, 2011:103–106). The distrust in others and the need to protect their children from risk is so strong that this can potentially put their children at risk of abuse and neglect. It has to be considered that a mother will rather choose to leave her children unsupervised

at home whilst running errands than entrusting them to another person. It is also concerning that a mother lacks the necessary capacity to attend to her child's basic and emotional care needs in a case where the mother presents with mental health problems and additional substance abuse problems.

In addition, Berlin (2011:174) confirms that social isolation is an underlying factor associated with abusive interactions between a mother and a child. The risk of becoming socially isolated is mainly due to the mother's difficulties to form healthy adult relationships that offer both general support as well as support for parenting and child protection. Social isolation and the mother's aggressive response bias have therefore been found to act as mediators between physical abuse and child maltreatment. It has to be considered that without sufficient social support, a mother with a history of childhood sexual abuse who has not received any form of therapy in respect of dealing with anger issues is likely to have great difficulty attending to the basic care needs and socio-emotional needs of her children.

9.2.5 Theme 5: Measures that can be taken to empower mothers with a history of childhood sexual abuse with parenting skills

Zoldbrod (2015:3) states that to date no empirically proven guidelines have been offered for treating women who have been sexually abused during childhood or during adolescence. Sexual abuse is described as a complex life experience, not a disorder or diagnosis (Putnam, 2003). It therefore leaves therapists and clinicians in a position where the symptoms of childhood sexual abuse are addressed in order to alleviate the impact it has on the person's general functioning.

Van Veen *et al.* (2013:242) indicate that specific types of childhood trauma might cause specific symptoms in an individual with specific vulnerabilities. According to the cognitive-behavioral approach, the type of emotion experienced by the person is influenced by thought and belief contents activated by various types of childhood experience (Luby *et al.* 2014:774). Depression is considered to be characterised by loss and self-deprecation, whereas anxiety is related with threat and danger (Etian *et al.* 2013:995; Javorska e*t al.* 2014).

The coping strategy used by victims of childhood sexual abuse can impact, to a lesser or greater extent, how likely the individual is to develop post-traumatic stress disorder (Canton-Cortès & Canton, 2010:504). It has been found that reducing

avoidance-type strategies such as denial, distancing and disengagement “appear to have a beneficial effect” (Canton-Cortès & Canton, 2010:504).

A number of studies have suggested that positive coping styles predict better emotional adjustment and decreased risk for revictimisation for women with histories of childhood sexual abuse (Gibson & Leitenberg, 2001:1358). Tapia (2014:70) highlights that it is very important for clinicians working with sexual violence survivors to be aware and sensitive to their patient’s unique concerns. It is considered very important to understand the ways survivors of childhood sexual abuse cope with the effect of it in order to halt the patterns that may lead to re-victimisation.

The participants were asked a question on the type of intervention they deem necessary for addressing childhood sexual abuse. Their recommendations are summarised below.

9.2.5.1 Sub-themes

9.2.5.1.1 Sub-theme 1: Individual therapy

Taking into consideration the information obtained from the interviews conducted with the participants, a general view was identified that individual therapy can be beneficial to victims of childhood sexual abuse. A general perception identified among the participants is that talking about your experiences of childhood sexual abuse brings about some level of relief. According to Lotter (2006:93) when a couple go for counselling and the counsellor becomes aware that one of the partners had been sexually abused, individual therapy must first be offered to the sexually abused partner.

From the participants’ responses it has, however, become evident that a victim of childhood sexual abuse will require a high level of motivation before being willing to engage in individual therapy. A participant responded to the question by stating: *“’n Mens voel verskriklik skuldig en skaam. Dit vat baie om daaroor te begin praat.”* (One feels terribly guilty and ashamed. It takes a lot to begin speaking about it). Another participant offered her view by stating: “’*n Mens wil eintlik nie terapie deurgaan nie, jy wil nie ‘n label hê nie.*” (One doesn’t really want to undergo therapy; you don’t want a label). She added: “*Jy wil dit beskerm, niemand mag daarvan weet nie.”* (You want to protect it; no one must know about it).

Participants' answers to the question relating to measures that could be taken to empower mothers with a history of childhood sexual abuse with parenting skills, reflects that however difficult a step acknowledging childhood sexual abuse and disclosing it is, it must be undertaken. One participant stated: "*Jy moet jouself vry spreek.*" (You must speak yourself free). She referred to the process during which she forgave herself and addressed her self-blame. She also added: "*Jy moet baie praat daaroor, hoe meer hoe beter.*" (You must speak about it; the more the better). This response was echoed by several other participants who referred to the self-blame they experience and their wish to be free from it.

The overall opinion of the participants is that individual therapy is an essential part of the healing process as this will offer an opportunity for trauma integration. High levels of resistance to engage in such a process were not particularly noted in any of the participants. It is, however, evident that the general opinion among the participants is that it can be particularly challenging for a victim of childhood sexual abuse to initially request individual therapy and that such a person might only get the opportunity to access therapy following a personal crisis.

Loeb *et al. (*2011:12) suggested that it is not possible to place survivors of childhood sexual abuse into categories. However, understanding where childhood sexual abuse survivors fall on a continuum of childhood sexual abuse experiences may be helpful in designing treatment options for these women.

A participant explained that she first came into contact with a therapist following her admission to a hospital due to general burnout. She explained: "*Ek was nege en twintig jaar oud toe ek opgeneem is met burnout. Daar het ek my eerste disclosure gemaak.*" (I was 29 years old when I was admitted for burnout. There I made my first disclosure). She offered a very negative view of her experience by explaining that the psychologist suggested that she must forgive the perpetrator. She remembered: "*Die sielkundige het voorgestel, 'Hoekom was jy nie sy voete nie?*'" (The psychologist suggested, 'Why don't you wash his feet?') She explained that this made her feel even more out of control and "*inferior*".

Feiring e*t al*. (2002:90) points out that a survivor of childhood sexual abuse remains at risk of being retraumatised depending on the nature of the response she receives. Should she be met with a dismissive or non-protective response, her

previous trauma can be relived. This should be kept in consideration by the therapist when engaging the survivor in individual therapy.

According to Lotter (2006:94) one of the principles in therapy with a survivor of sexual abuse is not to judge because: “before they can trust, they need to know that they are accepted as people of worth…”. Focusing on developing and improving interpersonal skills should therefore be given considerable focus during individual therapy. As trusting others poses an extreme challenge for mothers with a history of childhood sexual abuse, trust issues can most likely be addressed once interpersonal skills have been improved.

Taking into consideration the research findings of Bagge *et al.* (2014:28), it is evident that it is of very high importance that individual interventions with mothers who have a history of childhood sexual abuse, specifically focus on assisting them with developing coping and solution focused skills. This is deemed crucial in view of research evidence suggesting that these skills mediate the link between feelings of hoplessness and suicide attempts.

9.2.5.1.2 Sub-theme 2: Group therapy

The participants, in general, responded positively with respect to considering the possibility of joining a therapeutic group. It also became evident that the participants view a group setting as less threatening than individual therapy. According to Masson *et al.* (2012:491) the chance to speak openly about their experience in a supportive environment often helps survivors to gain courage to work more productively in their individual therapy sessions. It is, therefore, likely that group therapy will enhance the participants’ capacity to engage in individual therapy.

For most counsellors, leading counselling and group therapy is the most difficult but also the most rewarding of all therapy (Masson *et al.,* 2012:384). In therapy groups, members come together to solve their problems, to change their behaviour, to cope with personal problems or to rehabilitate themselves after physical, psychological or social trauma (Toseland & Rivas, 2012:25). Survivors of sexual abuse are likely to benefit from one or two kinds of groups, namely support or therapy groups (Masson, 2012:491). These groups provide an opportunity for the survivors to speak of their pain for perhaps the first time and because of the group they have the ability to share it with others who have also been victimised as a child or adolescent.

All the participants agreed that group therapy will be beneficial to them personally and will also benefit other victims of childhood sexual abuse. From the information obtained from the participants it is, however, evident that they question the willingness of other survivors of childhood sexual abuse to join such a group.

A participant explained: "*Hoe gaan jy vrouens kry om deel te neem? Jy voel vuil en jy gaan bang wees mense dink dit was jou skuld.*" (How are you going to get women to participate? You feel dirty and you're going to be scared that people think it was your fault). Another participant stated*: "Mense is skaam"* (People are embarrassed). A suggestion offered by a participant was to invite women to a group session that focuses on a broader theme, such as childhood trauma. Once the group has convened, the theme of childhood sexual abuse can be introduced as one of the topics.

9.2.5.1.3 Sub-theme 3: Couples therapy

Nasim and Nadan (2013:1) propose a clinical practice for therapy with couples in which one partner suffered sexual abuse in childhood. Taking into consideration that these couples often encounter unique difficulties with physical contact, intimacy, sexuality, communication and trust, the risk of separation leading to breakdown of the family unit is substantially high. Nasim and Nadan go on to point out that the relationship dynamics may be marked by re-enactments of past traumatic relational patterns which will also contribute to the potential breakdown of the relationship.

It is argued that the therapeutic process allows the survivor's partner the opportunity to witness the trauma's effect on the survivor's personal life and relationship. The partner's presence also facilitates acknowledgement of what happened to the survivor, and helps the survivor elaborate on her stories of resistance, survival, and strength. It is proposed that this practice can help break the cycle of traumatic re-enactment and help the survivor integrate the events of her life into a more coherent, continuous narrative.

9.2.5.1.4 Sub-theme 4: Parental guidance through parenting groups

There is a need for more information on empowering parents with parenting skills and strategies that would enable them to minimise the risk of their children being physically or sexually abused (Colman & Hagell, 2007:24; Ncanywa, 2014:46;

Nqaphi, 2013:42). Parents should be empowered with skills and knowledge about the importance of being self educated as well as educating their children regarding sexual abuse (Buchanan, 2014:50). The participants reported an increase in their self-esteem as well as their capacity to become more actively involved and protective in their relationships with their adolescent daughters due to the positive effects they experience from a combination of counselling, parent education, literature and parenting groups.

One of the main goals of such parenting groups would be to develop healthy parent-child communication in order to foster an environment in which children feel comfortable sharing information with their parents (Wang, *et al.,* 2014:501).

9.2.5.1.5 Sub-theme 5: Attachment therapy for mothers and their children

Cavanaugh *et al.* (2015:520) acknowledge that individual therapy focusing on improving affect and interpersonal relationships may be effective in alleviating the negative impact on childhood sexual abuse, however, they support findings by Suchman et al. (2010:520) who found attachment-based parenting interventions may help survivors who are mothers with some of the parenting difficulties, including strengthening their attachments with their children and expressing more affection.

10. RESEARCHER'S OBSERVATIONS

The researcher observed that the participants all reported unique experiences relating to their attempts to integrate the trauma associated with their childhood sexual abuse. Various emotions and views were observed and recorded during the interviews conducted. This alone, points to the complexity of considering the intervention required for a victim of childhood sexual abuse.

It is evident that a significant need exists in the field of child protection to assess the risk to the child who has a mother with a history of childhood sexual abuse considering the possible risks identified in this study. However, prior to being able to do that, greater focus needs to be on making practitioners aware of the importance of identifying mothers with histories that include childhood sexual abuse. It is not evident that this matter currently receives particular interest or attention during the intake and assessment processes conducted by social workers and family practitioners.

11. SUMMARY

The findings of this particular research study revealed the following:

- It is evident that upon intake and during the initial assessment process, the mother's history of sexual abuse is not recorded in the majority of the cases or reported to non-governmental welfare organisations who participated in this research study. It has to be considered that the reason for this is possibly due to the mothers not disclosing their sexual abuse histories voluntarily as well as the likelihood that the mother's sexual abuse history is not nessecarily enquired about by the social worker dealing with the case. Non-exploration of such an important factor can potentially lead to inaccurate assessments and ineffective intervention strategies.
- Taking into consideration research conducted on the impact of childhood sexual abuse, there is abundant evidence to confirm that it can have serious implications on a mother's physical, emotional and social well-being in adulthood. It is evident from the available research findings that childhood sexual abuse serves as an important etiological factor in the development of later parenting difficulties.
- As the effects of sexual abuse on a child are all-encompassing it has significant implications for many aspects of the female adult survivor's life. It is evident from this research study that it negatively affects her interpersonal relationships with her intimate partner, her parenting abilities and, consequently, her relationship with her children, her mental and physical health, as well as her social life.
- Certain factors increase the severity of the effect of the sexual abuse on the mother. It is evident that the negative impact of the sexual abuse escalates dramatically if the perpetrator was a trusted parent figure, if the abuse continued for extended periods, if maternal support was lacking or not available as well as the nature of the abuse, such as penetration.
- The intimate partner relationship is often characterised by challenges relating to the sexual relationship between the survivor of childhood sexual abuse and her partner as well as a significant risk of intimate partner conflict and possible domestic violence. Should these issues remain unresolved, there is a high

likelihood of the family system breaking down with negative consequences for the child.

- The risks involved for the child concerned relating to his or her mother's difficulties associated with her intimate partner relationship includes incest between the child and the father figure and/or siblings. It is also considered as a risk that the child's traditional family unit can be disrupted by a separation or divorce of the parental unit and that domestic violence is likely to occur. The dynamics relating to the general functioning of a mother with a history of childhood sexual abuse escalates the potential for children to be subjected to parental alienation and sexual allegations in divorce. These two factors are also considered as risks to the child of a mother with a history of childhood sexual abuse.
- The survivor of childhood sexual abuse experiences specific challenges in the parent-child relationship with her children. Lacking maternal support as a child proves to be a critical factor in the survivor's ability to trust other people later in her life. It also has a significant impact on her mental health as it can increase the prevalence of depression and other mental health problems.
- Strong evidence was obtained from the research study that mothers with a history of childhood sexual abuse experience significant difficulties in developing a secure attachment with their female children. This stems from over-identification with their daughters and the fear that they could also become victims of sexual abuse. The risk of the child therefore developing an attachment disorder becomes a concern as this will impact on the child's ability to form meaningful relationships in her life.
- Despite the lack of secure attachment, mothers were, on the other extreme, found to be overly protective of their daughters and less concerned over the safety of their sons. This potentially places their daughters at risk of not getting opportunities to develop on a personal and social level. The concern is also that their sons are at increased risk of sexual abuse due to this false perception.
- Evident from the research is that the parent-child attachment style can have a considerable impact on the therapeutic outcome of the sexually abused child. It is apparent that a mother with a history of childhood sexual abuse can have a

positive impact on the outcome of her child's therapy, depending on the level of support she offers the child and the extent to which she has been able to resolve her own trauma.

- It is agreed by various researchers that a history of childhood abuse predisposes a person to repeating the learned dysfunctional patterns as a parent. Poor mental health, substance abuse and poor interpersonal skills have been identified as parental risk factors which could alleviate the risk for child maltreatment. Positive social support and conducive home environments have been identified as protective factors which can counteract intergenerational child abuse.
- Sexual abuse in childhood has serious and longstanding psychological consequences for the survivor which can, under certain circumstances, develop into specific mental health problems which consequently can have adverse consequences for her children.
- Depression is the most frequently reported mental health problem of survivors of childhood sexual abuse. It is evident that when the survivor's self-esteem is low and she has a strong external locus of control, her depression and feelings of hopelessness will be exacerbated and the risk for suicide increases.
- Risk of mental illness, drug abuse, and suicide attempts in the household were the strongest when the mother was an alcoholic. The secondary problems stemming from alcohol abuse by the mother with a history of childhood sexual abuse becomes even more evident and the risk of child abuse and neglect escalates significantly. This places the child of a mother with a history of childhood sexual abuse at significant risk of being removed from the mother's care and placed in alternative placement.
- A mother's history of childhood sexual abuse is not necessarily an indicator of whether her children will be at risk of abuse and/or neglect. Rather, the extent to which the mother has been able to resolve her own trauma is considered a crucial factor to be taken into account when assessing the risk of child abuse in respect of her children. The level of maternal anger is considered the factor that will likely determine whether a risk to the child exists to be abused.

- Having access to a positive social support network has been shown to reduce the risk of negative parenting outcomes and consequently benefit the child of the mother with a history of childhood sexual abuse.
- It is evident that mothers who are currently known to a welfare organisation show the highest level of resistance towards participating in research studies. Mothers who are not known to welfare organisations are still hesitant to participate in research but by far less resistant. Mothers who had access to therapeutic services and positive social support systems are the most willing to give their consent to contribute to research studies.
- Limited research has been conducted in the South African context that focuses on exploring the impact of the mother's history of childhood sexual abuse on her children. Consequently, no evidence has been found by the researcher that interventions have been developed to address the risks posed to children born from mothers who have been sexually abused during childhood. This could contribute to the lack of awareness in respect of this matter observed among social workers and family practitioners responsible for child protection services.

12. RECOMMENDATIONS

In view of the information obtained from this study, the following recommendations are proposed:

- Practitioners, including psychiatrists, psychologists and especially social workers, should be informed of the extensive effect childhood sexual abuse can have on the general functioning of the adult survivor. These practitioners should be offered the necessary training which will enable them to apply effective assessment methods to obtain relevant information relating to the mother's background history.
- Relevant training should be offered to those practicioners involved with assessment procedures, investigations and therapeutic services which involve children of mothers with a known history of sexual abuse. The risks involved for children of mothers who were exposed to sexual abuse during childhood should be highlighted during training opportunities. Training should also highlight why some children of mothers with a childhood history of sexual abuse are more at

risk than others. The protective factors impacting on the risks involved for children should receive specific attention during training opportunities as this can assist the practitioner to plan effective intervention strategies.

- Further research must be conducted to explore and identify the reasons behind the high resistance noted especially in mothers with a history of childhood sexual abuse who are known to welfare organisations. General resistance from mothers not known to welfare organisations can also be explored.
- Mothers with a history of sexual abuse and who have been identified to have unresolved trauma should be encouraged to engage in individual therapy. Therapy should specifically focus on the mother's adult attachment difficulties. A therapeutic process can also focus on enhancing the mother's self-esteem and internal locus of control which will have a direct positive influence on her mental health and thereby reduce the risk of suicidal tendencies. Maternal anger should be identified and treated appropriately if found to be present in the mother. The mother's coping mechanisms should be identified during therapy and dysfunctional coping patterns, which include substance abuse, should be addressed.
- Group therapy should focus on engaging the mother in group discussions focusing on sharing traumatic experiences within the secure context of the group. Group discussions can also focus on addressing challenges related to parenting. Parental guidance can be offered within the group context. Challenges experienced within the intimate partner relationship can also be addressed in group therapy. Couples will be able to share their challenges and successes in the group.
- Couples therapy should be accessible to survivors of childhood sexual abuse and their intimate partners. In this context the survivor's trauma can be witnessed by her intimate partner, which in turn will offer her a sense of validation of her trauma associated with her abusive childhood experiences. It will also foster an increased understanding of the survivor's experiences and challenges relating to several aspects of the intimate partner relationship which may include the sexual relationship.

- Anti-natal classes can serve a very important purpose in that this could create an opportunity to identify mothers with a history of childhood sexual abuse. The risk factors can then be assessed and addressed prior to the mother giving birth.
- Protocols can be developed and put in place in hospitals to identify mothers with histories of sexual abuse who give birth to female children. These mothers should be offered specific instructions and guidance on how to care for their newborn baby daughters on a physical and emotional level. Special care should be taken to encourage them to bond with their babies as soon as possible in order to encourage the parent-child attachment process.
- Attachment therapy between the mother and her children should be strongly considered as intervention strategy in cases where dysfunctional dynamics and patterns are manifesting and observed in the mother-child interaction. The extent to which the mother has been able to integrate the trauma she associates with her adverse childhood experiences should, however, be considered before this form of therapy is commenced with. Role-reversal in the parent-child relationship should be identified and addressed accordingly during this form of therapy.
- Mothers with an identified history of childhood sexual abuse who present with unresolved trauma, challenges in her relationships with her intimate partner and children, and mental health problems which places her children at risk of abuse and neglect should be registered as clients at the relevant non-governmental welfare organisations for the purpose of having access to prevention services.
- Further research should be conducted in the South African context in order to explore the factors leading to the deterioration of the intimate partner relationship involving the mother with a history of childhood sexual abuse and the subsequent breakdown of the family unit.
- Research should be conducted in order to explore the link between children being placed in alternative care and their mothers' history of childhood sexual abuse in the South African context.
- Exploring the matter relating to mothers with a history of childhood sexual abuse being at increased risk to be reported to child protective services should be

done by means of further research studies conducted in the South African context.

- Current research findings pointing to difficulties in the mother-child attachment relationship that relates to the consequences of the childhood sexual abuse history of the mother, can be further researched, which will enable the development of effective prevention and intervention strategies.

13. CONCLUSION

This research study aimed to explore psycho-social risk factors for children of mothers with a history of childhood sexual abuse. It is evident from this study that such risks indeed exist. These risks specifically involve the welfare and safety of the children concerned and therefore ultimately pose a risk to their stability during childhood.

Concern is raised in respect of the level of awareness among social workers and family practitioners of the risks posed to children born from mothers who were sexually abused as children. Further research being conducted in South Africa will increase the level of awareness among professionals and equipped them with the necessary knowledge to assess and intervene effectively. The researcher trusts that this study will generate opportunities for further research to be conducted and for information to be disseminated among practicioners dedicating their lives and career paths to changing adversity in the lives of children considered to be at risk.

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SECTION B

ANNEXURES

ANNEXURE 1: ETHICAL APPROVAL

NORTH-WEST UNIVERSITY
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Tel: 018 299-1111/2222
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Dr AA Roux
Social Work

Faculty of Health Sciences
Tel: 018-299 2092
Fax: 018-299 2088
Email: Minrie.Greeff@nwu.ac.za

28 October 2014

Dear Dr Roux

Ethics Application: NWU-00027-09-A1 "The development and evaluation of programs and a protocol in Forensic Social Work"

Thank you for the amendments made to your application. All ethical concerns have now been addressed and the sub-study "Identifying psycho-social risk factors for children of mothers who were sexually abused in childhood" has been approved by the Health Research Ethics Committee for inclusion under the umbrella project until 30 June 2015.

Yours sincerely

Prof Minrie Greeff
Health Research Ethics Committee Chairperson

Original details: Prof Minrie Greeff(10187306) C:\Users\13210572\Documents\ETIEK\2009 ETHICS\NWU-00027-09-A1 (AA Roux-S Appelgryn) - Approval letter.docm
28 October 2014

File reference: 9.1.5.3

ANNEXURE 2: LETTERS GRANTING PERMISSION TO CONDUCT RESEARCH AT THE NON-GOVERNMENTAL ORGANIZATIONS

The Cradle of Hope

NPC Number 2007/030236/08
NPO Number 062-511-NPO • PBO Number 930 027 742
VAT Number 4760248593

P.O. Box 2648
NOORDHEUWEL, 1756
SOUTH AFRICA

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Krugersdorp West, Gauteng
SOUTH AFRICA

"BE THE DIFFERENCE"

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Fax : +27 86-528-9917

E-mail : admin@thecradleofhope.org
Website : http://www.thecradleofhope.org

To Whom It May Concern: 02 January 2015

We hereby confirm that Sandri Appelgryn, student number 11746297 has permission to conduct research on our premises and with the residents who agree to participate, for the Masters degree in Forensic Practice on the topic: Identifying psycho-social risk factors for children of mothers who were sexually abused in childhood.

We support her fully and will do anything in our power to be of assistance in all regards.

MELODIE VAN BRAKEL
CEO: THE CRADLE OF HOPE

TEDDY BEAR CLINIC
FOR ABUSED CHILDREN

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Child Health and Development
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Soweto:
Tel: (011) 980-8160/8873

Diversion Programme:
Tel: 079 374 4401
Krugersdorp:
Tel: 071 736 3989
Soweto:
Tel: 060 865 2097
Johannesburg:
Tel: 083 392 8100

www.ttbc.org.za

24th August 2015

Dear Sir/Madam

Permission for Sandri Appelgryn to conduct research at The Teddy Bear Clinic

This letter serves to confirm that Sandri Appelgryn has been granted permission to conduct her research on data that has been collected at The Teddy Bear Clinic for Abused Children.

If you would like any further information, please contact me via any of the details listed below.

Yours Sincerely,

Shaheda Omar
Clinical Director
shahedao@ttbc.org.za
011 484 4554

ANNEXURE 3: WRITTEN CONSENT OF PARTICIPANTS

CONSENT FORM OF PARTICIPANT

PARTICIPATION IN THIS RESEARCH IS VOLUNTARY

You are free to decline to be in this study, or to withdraw at any point even after you have signed the form to give consent, without any consequences.

This study is approved by the Health Research Ethics Committee (HREC) of the Faculty of Health Sciences of North-West University.

Should you be willing to participate you are requested to sign below:

I, _____ hereby declare that

- The researcher, Sandri Appelgryn, provided me with writing information in respect of the purpose of the research study as well as my participation in it.
- I have read and understood the information given in the written informed consent form for abovementioned study.
- I was given the opportunity to consider the information, ask questions about it and have had them answered satisfactorily.
- I voluntarily agree to participate in the research study and that I understand that I can withdraw from the research study at any time without having to give a reason.
- I have been informed that Sandri Appelgryn will make use of a tape recorder to record the interview that will be conducted with me.
- I have been informed that Sandri Appelgryn will make notes during the interview conducted with myself.
- I have given consent that Sandri Appelgryn may have access to my client file kept at the relevant welfare organisation.

- I have been informed that I will not receive any compensation for my participation in the study.
- I was informed that I will have access to debriefing sessions should it be required by me.
- I understand that the data gathered from this study will be accessible to other professionals at the North-West University and that the results will be published.

I hereby voluntarily agree to participate in the research study.

_____ _____

Signature of Participant Date

_____

Participant's Name

_____ _____

Signature of Researcher Date

ANNEXURE 4: INTERVIEW SCHEDULE

RESEARCH TITLE: Identifying psycho-social risk factors for children of mothers who were sexually abused during childhood

INTRODUCTION

The undersigned social worker is conducting a research in order to identify psycho-social risk factors for children of mothers who were sexually abused during childhood.

This social work research study aims to identify psycho-social risk factors for children of mothers with a history of childhood sexual abuse. By obtaining information from such mothers, the social worker working in the field of forensics will gain a better understanding of the extent to which a mother can potentially place her child at risk of being sexually abused.

IDENTIFICATION PARTICULARS

1. **TABLE 1: AGE OF PARTICIPANTS**

AGE	FEMALE
20-30	
31-40	
41-50	
51-60	
Above 60	

2. **TABLE 2: GENDER OF PARTICIPANTS' CHILDREN**

Participant	Gender of children	
	Female	Male

3. **TABLE 3: MARITAL STATUS OF PARTICIPANTS**

Participant number	Marital status	Family composition

4. How did the sexual abuse during your childhood affect your relationship with your spouse/partner?
5. How did the sexual abuse during your childhood affect your relationship with your children?
6. Please describe your overall mental and physical health?
7. How did the sexual abuse during your childhood affect your social life?
8. How do you ensure your child's safety in your absence?
9. What can be done to assist mothers who are survivors of sexual abuse during childhood, to empower them with skills as parent?

ANNEXURE 5: CONFIDENTIALITY AGREEMENT

NORTH-WEST UNIVERSITY
YUNIBESITI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT

CONFIDENTIALITY UNDERTAKING

entered into between:

I, the undersigned

Prof / Dr / Mr / Ms _____

Identity Number:_____

Address:_____

hereby undertake in favor of the **NORTH-WEST UNIVERSITY**, a public higher education institution established in terms of the Higher Education Act No. 101 of 1997

Address: Office of the Institutional Registrar, Building C1, 53 Borcherd Street, Potchefstroom, 2520

(hereinafter the "NWU")

1 Interpretation and definitions

1.1 In this undertaking, unless inconsistent with, or otherwise indicated by the context:

1.1.1 "Confidential Information" shall include all information that is confidential in its nature or marked as confidential and shall include any existing and new information obtained by me after the Commencement Date, including but not be limited in its interpretation to, research data, information concerning research participants, all secret knowledge, technical information and specifications, manufacturing techniques, designs, diagrams, instruction manuals, blueprints, electronic artwork, samples, devices, demonstrations, formulae, know-how, intellectual property, information concerning materials, marketing and business information generally, financial information that may include remuneration detail, pay slips, information relating to human capital and employment contract, employment conditions, ledgers, income and expenditures and other materials of whatever description in which the NWU has an interest in being kept confidential; and

1.1.2 "Commencement Date" means the date of signature of this undertaking by myself.

1.2 The headings of clauses are intended for convenience only and shall not affect the interpretation of this undertaking.

2 Preamble

2.1 In performing certain duties requested by the NWU, I will have access to certain Confidential Information provided by the NWU in order to perform the said duties and I agree that it must be kept confidential.

2.2 The NWU has agreed to disclose certain of this Confidential Information and other information to me subject to me agreeing to the terms of confidentiality set out herein.

3 Title to the Confidential Information

I hereby acknowledge that all right, title and interest in and to the Confidential Information vests in the NWU and that I will have no claim of any nature in and to the Confidential Information.

4 Period of confidentiality

The provisions of this undertaking shall begin on the Commencement Date and remain in force indefinitely.

5 Non-disclosure and undertakings

I undertake:

5.1 to maintain the confidentiality of any Confidential Information to which I shall be allowed access by the NWU, whether before or after the Commencement Date of this undertaking. I will not divulge or permit to be divulged to any person any aspect of such Confidential Information otherwise than may be allowed in terms of this undertaking;

5.2 to take all such steps as may be necessary to prevent the Confidential Information falling into the hands of an unauthorised third party;

5.3 not to make use of any of the Confidential Information in the development, manufacture, marketing and/or sale of any goods;

5.4 not to use any research data for publication purposes;

5.5 not to use or disclose or attempt to use or disclose the Confidential Information for any purpose other than performing research purposes only and includes questionnaires, interviews with participants, data gathering, data analysis and personal information of participants/research subjects;

5.6 not to use or attempt to use the Confidential Information in any manner which will cause or be likely to cause injury or loss to a research participant or the NWU; and

5.7 that all documentation furnished to me by the NWU pursuant to this undertaking will remain the property of the NWU and upon the request of the NWU will be returned to the NWU. I shall not make copies of any such documentation without the prior written consent of the NWU.

6 Exception

The above undertakings by myself shall not apply to Confidential Information which I am compelled to disclose in terms of a court order.

7 Jurisdiction

This undertaking shall be governed by South African law be subject to the jurisdiction of South African courts in respect of any dispute flowing from this undertaking.

8 Whole agreement

8.1 This document constitutes the whole of this undertaking to the exclusion of all else.

8.2 No amendment, alteration, addition, variation or consensual cancellation of this undertaking will be valid unless in writing and signed by me and the NWU.

Dated at Potchefstroom this _____ 20____

Witnesses:

1 .....

2 ....

(*Signatures of witnesses*) (*Signature*)