

**A STRUCTURED PLAY THERAPY INTERVENTION MODEL TO  
MITIGATE THE EFFECTS OF CHILDHOOD SEXUAL ABUSE**

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## ABSTRACT

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### A STRUCTURED PLAY THERAPY INTERVENTION MODEL TO MITIGATE THE EFFECT OF CHILDHOOD SEXUAL ABUSE

**Keywords:** Structured Play Therapy, Model, Sexual Abuse

The goal of the study is to develop a structured play therapy intervention model to mitigate the effect of childhood sexual abuse. South Africa has one of the highest prevalence rates for child sexual abuse, and professionals working with children are consequently faced with the phenomenon on an increasing scale. Many professionals find themselves ill-equipped to address the effect of sexual abuse on the child, and the lack of an integrated understanding of the phenomenon seems to exacerbate this need. In order to effectively address the effect of sexual abuse on the child, professionals need a holistic understanding of this phenomenon and its effects, as well as a clear outline of the necessary interventions.

The thesis consists of five sections, which can be outlined as follows:

**Section A** consists of the problem statement, the research questions, the research objective, the general theoretical assumption and the theoretical approach. It includes the research methodology, the limitations of the research, definitions of the key terms and the selection and structure of the dissertation. The research focused on the following specific objectives stemming from the problem statement:

- To conduct a thorough literature study on various aspects pertaining to childhood sexual abuse in order to form a holistic, well-researched perspective on the phenomenon of childhood sexual abuse and the available evidence-based interventions in the sexual abuse of children;
- To develop a structured play therapy intervention model to mitigate the effect of childhood sexual abuse;

- To subject the prototype of the proposed intervention model to peer review in order to determine its strengths and weaknesses and make the necessary adaptations to the model prior to its final dissemination.

**Section B** consists of four articles, in which the goals of the research, the outcomes of the literature study and the empirical study are reported. Each article is dealt with as a self-contained unit focusing on a specific aspect of the research and contributing to the collection of data necessary for the design and evaluation of the proposed intervention model.

### **Article 1**

Knowledge of the legislation pertaining to sexual abuse is imperative for health care professionals working with a child who has been sexually abused. This article provides a critical analysis of those aspects of the Criminal Law (Sexual Offences and Related Matters) Amendment Act, 32 of 2007, relevant to the health care professional. The shortcomings of the Act and the practical implications of these for healthcare professionals is pointed out. Focus also falls on the relevant sections of the Childcare Act, 38 of 2005 and how these sections complement the Criminal Law (Sexual Offences and Related Matters) Amendment Act, 32 of 2007).

### **Article 2**

In order to effectively help traumatised children to achieve positive outcomes, professionals must have a clearly-defined methodology, underpinned by theory and based on an integrated approach. The first step towards this is clearly to redefine the phenomenon of child sexual abuse. As sexual abuse is both a legal and a psychosocial phenomenon, the authors are of the opinion that a more integrative definition is necessary in the South African context. The information in this article therefore aims to provide health care professionals with an integrative definition that takes into account both the South African legal definition of sexual abuse and the underlying psychosocial factors associated with it.

### **Article 3**

Sexual abuse is a phenomenon with far-reaching effects. This article provides a holistic look at the effects of sexual abuse from an ecological systems perspective. The effect of sexual abuse on the child as the focus of the microsystems is emphasized, as well as the effects on the parents or the child's caregiver as the mesosystem. The article further considers the interactive dynamics between the different systems and explains how each system can contribute to either mitigating or exacerbating the effects of abuse on the child.

### **Article 4**

The research goal of this article is to develop and evaluate a structured play therapy intervention model to mitigate the effects of child sexual abuse. The intervention model was developed from the results of the previous articles as well as an in-depth literature study on existing therapeutic interventions. To fulfil the aim of this article, the following objectives are set:

- To give an outline of the research methodology underlying the study;
- To discuss the problem analysis and project plan;
- To outline the intervention model for mitigating the effects of child sexual abuse;
- To discuss the research findings on the proposed model.

**Section C** gives a summary of the most important findings and conclusions regarding the research in general. It also contains recommendations and points to the contribution made to the specific field of study.

**Section D** consists of the addenda to the research report, for example, the different instruments of measurement and the questionnaires.

**Section E** concludes the thesis with summarized references.

## UITTREKSEL

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# 'N GESTRUKTUREERDE SPELTERAPIE INTERVENSIE MODEL OM DIE EFFEK VAN SEKSUELE MISBRUIK IN DIE KINDERJARE TEE TE WERK

**Sleutelwoorde:** Speltherapie, Model, Seksuele Misbruik

Die doel van die navorsing is om 'n gestruktureerde speltherapie model te ontwikkel ten einde effektiewe terapeutiese intervensie te bied aan kinders wat slagoffers was van seksuele misbruik. Suid-Afrika het een van die hoogste voorkoms van seksuele misbruik van kinders. Professionele persone wat met kinders werk word vervolgens toeneemend gekonfronteer met seksuele misbruik. Professionele persone voel egter dikwels swak toegerus om die effek van seksuele misbruik op die kind effektief te hanteer – 'n leemte wat deur die gebrek aan 'n integreerde begrip van die fenomeen van seksuele misbruik vererger word. Ten einde die effek van seksuele misbruik op die kind effektief te hanteer, benodig professionele persone 'n holistiese begrip nie net van seksuele misbruik nie, maar ook die effek van misbruik op die kind en gevolglik duidelike riglyne ten opsigte van noodsaaklike intervensie.

Die tesis bestaan uit 5 afdelings wat soos volg uiteengesit kan word:

**Afdeling A** bevat onder meer die probleemstelling, navorsingsvrae, navorsingsdoelstelling en doelwitte, die sentraal teoretiese stelling en teoretiese benadering. Die navorsingsmetodologie, beperkings van die studie, omskrywing van begrippe en die keuse en struktuur van die navorsingsverslag word ook in die afdeling uiteengesit. Voortspruitend uit die probleemstelling is die volgende doelwitte nagestreef:

- Om 'n volledige literatuurstudie te onderneem rakende die aspekte relevant tot seksuele misbruik insluitende terapeutiese intervensies ten einde 'n holistiese, goed nagevorste begrip vir die verskynsel van seksuele misbruik te ontwikkel.
- Om 'n gestruktureerde speltherapie model te ontwikkel wat die effek van seksuele misbruik teëwerk.

- Om 'n prototipe van die voorgestelde intervensie model beskikbaar te stel vir portuurgroep oorweging ten einde te bepaal wat die sterktes en leemtes van die model is en sodoende die nodige aanpassings tot die model te maak vir finale afronding.

**Afdeling B** bestaan uit vier artikels wat die doelwitte van die navorsing asook die uitkomst van die literatuurstudie en empiriese studie weergee. Elke artikel word beskou as 'n selfstandige eenheid wat op 'n spesifieke aspek van die navorsing fokus en bydrae tot die insameling van data wat nodig was vir die ontwerp en evaluering van die voorgestelde intervensie model.

### **Artikel 1**

Kennis aangaande wetgewing wat van toepassing is op seksuele misbruik is noodsaaklik vir professionele persone wat met seksueel misbruikte kinders werk. Hierdie artikel bied 'n kritiese analiese van die aspekte van die Kriminele Wet (Seksuele Oortredings en Verwante Sake) Wysigings Wet , 32 van 2007, relevant vir professionele persone werksaam in dié veld. Die leemtes in die Wet, asook die praktiese implikasies vir professionele persone wat met seksueel misbruikte kinders werk, word uitgelig. Die fokus word ook geplaas op relevante afdelings van die Kindersorgwet, 38 van 2005, en hoe dié afdelings die Krimenele Wetgewing (Wt op Seksuele Oortredings en Verwante Sake) Wysigings Wet, 32 van 2007, komplementeer.

### **Artikel 2**

Ten einde getraumatiseerde kinders te help om positiewe uitkomst te bereik, benodig professionele persone 'n duidelik gedefinieerde metodologie wat gefundeer is in teorie en gebaseer is op 'n geïntegreerde benadering. Die eerste stap is vervolgens om seksuele misbruik duidelik te herdefinieer. Siende dat seksuele misbruik beide 'n wetlike sowel as 'n psigososiale verskynsel is, is die skrywers van mening dat 'n meer geïntegreerde definisie binne die Suid-Afrikaanse konteks nodig is. Die inligting in hierdie artikel is vervolgens daarop gemik om 'n geïntegreerde definisie, wat beide

Suid-Afrikaanse wetlike definisie sowel as die onderliggende psigo-sosiale faktore wat met seksuele misbruik geassosieer word, daar te stel.

### **Artikel 3**

Seksuele misbruik is 'n verskynsel met verreikende gevolge. Die artikel bied 'n holistiese uitkyk op die effek van seksuele misbruik binne 'n ekologieses sisteem perspektief. Die effek van seksuele misbruik op die kind as fokus van die mikrosisteem word uitgelig so wel as die effek op die kind se ouers of versorgers as die mesosisteem. Die artikel lig verder die interaktiewe dinamika tussen die verskillende sisteme uit en verduidelik hoe elke sisteem kan bydra om die effek van seksuele misbruik op die kind te werk of te vererger.

### **Artikel 4**

Die doel van die artikel is om 'n uitleg te gee van beide die navorsingstudie sowel as die voorgestelde speltherapie model om die effek van seksuele misbruik te werk. Die voorgestelde terapeutiese intervensie model is ontwikkel uit die resultate van vorige artikels sowel as 'n indiepte literatuur studie rakende bestaande terapeutiese intervensies. Ten einde die doel van die artikel te bereik is die volgende doelwitte gestel:

- Om 'n uiteensetting van die navorsings metodologie onderliggend tot die studie te gee;
- Om die probleem te analiseer en projek plan te bespreek;
- Om 'n uiteensetting van die intervensie model om die effek van seksuele misbruik te werk, te bied; en
- Om die navorsingsbevindings aangaande die voorgestelde model te bespreek.

**AFDELING C** vervat die samevatting van die vernaamste bevindings en gevolgtrekkings ten opsigte van die ondersoek in die geheel. Daarbenewens is aanbevelings gedoen en die bydra van die ondersoek uitgelig.

**AFDELING D** vervat die bylaes tot die navorsingsverslag, byvoorbeeld die vraag skedule.

**AFDELING E:** Hierdie afdeling sluit die tesis af met 'n samevattende bibliografie.

## KEY WORDS /SLEUTELTERME

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The following key words are applicable to this study:

Structured Play Therapy

Gestruktureerde Speltherapie

Model

Model

Sexual Abuse

Seksuele Misbruik

Molestation

Molestering

Sexual trauma

Sekuele trauma

## FOREWORD

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This thesis is submitted in the form of published research articles. It is presented as a unit and the guidelines of the concerned journals for the individual articles are included as Addenda. See the General Academic Rule of the North West University A 5.4.2.7 of 2014.

**Article 1** was published in the accredited journal *CARSA* (Child Abuse Research in South Africa).

**Article 2** was published in the accredited journal *CRIMSA* (Crime Research in South Africa).

**Article 3** was published in the accredited journal *CARSA* (Child Abuse Research in South Africa).

**Article 4** will be submitted to the journal *CARSA*. The length of the Article is currently (word count of 13,800) not in accordance with the requirements (word count of 10,000) of the journal, but will be revised to meet these after the thesis has been examined. When submitted the numbering and length of this article will be amended according to the requirements of the journal.

# EDITORIAL POLICY AND REQUIREMENTS CRIMSA

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**Acta Criminologica: The Southern African Journal of Criminology**, is a peer-reviewed academic journal which promotes academic and professional discourse and the publishing of research results on the subject of crime and victimisation, conflict, deviance, abuse of power and reaction to crime and other crime-related phenomena in the broad Criminological Sciences and applied criminal justice field.

Acta Criminologica is an accredited journal approved by the South African Department of Education and Higher Training and is published regularly by the **CRIMINOLOGICAL AND VICTIMOLOGICAL SOCIETY OF SOUTHERN AFRICA (CRIMSA)** (first published in 1988). Annual paid-up members of CRIMSA will automatically be subscribed to Acta Criminologica (hard copy or e-journal options).

An article contribution to the editor(s) will only be considered provided it has been edited and is **ready for processing**, namely: language edited, stylistically polished and carefully proofread and to follow the technical format and referencing guidelines as provided below. Manuscripts not following the journal style, referencing technique, technical format and language edited will be returned to author(s) for correction and re-submission before being sent out for refereeing. In submitting an article author(s) acknowledge that it is their own original work and that all content sourced from other authors and/or publications have been fully recognised and referenced according to the guidelines for authors.

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According to the Policy and Procedures for Measurement of Research Output of Public Higher Education Institutions, research output is defined as “**textual output where research is understood as original, systematic investigation undertaken in order to gain new knowledge and understanding**” (Ministry of Education, 2003: 3). Therefore, an uncritical synthesis of literature without contributing any new insight to existing knowledge falls outside the scope of this definition. Furthermore, “**peer evaluation of the research is considered a fundamental prerequisite of all recognised output and is the mechanism of ensuring and thus enhancing quality**” (Ministry of Education, 2003: 3-4).

The Journal also subscribes to and follows the peer review principles and guidelines as outlined in the Academy of Science of South Africa (ASSAF) document: **National Code of Best Practice in Editorial Discretion and Peer Review for South African Scholarly Journals** (Assaf, 2008).

Accordingly the Editorial Team will carefully examine submitted article manuscripts with a view to the selection of appropriate peer reviewers (who should be scholars who have not previously co-published extensively with the author(s), who are for this and other reasons free of known bias in relation to the subject matter, the author(s) and/or their institutions, and who can cover, from a position of authority and peer expertise, the topic(s) dealt with in the article

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The Editor(s) will submit article contributions to referees (in a double blind review process) for evaluation and may alter or amend the manuscript in the interests of stylistic consistency, grammatical correctness or coherence. The refereeing process is always anonymous and the identity of referees will remain confidential. It remains the prerogative of the editors to accept or reject for publication any submission and their decisions are final. They will not enter into any debate or correspondence regarding any decision made. Evaluators agreeing to referee articles are requested to provide, where possible, critical and constructive feedback on the work of their peers. They are requested to make a recommendation based on the following:

#### Editorial policy

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- ii. Accept with minor revisions as indicated; or
- iii. Resubmit with major revisions in accordance with critical and constructive feedback provided;
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Apart from scientific shortcomings or inconsistencies, the following evaluative criteria are considered:

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- The theme contributes to an existing (professional) body of knowledge (knowledge useful);
- Author(s)' goals and objectives are clearly stated;
- The article addresses (unpacks) themes logically, consistently and convincingly;
- The article demonstrates an adequate understanding of the literature in the field;
- The research design is built on adequate understanding, evidence, informational input;
- The interpretative potential of the data has been realised;
- The article demonstrates a critical self-awareness of the author's own perspectives and interests;
- Holistically, the article is properly integrated and clearly expresses its case measured against the technical language of the field (theory, data and critical perspectives are well structured and the presentation is clear);

- Conclusions are clearly stated and adequately tie together the elements of the article
- The standard of writing (including spelling and grammar) is satisfactory;
- The APA Acta Criminologica adapted reference technique is consistently applied throughout the article;
- Sources consulted are sufficiently acknowledged (included in a list of references) and consistently cited to:
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Effective and detailed source referencing is of paramount importance. Articles will be scrutinised and checked for bibliographic references and any proven evidence of plagiarism (including self-plagiarism where more than one-third of previously published work by the author(s) is being used in the author(s)' submitted article) will result in non-publication.

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The Editor-in-Chief: **Prof AdeV Minnaar**  
Email: **aminnaar@unisa.ac.za**

# EDITORIAL POLICY AND REQUIREMENTS CARSA

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## Publishing policy

Child Abuse Research a South African Journal (CARSA) has been published biannually in April and October since 2000. It was SAPSE accredited in 2003 for articles published in the journal from 2004 onwards. This means that CARSA is a peer reviewed, fully accredited, professional journal and academics at higher education institutions receive credits if their articles are published in CARSA. **Articles should be submitted to the Editor, Prof Michele Ovens, [ovensm@unisa.ac.za](mailto:ovensm@unisa.ac.za)**

CARSA is a national journal that promotes academic and professional discourse amongst professionals involved in child-care work in South Africa. It publishes high quality, peer-evaluated, applied, multidisciplinary articles focusing on the theoretical, empirical and methodological issues related to child abuse in the light of the current political, cultural and intellectual topics in South Africa. Authors of articles submitted for review will remain anonymous. The comments of the reviewers and peer evaluators should be constructive and helpful and designed to aid the authors to produce articles that can be published. The authors may then use these comments to revise their articles. However, the final decision on whether or not to publish an article rests with the editor. There should be an interval of at least two issues between articles published by the same author. The language of the journal is English.

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Empirical research should adhere to acceptable standards of descriptive and inferential statistics and empirical data should be manipulated statistically using an acceptable statistical program such as the Statistical Package for the Social Sciences (SPSS) or SAS.

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**It is the responsibility of the author that articles should be language and technically edited, before submission. Formal conversation is required that the final accepted article has been edited for language proficiency.**

### **Style**

Main headings should be typed in upper case and begin at the left margin. No indentation is allowed. Dates should be written as follows:

9 January, 2000. Bold, italics and underscore should be formatted as such in the original document. The recommended style for reference purposes is the abbreviated Harvard technique, for example, "Child abuse is rising (Author 1999:10)" or "According to Author (1999:10), child abuse is rising". In the case of legal articles, footnotes will be allowed.

To work towards uniformity in the alphabetical bibliography at the end of an article, the following examples of format are given:

Books:

Kuehnle, K. 1996. Assessing allegations of child sexual abuse. Sarasota: Professional Resource Press.

Articles:

Collings, SJ & Payne, MF. 1991. Attribution of causal and moral responsibility to victims of father-daughter incest: an exploratory examination of five factors. *Child Abuse and Neglect*, (15)4:513-521.

Where applicable, contributors should indicate sources of funding. It is the duty of the author to clear copyright on empirical, visual or written data. Simultaneous submission to other electronic or printed journals is not allowed.

### **Non-sexist language**

Gender specific nouns and pronouns should not be used to refer to people of both sexes. The guidelines on sexist, racist and other discriminatory language should be observed. The following is intended to assist contributors to refrain from sexist language by suggesting non-sexist alternatives.

**Sexist:** Each respondent was asked whether he wanted to participate. The child should have enough time to familiarise himself with the test.

**Non-sexist:** Respondents were asked whether they wished to participate. Enough time should be allowed for the child to become familiar with the test.

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# SECTION A

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# INTRODUCTION

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## 1. PROBLEM STATEMENT

Practitioners are increasingly faced with the phenomenon of sexual abuse. In 2009, the University of Barcelona conducted a meta-study analysing 65 research studies across 22 countries to determine the true global extent of the phenomenon. The findings of the study indicated that, geographically, the highest prevalence rate for child sexual abuse was found in Africa (34.4%). Shockingly, South Africa has the highest prevalence rates of sexual abuse for both men (60.9%) and women (43.7%) (Pereda *et al.*, 2009: 336). The phenomenon of child sexual abuse is a more widespread problem than previously estimated (Pereda *et al.*, 2009:336), and this is especially true of South Africa. The incidence of child rape in South Africa is as high as an average of 530 cases per day (Media Statement: Solidariteit Helpende Hand, June 2009).

The high statistics for child sexual abuse call for an in-depth understanding of the phenomenon. Although a variety of literature is available on the field of sexual abuse, it would appear that the definition of sexual abuse falls short by focussing on either the legal definition or the psychosocial definition of sexual abuse. Sexual abuse is, in essence, a criminal offence, so when a child has been the victim of sexual abuse, the child, the child's family and practitioners offering therapy are often brought into contact with the legal system. Although many practitioners and parents alike often motivate that their focus is only on the child's recovery from the potentially adverse effects of abuse, the legal system and legislation pertaining to sexual abuse cannot be ignored. Within the general provisions of the Criminal Law (Sexual Offence and Related Matters) Amendment Act, 32 of 2007, sections 54 (1)(2), reference is made to the obligation for any person to report their knowledge that a sexual offence has been committed against a child. The failure to report such information is treated as an offence. When practitioners fail to acknowledge their legal responsibility or still believe the fallacy that children are not allowed therapy while a criminal case is pending, they are failing to fulfil their two-fold responsibility of reporting and providing an effective intervention to mitigate the effect of abuse. In attempting to truly understand child sexual abuse, a more integrative definition of abuse is necessary, incorporating the psychosocial definition, the abuse dynamics and the legislative perspective.

Sexual abuse does not reflect in research studies and statistics alone. In the wake of sexual abuse, there are always victims to be found who are vulnerable to the long-term effects of abuse. The effect of sexual abuse on the child is clear. Various literature on abuse provides extensive lists of the symptoms that can be experienced by abused children (Currie & Widom, 2010:111; Karakurt & Silver, 2014:80; Saunders, 2012:186; Yonas, Lewis, Hussey, Thompson, Newton, English & Dubowitz, 2010:43). Within the phenomenon of sexual abuse lies the hidden potential to cause harm to the child in all areas of functioning (Colarusso, 2010:7; De Bellis, Woolley & Hooper, 2013:17; Karakurt & Silver, 2014:80; Spies, 2006:52; Webb, 2011:336). In studying the effect of sexual abuse on the child, the realization sets in that sexual abuse affects not only the child but also the broader system of which the child is a part (Colarusso, 2010:5; Gil, 2006:17; Karakurt & Silver, 2014:80-81; Webb, 2011:12-13, 16).

Various systems in the child's life, such as the family, the school, the judicial system and the broader community, are all affected by the sexual abuse of a child. Each of the systems with which a child interacts brings with it unique characteristics that can either mitigate or exacerbate the effect of sexual abuse (Easton, Coohy, Rhodes & Moorthy, 2013:212; Gil, 2006:7; Wurtele & Kenny, 2012:557). When attempting to truly understand the effect of abuse on the child, practitioners should therefore beware of generalizing the effects, and should rather take into account the various risk and protective factors in the child and the other systems with which he interacts. The holistic effect of sexual abuse on the child demonstrates the need for practitioners to study and understand sexual abuse from an ecological systems perspective.

As an understanding of the effect of abuse from an ecological systems perspective develops, the need for effective therapeutic intervention that recognizes the systemic effect of abuse becomes imperative. Practitioners are often ill-equipped to address the effect of child sexual abuse in its totality and the need for effective intervention guidelines for therapist is undeniable (Gaskill & Perry, 2014:191; Saunders, 2012:191).

Studying the phenomenon of sexual abuse holistically, practitioners can no longer ignore that our children, families and communities are facing a crisis that calls for responsible, effective intervention. Integrating various therapeutic methodologies and evidence-based practices, while understanding the effect of sexual abuse from an ecological systems perspective could result in therapeutic intervention that could mitigate the effect of sexual abuse on children.

## **2. RESEARCH QUESTIONS**

The problem statement gives rise to the following research questions:

- What considerations should practitioners take into account when attempting to form a holistic, well-integrated understanding of childhood sexual abuse?
- What aspects should form part of a structured play therapy intervention model to mitigate the effects of childhood sexual abuse?
- What does experts in the field of sexual abuse and play therapy feel are important to form part of an intervention model to mitigate the effects of childhood sexual abuse?

## **3. PURPOSE OF THE STUDY**

The purpose of the study can be outlined as follows:

### **3.1 AIM**

The aim of the study is to develop a structured play therapy intervention model to mitigate the effect of sexual abuse. The development of the therapeutic model will be based on a thorough study of various aspects pertaining to childhood sexual abuse in order to form a holistic and integrated understanding of the phenomenon. The study further aims to subject the proposed intervention model to a peer review by experts in the field of sexual abuse in order to determine the strengths, weaknesses or limitations of the proposed model. Critical evaluation by experts will then be used to refine the model in order to provide professionals with an effective, researched intervention model for children who are victims of sexual abuse.

## **3.2 OBJECTIVES**

In order to reach the aim of the study the following objectives are set:

### **Objective 1**

To conduct a thorough literature study on various aspects pertaining to childhood sexual abuse in order to form a holistic, well-researched perspective of the phenomenon of childhood sexual abuse and available evidence-based interventions for sexually abused children.

### **Objective 2**

To develop a structured play therapy intervention model to mitigate the effect of childhood sexual abuse.

### **Objective 3**

To subject the prototype of the proposed intervention model to peer review in order to determine the strengths and weaknesses of the proposed model and make the necessary adaptations to the model prior to its final dissemination.

## **4. CENTRAL THEORETICAL STATEMENT**

The central theoretical statement is that a structured play therapy intervention model can be developed to mitigate the effect of sexual abuse by means of an in-depth literature study and empirical study on the proposed model.

## **5. THEORETICAL FOUNDATION**

The theoretical foundation for this study includes systems theory, psychosocial therapy and a strengths-based approach. These three approaches complement one another and form the theoretical foundation on which the proposed structured play therapy intervention model will be founded.

### **5.1 SYSTEMS THEORY**

Social workers, more than any other profession have directed their involvement with clients beyond the individual to the broader environment, thereby addressing relationships,

interaction and interdependence between the client and his environment (Ambrosino, Heffeman, Shuttlesworth & Ambrosino, 2012:49). The use of an ecological systems framework is therefore a natural outflow of the discipline of social work. Ambrosino *et al.* (2012:49) concur that the general foundation of social work is based on a framework that incorporates both the ecological and the systems perspective. The theoretical foundation that will form the basis from which the study will be conducted flows from the ecological systems framework, which emphasizes the interaction within and between the various systems. Incorporated in the ecological systems framework are the concepts of system, synergy and equifinality.

### **5.1.1 System**

Within the ecological systems framework, the first concept that has to be defined is **system**. Ludwig Von Bertalanffy (1968), one of the pioneers of systems theory, defined the term system as “a set of units with relationship amongst them” (Ambrosino *et al.*, 2012:50; Friedman & Allen, 2011:4). A system can also be defined as a whole, consisting of separate but interacting, interdependent parts (Ambrosino *et al.*, 2012:50). A family can be viewed as a system consisting of separate individuals who are all interacting with one another and are interdependent. Sexual abuse is a phenomenon that involves the child victim. Often sexual abuse is perpetrated within one of the systems of the child’s life, whether it be the family system, the school system or an individual within the broader community system. When contemplating the phenomenon of sexual abuse, it is therefore important that professionals also contemplate and understand the system in which the abuse took place. By incorporating the various systems in our understanding of child sexual abuse, we avoid a simplistic, one-sided understanding of a multi-faceted, complex phenomenon.

### **5.1.2 Synergy**

The contribution of biology to systems theory adds the concept that the whole is greater than the sum of its parts – synergy. Ambrosino *et al.* (2012:50) state that, when all the smaller systems or subsystems function in tandem, they produce a larger system that is far more significant and effective than the subsystems functioning independently. Synergy therefore refers to the increased effectiveness that results when two or more people or systems work together (Friedman & Allen, 2011:4; Merriam-Webster Online Dictionary, 2014).

A family system consisting of individuals can function in cohesion, resulting in more effective functioning, or they can function independently and in isolation from one another. Within the phenomenon of sexual abuse, children cannot recover from the harmful effects of abuse in isolation, but in cohesion with and support from their families the harmful effects of sexual abuse can be mitigated. The professional working with child sexual abuse therefore should include the family when addressing the effects of sexual abuse. Therapy with the sexually abused child should be carried out in conjunction with the legal system's requirements of mandatory reporting. The concept of synergy brings with it an understanding that the more systems in a child's life who are knowledgeable about abuse and who work together to mitigate the effect of sexual abuse on the child, the better will be the outcome for the child.

### **5.1.3 Equifinality**

The last concept within the ecological systems framework is equifinality. Equifinality refers to the idea that the final state of a system can be achieved or attained in many different ways (Ambrosino *et al.*, 2012:54). From a psychological perspective, equifinality is defined as the concept that similar outcomes can stem from different early experiences and developmental pathways (Cicchetti, 2006:13; Lesser, 2011:292; Mash & Wolfe, 2013:14). Equifinality therefore explains how several different experiences or factors can produce the same constellation of symptoms or outcomes.

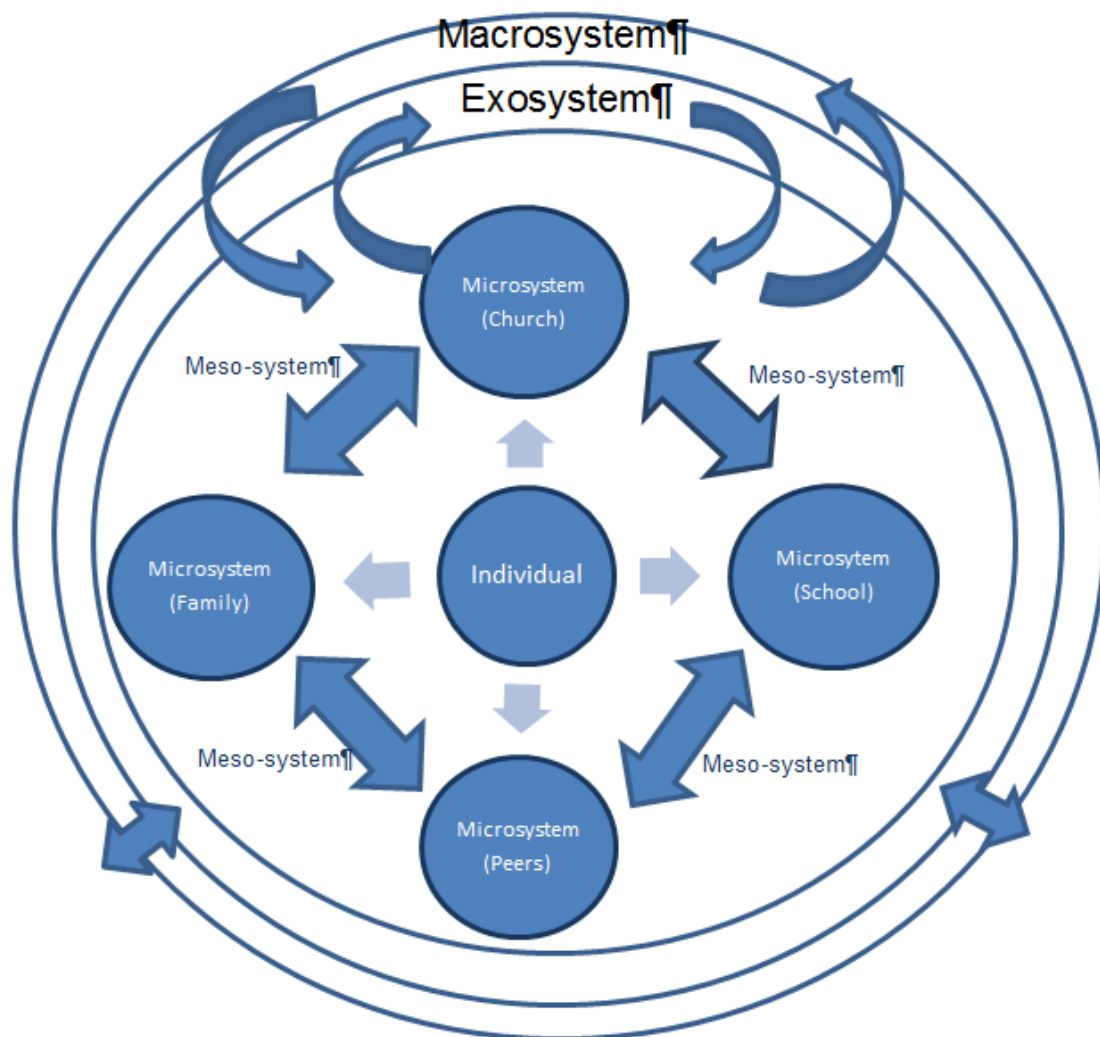
When considering the effect of sexual abuse on the child, it is paramount for the health care professional to understand the concept of equifinality, thereby acknowledging both the individualized effect of abuse on the child and the various factors that can either mitigate or exacerbate the effect of abuse. Equifinality brings with it the understanding that different experiences of sexual abuse can have the same traumatic effect on children. This points to the need for a comprehensive understanding of abuse that does not minimize the outcome of abuse based solely on its nature.

Considering intervention in child sexual abuse while bearing in mind the concept of equifinality, practitioners should consider that various combinations of intervention can lead to positive outcomes (Ambrosino *et al.*, 2012:54). Pathways leading to any particular outcome are numerous and interactive rather than one dimensional and static (Mash & Wolfe, 2013:15). The concept of equifinality therefore brings with it the realization that the effect of sexual abuse

is multi-dimensional, and that an integrated approach is called for in addressing the phenomenon of child sexual abuse.

## **5.2 BRONFENBRENNER'S ECOLOGICAL SYSTEMS APPROACH**

Considering the broader ecological systems framework and underlying concepts, brings the realization that an ecological systems approach is helpful in understanding the phenomenon of sexual abuse. Bronfenbrenner's ecological systems approach incorporates the broader ecological environment while at the same time acknowledging the individual as a highly valued system within the wider environment (Ambrosino, *et al.*, 2012:54; Shaffer & Kipp, 2014:639). Bronfenbrenner (1994:39) argues that the ecological environment is conceived as a set of nested structures, each inside the other, like a series of Russian Dolls. Figure 1 provides an outline, explaining the concept of Bronfenbrenner's ecological systems approach.



**Figure 1: Levels of the ecological system (Ambrosino *et al.*, 2012:55)**

The core of the system refers to the microsystem that incorporates the individual and everyone who is included in the individual's day-to-day functioning. This level also incorporates the individual's characteristics and level of psychosocial and intellectual functioning. The next level is called the meso-system. The meso-system involves the relationship between two microsystems in which the individual is involved. A child, who functions in both the family and school microsystems, therefore creates the link between school and family, creating a meso-system between these two microsystems. The third level, exo-system, incorporates community factors that may not relate directly to the child, but may affect one or more of the meso-systems, thereby indirectly affecting the child. The exo-system includes factors such as a parent's workplace, community policies, and socio-economic factors. The final level, the macro-systems, incorporates societal factors such as values, morals and cultural attitudes

(Ambrosino *et al.*, 2012:55-56; Bronfenbrenner, 1994:39-40; Friedman & Allen, 2011:10; Shaffer & Kipp, 2014:639-640).

All the parts of the structure are connected with each other and interaction occurs among the members of the system as well as between the different systems. Each layer therefore impacts on the other layers (Ambrosino, *et al.*, 2012:54; Friedman & Allen, 2011:10). Just like the ripple effects when a stone is thrown into one area of a pond, an event or the effect of an event in one system ripples out and affects the other systems. As each of the systems is interdependent and interactive, the effect of abuse in one system will have a widespread effect in the other systems. The relationships within the systems are therefore not linear but circular, as each system in the interaction affects the other (Friedman & Allen, 2011:10). Bronfenbrenner (1994:39) refers to this reciprocal effect as bi-directional influences, which are considered to be strongest within the microsystem (Karakurt & Silver, 2014: 81; Pynoos, Steinberg & Goenjian, 2007:350; Webb, 2011:61,338). While the influences within the meso-system are often apparent, the impact of macrolevel influences may not always be readily apparent in the individual, but are always present in salient ways (Shaffer & Kipp, 2014:640). Ambrosino *et al.* (2012:56) summarize how the different levels of the environment affect the individual in Table2.

Ecological Level	Definition	Example	Issues affecting the individual
<b>Micro-system</b>	Situations in which the person has face to face contact	Family, school, peers, workplace, church	Positive regard and acceptance of the person Exposure to harmful experiences Exposure to positive or negative role models
<b>Meso-system</b>	Connection, interaction or relationship between two microsystems	Home-school; home-workplace; home-church	Respect or lack thereof between different systems Consistency between different systems Cohesion and joined responsibility
<b>Exo-system</b>	Settings in which the person does not participate but where significant decisions are made that affect the person or others he directly interacts with	Place of employment of others in the persons microsystem; school board, local government, peer groups of others in the person's microsystem	Are decisions made with the person and families best interest at heart? Does support for families balance the stressors that parents and children face?
<b>Macro-system</b>	Blueprints for defining and organizing the institutional life of society	Ideology, social policy, values, morals, shared assumptions	Are some groups / ideas / systems valued at the expense of others? Are some groups / systems oppressed? What is the community norms and values regarding children What is the community stance or assumptions regarding phenomena in the community such as sexual abuse?

**Table 1: How ecological levels affects the individual (Adapted from Ambrosino *et al.*, 2012:56)**

Within Bronfenbrenner's ecological systems approach it is suggested that, for all individuals, each of the environmental levels holds both risk and the protective factors that possess either a threat to or an opportunity for the individual regarding to healthy functioning (Ambrosino *et al.*, 2012:54). The last column in Table 1 touches on some of the factors that can be considered risk or protective factors in the individual's life. In any working context, social workers need an understanding of both risk and protective factors in the client's environment in order to effect positive change and outcomes. The same is true when dealing with sexual abuse. Literature shows various risk and protective factors, for the child but also in the systems in which the child functions, in that these can either mitigate or exacerbate the effects of abuse of the child.

Bronfenbrenner's ecological systems approach is helpful in understanding the effect of sexual abuse on the child, as it provides an interactive model that includes all the systems in which children function, as well as the interaction between the various systems. Social work clinicians need a theoretical framework that enhances their understanding of the child-in-environment interactions which the ecological systems framework provides (Friedman & Allen, 2011:17).

### **5.3 PSYCHOSOCIAL THEORY**

Psychosocial theory originated in the writings of Mary Richmond (1917, 1922) on psychosocial treatment and was further strongly influenced by Frank Hankins (1930) and Florence Hollis (1958, 1972) (Teater, 2010:6; Turner, 2015:264). This theory formulates a multi-method intervention based on a diagnostic assessment of not only the client but also significant persons and relevant systems in the client's life (Turner, 2015:264). According to Teater (2010:6), psychosocial theory provides the context in which other theories or methods of social work should be understood. The psychosocial perspective is based on eco-systemic thinking and thus follows naturally from the systems perspective on which this research study is theoretically established. The following principles of psychosocial treatment should be noted:

### **5.3.1 Psychosocial understanding is eco-systemic**

The psychosocial approach is solidly grounded in the understanding that individuals develop in the context of many systems interacting in mutually causative ways. Human change, growth and adaption is therefore based upon the dynamic interplay between person and situation (Turner, 2015:266). Teater (2010:10) summarizes this principle, saying that it stresses the importance of interrelationship and interconnectedness of the person and the environment. Bearing the psychosocial theory in mind, the proposed therapeutic model supports this understanding and therefore views parents and caregivers as indispensable in the broader therapeutic intervention with the sexually abused child.

### **5.3.2 Relationship is essential to treatment**

One of the underlying principles of the psychosocial theory is that relationship is essential to treatment and brings about a significant source of change in itself (Turner, 2015: 266; Teater, 2010:7). Most theories and practitioners involved in therapeutic intervention with children agree that successful therapy depends heavily on the quality of the relationship between the client and the therapist (Turner, 2015:266). The therapist's ability to engage with children in therapy both empathetically and authentically is central to establishing the construct of the therapeutic working alliance with the child. Especially within the context of child sexual abuse, the therapeutic relationship may serve not only as a reparative but also as a corrective experience different from the harmful patterns of interaction between the child and the abuser.

### **5.3.3 Client reflections are central to psychosocial study**

From a psychosocial perspective, professionals are keenly aware that people ascribe individual and collective meanings to events and situations. Based on repeated family and social experiences, each person represents a subjective universe of perception. The opportunity to reflect within a helping relationship can lead to more effective functioning (Turner, 2015:266; Teater, 2010:10). Within the phenomenon of child sexual abuse, this principle and subsequently the child's unique and individualized experience of the abusive experience cannot be emphasized enough. With each child there are unique characteristics that can pose as factors "in" the child, that influence the child's vulnerability or resilience to trauma and thus their unique experience of the trauma. Child variables influencing the effect of sexual abuse on the child include temperament, age and developmental phase as well as previously formed internalizations or working models that form through interactions with

significant others in the child's life (Davies, 2011:62; Fishbein, Warner, Krebs, Trevarthen, Flannery & Hammond, 2009:299; McFarlane & Yehuda, 2007:158; Simon, Feiring & McElroy, 2010:230; Webb, 2011:84).

#### **5.3.4 Psychosocial treatment is based on the study and assessment of the client**

Treatment planning from a psychosocial perspective flows from careful consideration of all the facts of a case in order to understand the multi-systemic dynamic of the person-situation configuration (Turner, 2015:265). This principle points to the need for an acknowledgement and an assessment of the individual, his interpersonal relationships, the environment in which he finds himself and its resources (Turner, 2015:265; Teater, 2010:7). An assessment from the psychosocial perspective asks the following questions:

- Who is the client historically and in the present?
- What individual strengths can be tapped?
- What are the current limitations?
- What does the client want and need?
- What family members are most accessible or most motivated?
- What community systems and resources can be located or mobilised?

These questions highlight the aspects most relevant in the assessment (Turner, 2015:265). Parallel to psychosocial theory and enriching the principle of assessment lies research focussing on protective factors and risk factors. Davies (2011:61) defines protective factors as factors in either the child or the environment that mitigate risk by reducing stress and providing opportunities for growth, and/or strengthening the coping capacities. In turn, risk factors can be described as conditions such as vulnerabilities in the child, and parenting or socio-economic factors that compound the levels of stress and vulnerability experienced (Yonas *et al.*, 2010:44; McFarlane & Yehuda, 2007:157-158).

Psychosocial study and assessment underpin the psychosocial method and provide workers with a professional framework for practice. The process of therapeutic intervention with sexually abused children should therefore begin with a complete understanding of all the factors that have contributed to the current problem situation and experience of the child, so that the practitioner can formulate, propose and implement an appropriate intervention (Webb, 2011:59).

## **5.4 STRENGTHS-BASED APPROACH**

The strengths-based approach emerged during the last decade and is founded on the beliefs of empowerment that assume that there is power embedded in people and the community (Jones-Smith, 2014:4). This approach asserts the exploration, assessment and development of a client's strengths and abilities for recovery in the intervention process by focussing on resilience, possibilities and transformation (Desai, 2010:56; Pulla & Francis, 2014:104). The strengths-based approach focuses on the client's strengths for achieving positive and lasting change instead of trying to eliminate problems. The strengths-based perspective brings an important counterbalance to the preoccupation with problems and deficits that are pervasive in various service delivery models (Desai, 2010:56; Jones-Smith, 2014:4). The following underlying principles underline the foundation of a strengths-based approach:

- Every individual, family and community has strengths (assets, resources, wisdom and knowledge); and the focus is on these strengths rather than on pathology, diagnoses or labels;
- Trauma and abuse may be injurious but may also be a source of challenge and opportunity;
- No assumption is made about the child's, the family's or the community's capacity for growth. Thus believing that all people have the inherent capacity to learn, grow and change;
- Collaboration is central, with the practitioner-client relationship as primary and essential;
- Every environment is full of resources such as informal systems, associations, groups and institutions. The community is therefore seen as abundant in resources that can be utilized; and
- Problems are seen as the result of interaction between individuals, organisations or structures rather than deficiencies in the individual (Desai, 2010:56; Pulla & Francis, 2014:130; Jones-Smith, 2014:8; Scerra, 2011:1).

These principles can be enacted in different ways, in a range of contexts to achieve positive outcomes for children (Scerra, 2011:1).

In line with psychosocial theory, the strengths-based approach acknowledges not only the value of the broader community and their resources but also clients' individual perceptions and the value of assessment. Psychosocial theory highlights the value of the therapeutic relationship. Pulla and Francis (2014:131) concur from their strengths-based perspective by stating that a personal, friendly and empathetic therapeutic relationship provides the atmosphere for healing, transformation, regeneration and resilience.

Assessment within a strengths-based approach is seen as a working tool that is constantly being updated. The assessment process helps clients to tell their "story" according to their unique socially-constructed reality (Pulla & Francis, 2014:135). This corroborates the importance of the unique and individual meaning that people ascribe to their experiences both from a psychosocial perspective and within the realities of the phenomenon of child sexual abuse (Turner, 2015:266; Teater, 2010:10).

The strengths-based approach cautions against the use of cause-and-effect thinking, as this is usually based on simplistic, cause-and-effect relationships that do not consider the multiple dimensions and complexity of a client's realities (Pulla & Francis, 2014: 137). This aspect is exceedingly important within both the phenomenon of child sexual abuse and therapeutic intervention. Sexual abuse has a multi-faceted effect on the child and his functioning and therefore a multi-level approach is necessary to understand the effect of sexual abuse on the child (Karakurt & Silver, 2014:81; McFarlane & Yehuda, 2007:157; Van der Kolk & McFarlane, 2007:15-16; Webb, 2011:18).

Not only does the strengths-based approach correlate with the principles and foundational elements of both the systems approach and the psychosocial approach, but it expands on these by adding the much-needed focus on the strengths and abilities of clients, families and the community that can lead to recovery, hope and sustained growth – even in the aftermath of trauma.

## **5.5 INTEGRATING THE THEORETICAL CONCEPTS FOR THE PROPOSED RESEARCH**

The systems approach, the psychosocial approach and the strengths-based approaches provide the broad theoretical foundation for the study and the structured play therapy model to mitigate the effects of child sexual abuse. Stemming from the various discussions of the different foundational theories, the researcher has formulated the following broad theoretical principles that underscore the therapeutic attributes of the model:

- The child suffering sexual abuses trauma cannot be viewed in isolation but must be seen within the context of the broader systems (micro, meso, exo and macro) in his unique world (ecological-systems perspective);
- The child's unique and individualized experience of the abusive experience cannot be over-emphasised (psychosocial perspective);
- The therapeutic relationship is a cornerstone of effective therapy that may serve not only as a reparative but also as a corrective experience for the child (psychosocial and strengths-based perspective);
- Assessment both initially and throughout the therapeutic intervention is imperative. Assessment includes assessment not only of the child's unique abuse experience but also of his interpersonal relationships, inner strengths and community resources (psychosocial and strengths-based perspective);
- The multi-method approach that incorporates an integrated understanding of the phenomenon of abuse is necessary for addressing the multi-faceted effect of child sexual abuse (ecological systems approach, psychosocial approach); and
- Trauma may bring with it certain challenges for the child and his family, but ultimately trauma also brings with it new opportunities and the change that effective therapy can facilitate.

These principles are fundamental to the effective understanding and implementation of the therapeutic model.

## **6. RESEARCH METHODOLOGY**

Research is an organized, systematic and logical process of inquiry using empirical information to answer questions or test hypotheses (Punch, 2014:5). The research methodology involved two interlinked processes, a literature study and an empirical study.

### **6.1 LITERATURE STUDY**

The purpose of a literature study is to help the researcher determine the state of the science and how the proposed study extends what is already known in the field (Melnyk & Morrison-Beedy, 2012:6). The study of both empirical and theoretical literature stands central to any literature study. Punch (2014:94) clarifies that a thorough literature study will review relevant literature of an empirical nature (thus previous empirical evidence on the research topic or question) as well as relevant theory. Theoretical literature is defined by Punch (2014:95) as literature including relevant concepts, theories, theoretical concepts and analytical literature relevant to the research topic. A thorough literature study, including both empirical and theoretical literature, were undertaken. Scientific literature sources, including, books, journals, internet resources and information from courses attended, were utilized. Databases that were utilized includes the Internet, Academic Search Premier, ISAP, EBSCO and PsycINFO.

Bryman (2012:101) indicates that the researcher should conduct a literature study in such a way as to prove that a wide swathe of literature has been integrated. The purpose of this is to assist the researcher in developing an appreciation for the disciplinary content of the literature, to develop or sustain arguments and critically evaluate the existing knowledge base (Bryman, 2012:101). Aspects that were covered as a part of the literature study includes the legislation pertaining to children, a comprehensive study on the definition of sexual abuse as found in various psycho-social literature sources, an in-depth look at the effect of sexual abuse on the child, as well as various evidence-based interventions for addressing these effects. Bearing in mind the purpose of the literature study, as outlined by Bryman (2012:101), the researcher did conduct a thorough study of all the relevant literature in order to form a holistic, well-integrated understanding of all the aspects pertaining to the sexual abuse of children.

## 6.2 DEFINITION OF TERMS

### 6.2.1 Sexual abuse

Sexual abuse is defined by the Criminal Law (Sexual Offences and Related Matters), Amendment Act 32 of 2007, as any person who engages a child (*a person under the age of 18*) in a sexual act, with or without the consent of the child. A *sexual act* is defined as an act of sexual penetration or an act of sexual violation. *Sexual penetration* is seen as any sexual form of penetration to any extent whatsoever by the genital organ, any body part and/or object by one person into or beyond the genital organs, anus or mouth of another person [Criminal Law (Sexual Offences and Related Matters) Amendment Act, 32 of 2007].

*Sexual violation* includes any act which causes:

- direct or indirect contact between the genital organs, anus or breasts of one person and any part of the body of another person, including any object resembling or presenting the genital organs or anus of a person or animal;
- the mouth of one person and the genital organs, anus, breasts or mouth of another person;
- any other part of the body of another person that could cause sexual arousal or stimulation;
- masturbation of one person by another person; or
- insertion of any object resembling or representing the genital organs of a person or animal into or beyond the mouth of another person [Criminal Law (Sexual Offences and Related Matters), Amendment Act, 32 of 2007].

The Criminal Law (Sexual Offence and Related Matters) Amendment Act, 32 of 2007, represents a huge step in the right direction. There are, however, several shortcomings in the Act, with specific reference to the definition of sexual abuse. The legal definition of sexual abuse, as expressed in the Act, falls short when it comes to both non-contact sexual behaviour and a comprehensive definition of grooming as integral parts of sexual abuse. The Act further fails to make any reference to the role that the motivation of the perpetrator plays in determining whether an act should be considered abusive. Although the perpetrator's motivation poses various difficulties, it none the less is a central variable to consider in allegations of abuse (Aucamp, Steyn & van Rensburg, 2012:9).

As sexual abuse is both a legal and a psychosocial phenomenon, professionals need an integrated definition of sexual abuse that encompasses both these aspects. Taking into consideration both the legal aspect and various abuse dynamics, as well as the individual experience of the child, the researcher would like to conclude that currently the definition of sexual abuse as found in legislation presents various shortcomings.

### **6.2.2 Molestation**

In the field of sexual abuse the term molestation is often used as a substitute for the term sexual abuse. The term molestation can be considered an archaic term which is not currently defined by the Criminal Law (Sexual Offence and Related Matters) Amendment Act, 32 of 2007. Dunn and Lachkovic (2012:11) state that a simple yet modernised definition of the term molestation is currently lacking.

Molestation can be defined as: abuse, aggravation, annoyance, bother, disturbance, ill treatment, ill usage, inconvenience, interference, interruption, intrusion, irritation, meddling, mistreatment, nuisance, oppression, vexation (Burton, 2007). From this broad definition it is clear that the term molestation does not refer to sexual abuse alone, but incorporates a much wider array of acts. Dunn and Lachkovic (2012:11) however maintain that the lack of a clear statutory definition keeps the term flexible and able to adapt to novel circumstances.

The researcher is of the opinion that practitioners should avoid the use of the word molestation, due to its archaic nature, omission from latest legislation as well as lack of a clear definition that clearly links it with child sexual abuse.

### **6.2.3 Sexual trauma**

Before addressing sexual trauma it is important to look at some terms used in conjunction with sexual trauma. The first concept that needs to be defined is trauma. Trauma can be defined as “an experience or witnessing an event involving actual or threatened death or serious injury or threat to physical integrity of self and other” (Smyth, 2008:241). Valent (2012:678) defines trauma as a state of disruption caused by stressors never enough to threaten life or make one

believe that their life is threatened. The definition of trauma encompasses a wide range of experiences which can include sexual abuse.

The context in which trauma occurs is a *traumatic situation*. The source or cause of the trauma is a traumatic stressor (Valent, 2012:676). Sexual abuse is seen as a traumatic stressor that can result in trauma and more specifically emotional and psychological trauma (Suri, 2012:674; Valent, 2012:676). In sexual trauma the traumatic stressor lies in both the sexual encounter as well as the traumagenic dynamics. Traumagenic dynamics, as described by Finkelhor and Brown (1985:530-541) found in the traumatic situation that it includes sexualisation, betrayal, powerlessness and stigmatisation.

#### **6.2.4 Structured play therapy**

The Association of Play Therapy (APT) has defined play therapy as: “The systematic use of a theoretical model to establish an interpersonal process wherein a trained play therapist uses the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development.” (Association of Play Therapy, 2014). Play therapy can thus be seen as a helping interaction between a trained therapist and a child for the purpose of relieving emotional distress by using the symbolic communication of play (Webb, 2007:46).

The phenomenon of play has always been seen as having healing powers. The therapeutic powers of play can be divided into eight categories: communication, emotional regulation, relationship enhancement, moral judgement, stress management, ego boosting, preparation for life and self-actualization (Nash & Shaefer, 2011:4). Bringing play into therapeutic work not only makes sense but is often essential for therapeutic progress (Gaskill & Perry, 2014:179). The primary purposes of play therapy are summarized by Webb (2007:49) as (1) to help troubled children express and obtain relief from conflicts and anxieties symbolically through play in the context of a therapeutic relationship; and (2) to facilitate children’s future growth and development.

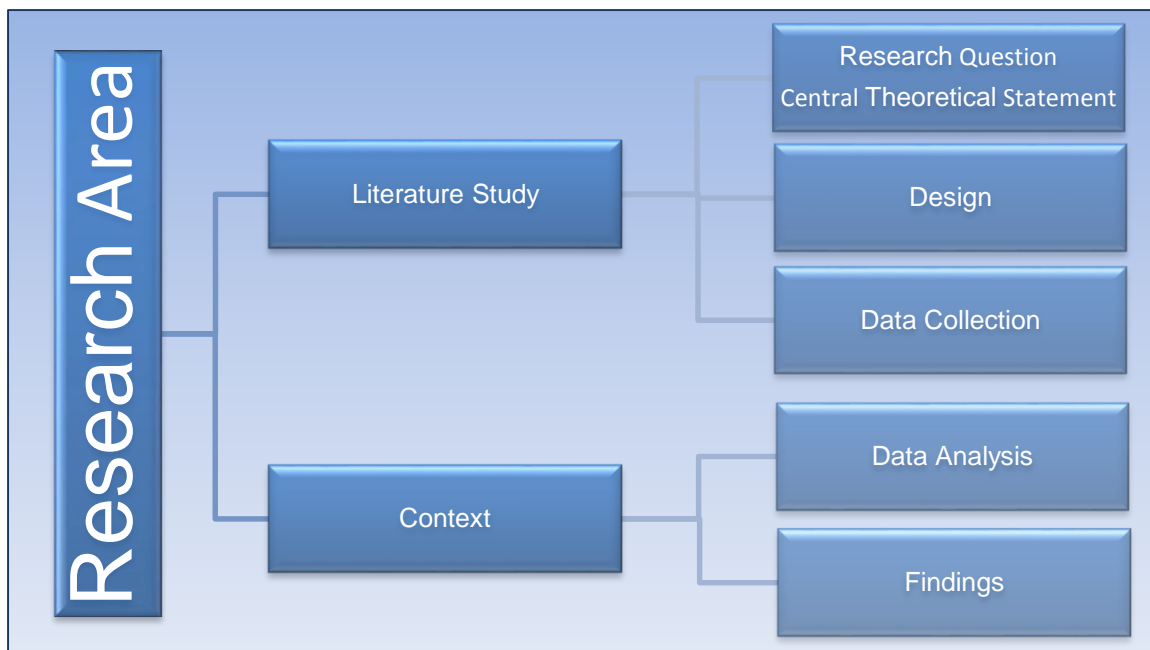
Like traditional adult therapies, play therapy can be implemented in a variety of formats, one being a structured play therapy approach. Structured play therapy, known as directive or active play therapy, emerged from a psychoanalytical framework (Bowers, 2013:27). It actually emerged from the belief in the cathartic value of play, combined with the active involvement of the therapist determining the focus and course of therapy (Bowers, 2013:27). Structured play therapy is described by Gove Hambidge (1982) as a series of specific play situations that are structured to serve as stimuli for the relative, but independent, creative play of children (Ray, 2011:12). This type of therapy is more direct in introducing events stemming from the belief that goals are more readily achieved through structure provided by the therapist (Bouwers, 2011: 28). The therapy thus follows a more directive approach that supports the notion that in order for traumatic experiences to be resolved, some form of retrospective review is necessary (Webb, 2007:51).

### **6.2.5 Model**

A model refers to a collection of beliefs about human functioning and what is needed to bring about change with clients who present with particular problems and situations. Models generally include techniques or actions that are extensions of beliefs about the cause and nature of the problem and how to bring about change (Bogo, 2006:5; Gray, 2010:97). Models can also be seen as specialized approaches that provide a particular way of understanding functioning or defining a problem. Models usually vary in their understanding of how to bring about change and how this understanding is translated into principles and techniques (Bogo, 2006:121) and thus attempts to convert theory or knowledge into practice (Gray, 2010:97). A structured play therapy intervention model can thus be seen as a blueprint that gives a step-by-step guide to the therapist on how to resolve sexual abuse-related trauma and effect change.

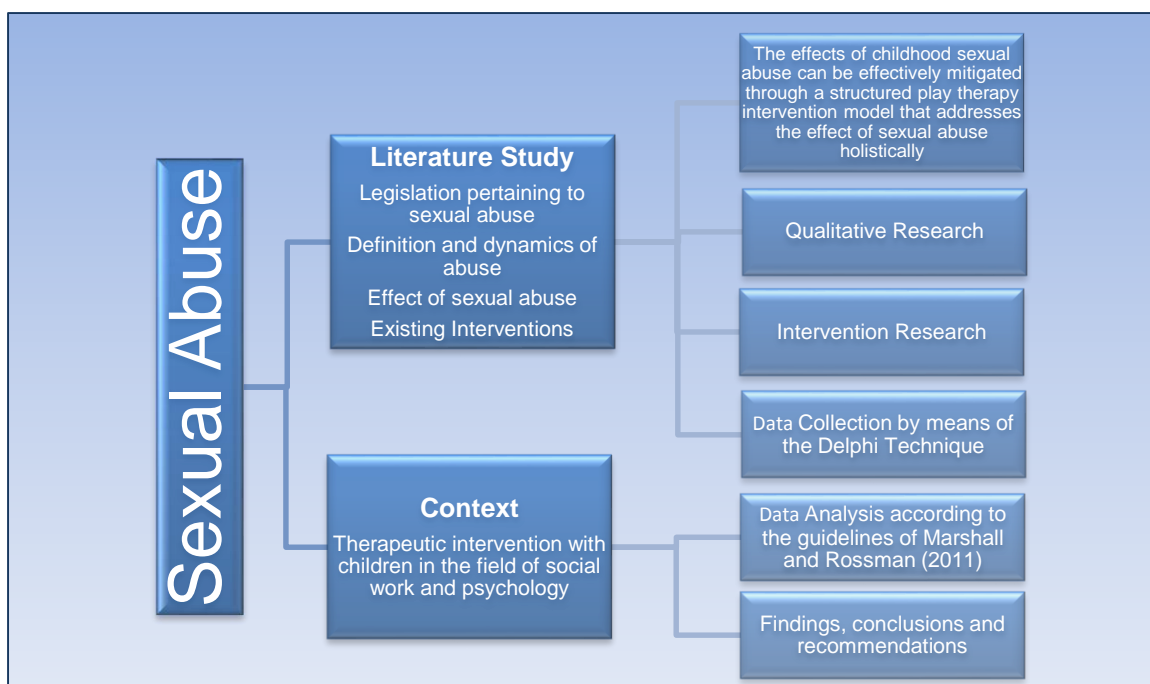
## **6.3 EMPIRICAL STUDY**

The empirical study refers to the design of the study, the tools and techniques used for data collection and how data was analysed (Punch, 2014:318). The empirical study and its components are outlined in Figure 2.



**Figure 2: Outline of the empirical study (Adapted from Punch, 2014:5)**

The empirical study outlined in Figure 2 guided the researcher in planning the research and was subsequently individualized to best address the specific research questions resulting from the problem statement. Figure 3 provides an outline of the template of the empirical study which will also serve as an outline for the research report.



**Figure 3: Outline of the specific research process followed**

### 6.3.1 The research design

According to Creswell (2014:12), the researcher's world perspective, strategies and methods determine the research design, which can be a qualitative, a quantitative or a mixed method design. Qualitative research is designed to answer questions about the complex nature of a phenomenon with the purpose of describing, explaining and understanding the specific phenomenon. Qualitative research incorporates both an epistemological position described as interpretive (*the focus on understanding a social phenomenon*) as well as an ontological position described as constructionist (*which implies that social properties are the outcome of interaction between individuals*) (Bryman, 2012:381). Stemming from the research questions, qualitative research is seen as the most appropriate form of research for this specific study.

Within qualitative research, three practices have been found that attempted to find ways in which research methodology can be used to design and develop human social technology. The three practices, the Intervention Knowledge Development Model (KD-Model), the Intervention Knowledge Utilization Model (KU-Model) and the Intervention Design and Development Model (D&D Model) all fell within the genre of applied research, and all three had a social intervention mission (Thomas & Rothman, 2009:4). The need for an integrated approach that would assist in the development of new interventions within social sciences gave rise to the integration of the aforementioned models into what is now accepted as intervention research (Strydom, Steyn & Strydom, 2007:331).

De Vos and Strydom (2011:475) defines intervention research as: "Research directed at the establishment of procedures for designing, testing, evaluating and refining techniques and instruments with a view to intervening in social problems in communities and groups". Intervention research also refers to the scientific study of interventions for social and health problems (Saydan, 2008:536). De Vos and Strydom (2011:475) concurs, describing intervention research as studies carried out with the purpose of conceiving, creating or testing innovative human service approaches to prevent or mitigate problems or to improve the quality of life. Melnyk and Morrison-Beedy (2012:1) explain that intervention research is all about finding out what treatments or strategies work best to achieve and improve the desired outcomes and make a difference. Intervention research involves both creative and evaluative processes that result in two products: (a) a detailed description of a new product or program; (b) evaluation of the effectiveness of the program (Fraser, Richman, Galinsky & Day, 2009:4).

In the light of this, the research aims to design and evaluate an intervention model to mitigate the effect of child sexual abuse. The intervention model is seen as the most appropriate model to use in order to achieve this goal. Intervention research is rooted in scientific methods but follows a process in which all kinds of evidence are used in the design and development of programs (Fraser *et al.*, 2009:13). Intervention research design usually follows a phased developmental sequence, which is set out in Table 2:

PHASE	DESCRIPTION OF PHASE	PROPOSED COMPONENTS
Phase 1	Problem analysis and project planning	1.1 Identifying and involving clients, 1.2 Gaining entry to and cooperation from settings, 1.3 Identifying concerns of the population, 1.4 Analysing concerns or problems identified 1.5 Setting goals
Phase 2	Information gathering and syntheses	2.1 Use of existing literature and sources of information 2.2 Studying natural examples 2.3 Identifying functional elements of existing models
Phase 3	Design	3.1 Designing and specifying elements of an intervention model and procedures
Phase 4	Evaluation of the proposed model	4.1 Identifying participants 4.2 Collecting data by means of the Delphi Technique Analysing data
Phase 5	Advance development and dissemination	5.1 Advance development 5.2 Dissemination

**Table 2: Outline of the phases of intervention research as adapted to the specific research study (De Vos & Strydom, 2011:476-489)**

The phases of intervention research outlined in Table 2 and the specific process that will be followed in the research study will be discussed in the following paragraphs.

### **6.3.2 Procedure**

The research procedure will consist of the different phases outlined in Table 2.

#### **Phase 1: Problem analysis and project planning**

Problem analysis and project planning involve four interlinked steps, namely, identifying and involving clients, gaining entry and cooperation from settings, identifying the concerns of the population, analysing the concerns or problems identified and setting goals (De Vos & Strydom, 2011:477; Fraser *et al.*, 2009:29). The first step in this phase involves identifying and involving clients (De Vos & Strydom, 2011:477). When engaging in intervention research, it is crucial that the researcher is an expert in the problem area and understands the dilemmas faced in practice (Fraser *et al.*, 2009:4). This assists the researcher in effective problem analysis and planning. Identifying clients and gaining entry to and cooperation from various settings will follow as a natural result of the researcher's existing involvement in the field of child sexual abuse.

The researcher's own practice experience gave rise to the identification of the absence of an integrated intervention model to address the needs of the sexually abused child. This need was further identified and analysed through involvement with other professionals working in the field, through peer discussions and supervision sessions. During the author's practice experience and involvement with other role players on various levels, it became clear that most practitioners in the field experienced a need for guidelines and an integrative approach to addressing the effect of sexual abuse on children.

After the need for an integrated intervention model was identified and explored with professionals working in the field, goals and objectives were set in order to determine how best to address the problem with which professionals are faced. Setting goals and objectives serves the purpose of clarifying the means and end of the research and thus the proposed intervention (De Vos & Strydom, 2011:479). The long-term goal of the research further directed the researcher regarding the information that need to be collected, as well as the

research design most appropriate for the study (Collins, 2010:369). The goal and objectives set for the proposed research are discussed under point 3 in this section and followed from both the problem analysis and gathering and synthesising information.

### **Phase 2: Information gathering and synthesis**

The second phase of the research study is aimed at knowledge acquisition in order to identify functional elements from existing information sources that can be used in the design of the intervention program (De Vos & Strydom, 2011:480). The research study started off with an in-depth literature study of various aspects pertaining to sexual abuse. The purpose of the literature study is to develop a body of knowledge that underlines the research problem and highlights existing evidence-based practices. Other aspects pertaining to the literature study are discussed in point 6.1 of this section.

Punch (2014:97) identifies five stages that should form part of information gathering: searching, screening, summarizing, organizing, analysing and synthesising. Once various literature is screened and summarized, the existing literature will be organized and compared in terms of differences and similarities, thereby synthesizing the literature so that the strengths and limitations of the existing body of knowledge are revealed (Fleury & Sidani, 2012:11).

### **Phase 3: Development of procedural elements and design**

The third phase of the research process involved specifying the procedural elements of the intervention and the early development of the intervention model (De Vos & Strydom, 2011:482-483). In this specific research study, the researcher propose a slight deviation from the proposed phases of intervention research as described by De Vos & Strydom (2011:476-489). This deviation in the process is motivated by an ethical stance, which is the decision not to subject sexually abused children to a prototype of the proposed model. Monette, Sullivan, DeJong and Hilton (2014:67) state in this regard that, if the goals of the research can be accomplished by targeting a less vulnerable group than the research participants, then the researcher should follow that route.

As a product of the analysis and syntheses of literature, the researcher identified both the effects of sexual abuse that need to be addressed by an intervention model as well as the limitations of the existing models of intervention. The procedural elements for the intervention

were thus identified through the literature study and existing therapeutic programmes in the field of sexual abuse. The procedural elements identified, served as the guideline for the early development of the proposed intervention model. During this phase a prototype of the intervention model were developed. The proposed intervention model is discussed thoroughly in Section B, Article 4 of this report.

#### **Phase 4: Evaluation of the proposed model**

The fourth phase of the research study involved the evaluation of the prototype. During this phase, the researcher made use of the Delphi Technique to identify research participants and collect data. The Delphi Technique is a widely used and accepted method of gathering data from the participants within their domain of expertise. The Delphi Technique is well suited as a method of collecting data and consensus building by using a series of questions to obtain data from a panel of selected participants. The Delphi Technique consists of several rounds of data collection, and the number of Delphi iterations largely depends on the level of consensus achieved and the extent to which clarification of the data provided is needed (Hsu & Stanford, 2007:3). As part of the evaluation and advance development of the prototype, the researcher (a) identified the research participants; (b) collected data and (c) analysed the data.

##### **(a) Research participants**

Sampling in qualitative research should be determined by the purpose, question and overall strategies of the research project (Bryman, 2012:418; Punch, 2014:164). Bryman (2012:416) states that most qualitative research designs make use of purposive sampling, as the latter places the research question at the heart of the sampling considerations. This ensures that the researcher gains access to a wide number of individuals and thus the information relevant to the research question, so that many different, yet relevant perspectives can be gained (Bryman, 2012:416). The use of purposive sampling is in line with the method of sampling used for the Delphi Technique. In the Delphi Technique, the selection of the subjects is dependent on the different disciplines of expertise relevant to the specific research project (Hsu & Sandford, 2007:3). The ethical concerns stemming from purposive sampling and how these are addressed in the research study and discussed under ethical issues (point 6.5) in the research report.

Experts in the field of trauma and therapy with children were identified by means of purposive sampling. Exclusion and inclusion criteria were chosen for specific scientific reasons and to ensure that participants were involved in the research study on grounds that are ethically fair (O'Mathuna, 2012:80).

### **Inclusion criteria**

The criteria that guided the researcher in purposive sampling include social workers or psychologists with at least two years' experience in the field of child sexual abuse and/or therapy with traumatized children who were working in the private sector and/or welfare sector. The focus were on experience in these two fields specifically, with either pre-school aged children or children in middle childhood.

### **Exclusion criteria**

Social workers and psychologists with limited or no direct experience in working with children on a daily basis was excluded from the sampling group, as well as those whose expertise lies more in working with teenagers.

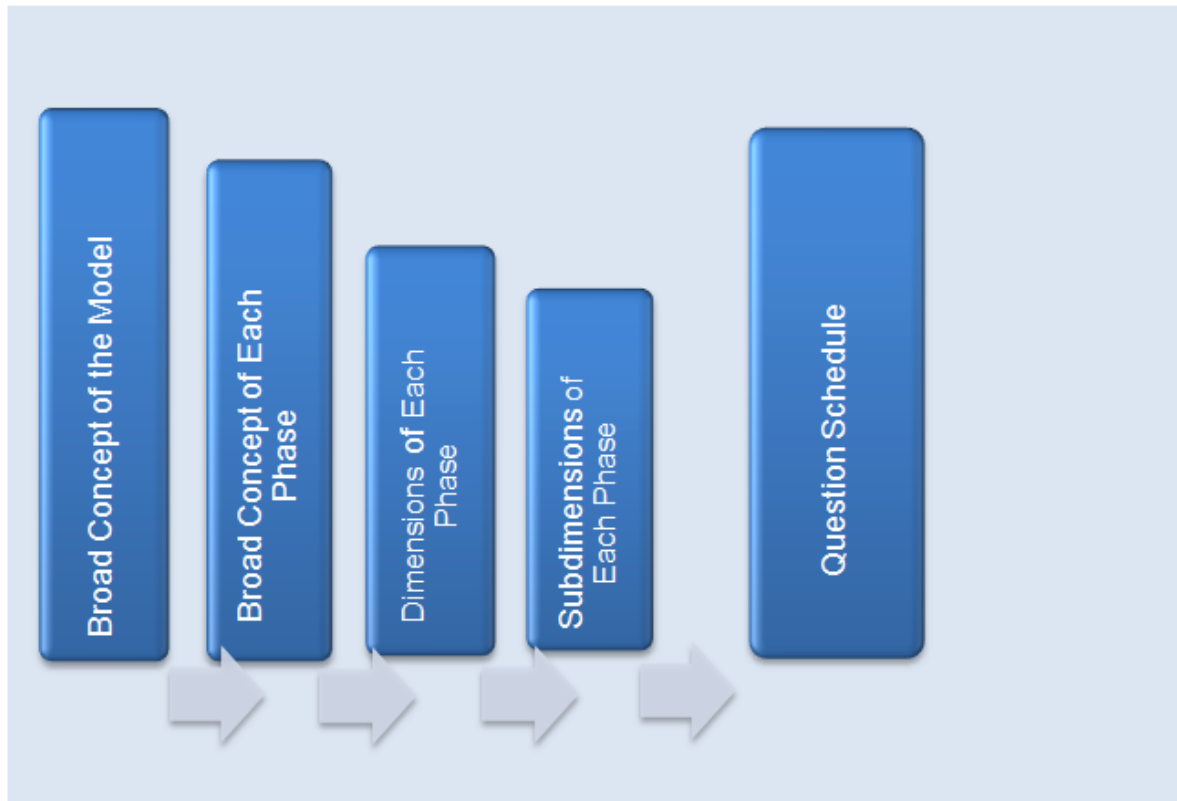
The size of the sample was determined by the size necessary for supporting convincing conclusions and which will ensure theoretical saturation (Bryman, 2012:425-426). An estimate of 30 participants was identified and contacted with a brief outline of the purpose of the research study (*Addendum 1*) and asked to indicate their willingness to participate in the research study. In the second round of data collection, participants were provided with an outline of the research model and a question schedule. As participation in the study was voluntary, the researcher respected any non-comments as part of the participants' choice not to participate.

### **(b) Data collection**

Data collection represents the key point of any research project (Bryman, 2012:12). The researcher made use of the Delphi Technique to collect data from a panel of experts by using a question schedule through two rounds of data collection (Hsu & Sandford, 2007:2). In the first round participants will have the opportunity to work through the question schedule which will then be returned to the researcher. The researcher will collect all the data, and return

a summarized statement of the position of the whole group to each participants for further comments and elaboration. The number of Delphi iterations will largely depend on the level of consensus achieved and the extent to which clarification of the data provided is needed (Hsu & Stanford, 2007:3). In this study only two rounds of active data collection was enough to capture the essence of the participants' contributions.

The researcher followed a structured approach to data collection insofar as she will determine in advance the broad contours of what information will be needed, and design a research instrument to implement this (Bryman, 2012:12). The researcher developed a semi-structured question schedule that were implemented during the use of the Delphi Technique. This were made available to the research participants, together with the proposed intervention model. In developing the question schedule, the researcher used the framework of a descending ladder of abstraction (May, 2011:106). Starting with the broad concept of the intervention model, the researcher began with constructing questions regarding the broad concept of each phase of the proposed model. This was followed by considering the different dimensions and sub-dimensions of each phase (May, 2011:106) and formulating open questions around these aspects. Figure 4 provides an outline of the process whereby the question schedule were developed.



**Figure 4: Outline of the framework of descending abstraction through which the question schedule was developed**

The objective of the question schedule were to aid participants, who are experts in the field of trauma and therapy with children, to review and comment on the proposed therapeutic model. The question schedule made use of open questions, giving the participants the opportunity of writing an answer in the space provided. Asking open questions allowed the participants to answer adequately and thoroughly, thereby adding richness to the detail obtained. The question schedule was piloted with a subsample to assess the effectiveness of individual questions as well as to gauge how the question schedule function as a coherent whole to meet the goal of the research study (May, 2011:107).

The researcher decided to use a semi-structured question schedule, as the identified research participants are practising over a wide geographical area (Pretoria, Krugersdorp, Stellenbosch, and Kathu). Once the participants' consents to be involved in the research, the prototype (*Addendum 2*) was made available to them together with the question schedule to guide their review of the prototype (*Addendum 3*). The research participants also had the opportunity of studying the proposed therapeutic model and completing the question schedule in their own time.

(c) Proposed method of data-analysis

According to Punch (2014:200), the method of data analysis should follow from the way the research and research questions have been framed and developed (Marshall & Rossman, 2011:209). During data analysis, researchers learn whether their ideas are confirmed or refuted by the empirical reality (Monette *et al.*, 2014:10). The data generated by the proposed study was analysed in the following steps:

Step 1: Organising and immersion in data

Data organising entails the researcher familiarising herself with the data and transferring the data into the pre-developed data recording chart (Marshall & Rossman, 2011:211). The data recording chart and categories will be developed in conjunction with the question schedule by identifying broad concepts, dimensions and sub-dimensions of the proposed intervention model. Figure 4 of this section provides an outline of the process that was followed during the development of the question schedule and subsequently the data recording chart. Data recording chart was developed in advanced.

### Step 2: Generating categories, themes and patterns and coding the data

The intellectual component of data analysis is found in the generating of categories, themes and then identifying codes (Marshall & Rossman, 2011:212). This step was implemented during the development of the question schedule and subsequent development of a data recording chart. Once the data was entered into the data recording chart all entries was studied thoroughly by the researcher (Marshall & Rossman, 2011:211).

### Step 3: Interpretation through analytical memos

Once all data was recorded in the data recording chart the researcher interpreted the data. The interpretation of data through theoretical and analytical memos included notes by the researcher on the themes as the data accumulates (Marshall & Rossman, 2011:212). This process included studying the data in the light of the available literature, developing critical insights into the data moving from mundane to more specific thoughts and conclusions (Marshall & Rossman, 2011: 213). During this aspect of the data analysis, the researcher also considered alternative hypotheses and explanations for the findings, based on the literature available as well as the researcher's practical experience.

### Step 4: Writing the final research document

Marshall and Rossman (2011:209) identify the last component of the data analysis as the writing of the research document. This aspect, however, formed a part of the last phase of the research process and are discussed under Phase 5 of the research process.

### Phase 5: Advance development and dissemination

The final phase of the intervention research process consists of five steps aimed at the dissemination of the research. The steps included in this phase consist of preparing the research document, determining a product name and price and providing support to the users (De Vos & Strydom, 2011:487). After the data obtained from the empirical study is analysed, adaptations will be made to the proposed therapeutic model as part of the advance development of the model.

The first three articles pertaining to the research project were published in scientific journals as part of the dissemination process of the research. Table 3 gives an outline of the published articles:

Article	Name of article	Scientific journal
1	Critical analysis of legislation pertaining to children	<i>Child Abuse Research: A South African Journal (CARSA)</i> , 13(1) 2012
2	Redefining sexual abuse from a legal to a psycho-social perspective	<i>South African Journal of Criminology (Acta Criminologica)</i> , 26(2) 2013
3	An ecological systems perspective on the effect of childhood sexual abuse	<i>Child Abuse Research: A South African Journal (CARSA)</i> , 15(1) 2014

**Table 3: Outline of the various articles published as part of the dissemination of the research study.**

The final article, which contains the proposed therapeutic model as well as the empirical study on the model (Article 4) will be prepared for dissemination in CARSA (*Child Abuse Research: A South African Journal*).

## 6.4 THE TRUSTWORTHINESS OF QUALITATIVE RESEARCH

The phrase trustworthiness of research refers to the quality of research that includes both the adequacy and the appropriateness of the research (Rubin & Babbie, 2010:231; Tappen, 2011:153). Holloway and Wheeler (2010:302) state that trustworthiness refers to the methodological soundness of the research study. The trustworthiness of qualitative research is equivalent to the concepts of validity and reliability, which are paramount in quantitative research and aid in determining whether the findings of the qualitative research are credible, dependable, confirmable and transferable to other situations (Tappen, 2011:153).

### **6.4.1 Credibility**

Credibility in qualitative research refers to the internal validity of the research, which can be established through prolonged engagement and persistent observation; member checking; peer debriefing; negative case analysis or triangulation (Tappen, 2011:155). The credibility of the research are achieved through the adoption of a recognised research method namely the qualitative approach to gain insight in the opinions of experts regarding the research topic; the semi-structured schedule used to collect the data based on the sections of the proposed model, the data analysis by means of the Delphi technique, triangulation were applied by means of comparing the data with literature and collecting the data from 10 different expert.

Prolonged engagement and persistent observation imply that enough time and opportunity have been allowed to ensure a trusting relationship with the participants, as well as to test possible explanations that lead to full understanding and thus prevent premature and superficial conclusions (Rubin & Babbie, 2010:232; Tappen. 2011:155). The researcher allowed enough time to establish an ethical and trusting relationship with participants free of any undue influence or deception. Enough time was allowed for the in-depth study of the data and the review of emerging themes and findings to ensure that the findings of the study are credible.

The credibility of the study was further enhanced through negative case analysis. Tappen (2011:158) describes negative case analysis as the lack of agreement and alternative points of view that emerge out of a research study. By highlighting differing opinions in the research report, which emerged from the data analysis, the researcher acknowledged that these did exist and were considered prior to drawing the final conclusions.

### **6.4.2 Transferability**

Transferability is another criterion that helps establish the trustworthiness of qualitative research. Transferability refers to the applicability of the findings of a specific research study to other situations (Holloway & Wheeler, 2010:303; Tappen, 2011:160). It is thus the degree to which careful comparisons can be made between different studies, settings and people. Transferability will be achieved in this study by means of detailed and accurate descriptions

of the research sample, the participants, the procedures and the context in which the research took place.

### **6.4.3 Dependability**

The dependability of the research centers on the degree to which the research process is visible, transparent and open to review (Rubin & Babbie, 2010:232; Tappen, 2011:160-161). If qualitative research is to be dependable it should be consistent and accurate (Holloway & Wheeler, 2010:303). In order to establish dependability, an audit trail should be established whereby the research process can be reviewed (Holloway & Wheeler, 2010:303; Tappen, 2011:161). The dependability of the said research study was achieved through careful record-keeping in the conducting of the study, semi-structured question guidelines that was reviewed by the researcher's supervisors before using during the research as well as the data analysis process. The collected and analysed data are available at the School for Psycho-Social Behavioral Sciences, Social Work Division, North West University, Potchefstroom Campus.

### **6.4.4 Confirmability**

Confirmability is similar to objectivity, yet, in a qualitative study, confirmability is achieved through the way in which findings and conclusions achieve their aim and are not the product of the researcher's preconceived ideas or assumptions (Holloway & Wheeler, 2010:303; Tappen 2011:162). In order to establish confirmability, an audit trail of the research process, intellectual honesty and openness on the part of the researcher are necessary (Holloway & Wheeler, 2010:303). Confirmability was achieved through detailed record-keeping of all the processes, honest reporting of all the findings, own opinions and intellectual sources. All the records relevant to the study are further available for auditing as part of a transparent and open process as indicated under paragraph 6.6.3. The researcher made sure that the same conclusions will be drawn from the data when being reviewed.

## **6.5 ETHICAL ASPECTS**

Ethical considerations should be seen as an integral part of good research (O'Mathuna, 2012:75). Ethics can be seen as more than just a set of overarching rules or guidelines that

guide research but should be evident in the actions and the practice of doing research (Marshall & Rossman, 2011:47). O'Mathuna (2012:75) explains the essence of ethics by stating that the most important determinants of ethical research are the researcher's ethics and personal integrity. Ethical aspects addressed in conducting the research study included:

### **6.5.1 Right to privacy and confidentiality**

O'Mathuna (2012:81) states that the manner in which research participants are recruited should show evidence of respect for others, their privacy and their right to confidentiality and informed consent (Cotrell & McKenzie, 2011:111-115). All the research participants' right to privacy were respected insofar as the participants were first contacted to obtain permission to use their personal information and contact details, in order to send them information on the proposed research study. The research participants identified then had the option of contacting the researcher if they are interested in being part of the research study. They were assured of confidentiality in that the identity of all the research participants are kept confidential by not making any of their names known at any stage, or to any person.

### **6.5.2 Informed consent**

Research participants have the right to make fully informed decisions about their participation in research studies (Bryman, 2012:146; Cotrell & McKenzie, 2011:107; O'Mathuna, 2012:82). All the research participants received adequate information regarding the goal of the investigation, procedures, advantages and potential disadvantages of the study (Strydom, 2011:116).

At first the researcher contacted over 30 potential participants, informing them of the research study and requesting permission to send them more information on becoming involved in the research project. Of the original 30+ potential research participants contacted, 20 professionals gave their permission to be contacted with further information. Although all 20 of the research participants agreed to participate in the research study, only 10 participants completed the question schedule. The research participants were informed that they were at liberty to withdraw from the research at any given moment. From the process followed it is clear that not only did the potential research participants feel at liberty to deny consent to be

contacted by the researcher, but professionals who originally agreed to participate felt at liberty to withdraw their consent and did not complete the semi-structured question schedule that was sent through to them. Therefore the researcher has reason to believe that the 10 participants who sent their comments, participated voluntarily.

### **6.5.3 Prevention of harm**

The prevention of physical and emotional harm is paramount in ethical research (Strydom, 2011:115). The research aims to develop an intervention model to mitigate the effects of sexual abuse. Owing to ethical concern, the researcher opted not to conduct a pilot test of the proposed model with a sexually abused child but will instead rely on professionals to provide a critical analysis of the proposed intervention model. This decision is supported by Monette *et al.* (2014:67), who state that, if the goals of the research can be accomplished by targeting a less vulnerable group than the research participants, then that should be the route to be followed by the researcher.

### **6.5.4 Ethical responsibility towards the discipline of science**

The findings of the research study were correctly and accurately reported in Section B and Section C of the research report. The limitations of the research study were indicated, acknowledged and discussed under point 7 of this section.

The proposed research study was submitted to the Ethical Review Board of NWU, at the inception of the research study to identify any ethical standards or issues the researcher might have overlooked and/or suggest alternative ways of addressing ethical issues. Approval number allocated was *NWU – 00037 – 07 – S7*.

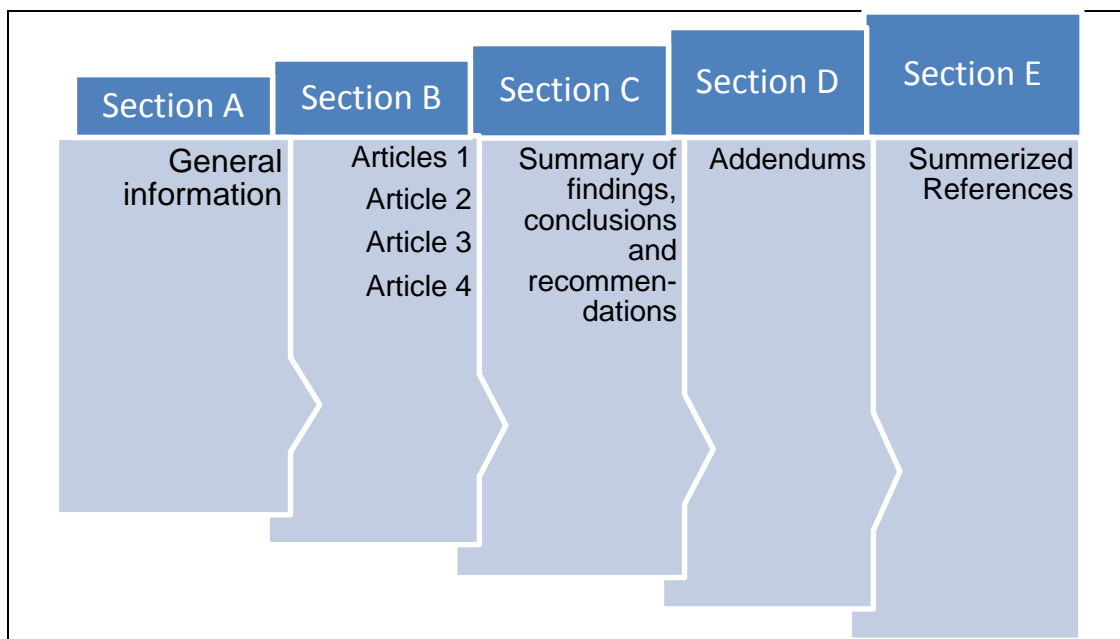
## **7. LIMITATIONS OF THE STUDY**

A limitation of the study can be seen as the fact that the proposed model was not tested by using the model in individual case studies, whereby the model would have been applied in therapeutic intervention with sexually abused children. The next step in the research process,

after the model had been made available for peer review and advance development had taken place, could have been to test the model in practice. This would have added more empirical value to the proposed research. After the finalization of the current research study, the prototype can be regarded as ready for the second phase of research whereby the model can be implemented in practice in service delivery to children who had been sexually abused, through practitioners who have been trained in the model.

## 8. OUTLINE OF THE RESEARCH REPORT

The research report and presentations of the research findings are presented in article format as specified in the Yearbook of the University of North West. The research report can be divided into 5 Sections and is outlined in Figure 5.



**Figure 5: Outline of the research report**

### 8.1 SECTION A: GENERAL INTRODUCTION

This section consists of the problem statement, research questions, research objective, the general theoretical assumption, the theoretical approach, the period during which the research

was done, the research methodology, restrictions of the research, definitions of key terms and the selection and structure of the dissertation.

## **8.2 SECTION B: COMPILATION OF RESEARCH ARTICLES**

Section B consists of the four articles that contain the reports on the research results. The articles with their underlying aim and objectives can be summarized as follows:

### **Article 1: Critical analysis of legislation pertaining to sexual abuse**

The aim of this article is to provide a literature analysis with regard to current legislation pertaining to the sexual abuse of children. To achieve the aim of this article, the following objectives are set:

- To critically evaluate current definitions of sexual abuse from a legal perspective, thereby providing health care professionals with a clear outline of what constitutes sexual abuse in legal terms;
- To critically evaluate the Criminal Law (Sexual Offences and Related Matters) Amendment Act, 32 of 2007 with specific reference to the aspects relevant to the helping professionals, thereby providing those in the field with a clear understanding of the practical implication of legislation when working with a child who has been sexually abused; and
- To critically evaluate the relevant articles in the Child Care Act (38/2005) pertaining to the sexual abuse of children, highlighting the roles and responsibilities of the professionals working in the field of sexual abuse.

### **Article 2: Redefining sexual abuse from a legal to a psychosocial perspective**

The aim of this article is to redefine sexual abuse from a legal to a psychosocial perspective. In order to do this the article will:

- Summarize the legal definition of childhood sexual abuse within the South African context;
- Critically evaluate current definitions of sexual abuse from a psychosocial perspective;
- Formulate a new integrative definition of sexual abuse that encompasses both legal and psychosocial factors pertaining to child sexual abuse.

### **Article 3: An ecological perspective on the effect of childhood sexual abuse**

The aim of this article is to provide an ecological perspective on the effects of sexual abuse of the child. In order to achieve this aim, the following objectives are set:

- To describe the multi-faceted effect of sexual abuse on the child; and
- To outline various factors that play a role in determining the child's individual experience of trauma.

### **Article 4: A structured play therapy intervention model to mitigate the effect of childhood sexual abuse**

The aim of this article is to outline the research study on the proposed structured play therapy intervention model to mitigate the effects of child sexual abuse. To reach the aim of this article the following objectives are set:

- To give an outline of the research methodology underlying the study;
- To discuss the problem analysis and project plan;
- To outline the intervention model for mitigating the effects of child sexual abuse;
- Discuss the research findings on the proposed model.

## **8.3 SECTION C: SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS**

This section contains the summary of the most important findings and conclusions with regard to the research in general. It also contains recommendations and lists the contribution made to the specific field of study.

## **8.4 SECTION D: ADDENDA**

This section consists of the addenda to the research report, including, for example, the outline of the model and the question schedules.

## **8.5 SECTION E: SUMMARIZED REFERENCE LIST**

This section concludes the dissertation with summarized references.

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# **SECTION B: THE ARTICLES**

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**ARTICLE 1**

**A CRITICAL ANALYSIS OF LEGISLATION PERTAINING TO  
THE SEXUAL ABUSE OF CHILDREN**

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**ABSTRACT**

*Knowledge of legislation pertaining to sexual abuse is imperative for health care professionals working with the child who has been sexually abused. This article will provide a critical analysis of those aspects of the Criminal Law (Sexual Offences and Related Matters) Amendment Act, 32 of 2007, relevant to the health care professional. The shortcomings of the Act and the practical implication of these for healthcare professionals will be highlighted. Focus is also placed on the relevant sections of the Childcare Act, 38 of 2005 and how these sections complement the Criminal Law (Sexual Offences and Related Matters) Amendment Act, 32 of 2007.*

**1. INTRODUCTION**

The phenomenon of sexual abuse is one that helping professions are faced with on an increasing basis. In order to address this phenomenon effectively in practice – whether in assessment, evaluation, intervention planning or therapy – it is of the utmost importance that professionals are aware of current legislation pertaining to sexual abuse of children and the practical implication of legislation. When professionals are without knowledge of relevant legislation pertaining to cases of alleged sexual abuse, intervention is often planned without taking relevant legal aspects into account, with the result that interventions fail to meet legal requirements and prerequisites.

Health care professionals often have various misconceptions and different opinions regarding what constitutes sexual abuse. Due to these misconceptions and differences in opinion, health care professionals either neglect to report cases of alleged sexual abuse and/or are unsure when they are legally required to report such a matter to authorities. The information in this article is therefore intended to provide health care professionals with a comprehensive yet critical analysis of current definitions of sexual abuse and the correlation between these

definitions and the Criminal Law (Sexual Offences and Related Matters) Amendment Act, 32 of 2007 (further on “the Act”). A clear outline of the roles and responsibilities of health care professional arising from the Criminal Law (Sexual Offences and Related Matters) Amendment Act, 32 of 2007 as well as the new Child Care Act’ 38 of 2005 is also critically analysed in terms of those aspects relevant to the professional working with the child who has been sexually abused.

## **2. THE AIM AND OBJECTIVES OF THE ARTICLE**

The aim of this article is to provide a literature analysis with regard to current legislation pertaining to the sexual abuse of children. To achieve the aim of this article, the following objectives are set:

- To critically evaluate current definitions of sexual abuse from a legal perspective, thereby providing health care professionals with a clear outline of what constitutes sexual abuse in legal terms;
- To critical evaluate the Criminal Law (Sexual Offences and Related Matters) Amendment Act, 32 of 2007 with specific reference to aspects relevant to the helping professional, thereby providing professionals in the field with a clear understanding of the practical implication of legislation when working with a child who has been sexually abused; and
- To critically evaluate the relevant articles in the Child Care Act, 38 of 2005 pertaining to the sexual abuse of children, highlighting the roles and responsibilities of the professional working in the field of sexual abuse.

## **3. DEFINING SEXUAL ABUSE WITHIN CURRENT LEGISLATION**

Until the recent commencement of the Criminal Law (Sexual Offences and Related Matters) Amendment Act, 32 of 2007, behaviour that was previously described as sexual offences against children was mainly dealt with by the common law. The definition of sexual abuse of children was further limited to terms in the common law such as *rape*, *indecent assault* and/or *incest* (Minnie, 2009:526).

In the Criminal Law (Sexual Offences and Related Matters) Amendment Act, 32 of 2007, however, sexual offence against children is defined in much clearer and broader terms, while the various underlying dynamics of sexual abuse, such as grooming of a child, is for the first time addressed by legislation pertaining to the sexual abuse of children. Although the Criminal Law (Sexual Offences and Related Matters) Amendment Act, 32 of 2007, is a welcome addition to legislation aimed at protecting children, the authors are of the opinion that there are still a variety of weaknesses in the Act that needs to be addressed. In the section to follow, the relevant content of the Act and those aspects relevant to the health care professional working with children who have been sexually abused will be critically analysed.

### **3.1 DEFINING SEXUAL ABUSE IN THE FRAMEWORK OF THE CRIMINAL LAW (SEXUAL OFFENCES AND RELATED MATTERS) AMENDMENT ACT, 32 OF 2007.**

Child sexual abuse encompasses a wide spectrum of acts and there are often disagreement between professionals about both when and whether certain sexual acts are abusive. From a legal point of view, sexual abuse is defined by the Act as any person who engages a child (*a person under the age of 18*) in a sexual act, with or without the consent of the child. A *sexual act* is defined as an act of sexual penetration or an act of sexual violation. *Sexual penetration* is seen as any sexual form of penetration to any extent whatsoever by the genital organ, any body part and/or object by one person into or beyond the genital organs, anus or mouth of another person [Criminal Law (Sexual Offences and Related Matters) Amendment Act, 32 of 2007]. *Sexual violation* includes any act which causes:

- direct or indirect contact between the genital organs, anus or breasts of one person and any part of the body of another person, including any object resembling or presenting the genital organs or anus of a person or animal;
- the mouth of one person and the genital organs, anus, breasts or mouth of another person;
- any other part of the body of another person that could cause sexual arousal or stimulation;
- masturbation of one person by another person; or
- insertion of any object resembling or representing the genital organs of a person or animal into or beyond the mouth of another person [Criminal Law (Sexual Offences and Related Matters) Amendment Act, 32 of 2007].

The terms *sexual penetration* and *sexual violation* provide a legal definition of what is often referred to in literature as *contact sexual abuse*. In sexual abuse literature, contact sexual abuse is described as sexually abusive behaviour where there is direct or indirect contact between the body of the child and that of the perpetrator(s) (Durbin, 1998:16; Faller, 2003:21-22; Labuschagne, 1998:9; Potgieter, 2000:19).

When defining sexual abuse, it is important to realise that sexual abuse is not limited to contact sexual behaviour, as described in the legal terms of sexual penetration and/or sexual violation. Much of sexual abusive behaviours as described in literature may be described as non-contact sexual abuse. Non-contact sexual abuse is viewed as sexually abusive behaviour where there is no direct contact between the child's body and that of the alleged perpetrator, and it thus involves other forms of sexual abusive behaviour in which actual physical contact is excluded (Durbin, 1998:16; Faller, 2003:21-22; Labuschagne, 1998:9; Potgieter, 2000:19).

Although the Act does make reference to behaviours that literature would describe as non-contact sexual abuse, it does not treat these non-contact sexual behaviours as sexual abuse. A person who commits these acts is guilty of the offence of compelling or causing a child to witness pornography, a sexual offence, a sexual act or self-masturbation (Criminal Law (Sexual Offences and Related Matters) Amendment Act, 32 of 2007 (3) (19a,b,c,); (21,1, 2, & 3)).

### **3.2 A CRITICAL ANALYSIS OF THE DEFINITION OF SEXUAL ABUSE AS DESCRIBED IN THE CRIMINAL LAW (SEXUAL OFFENCES AND RELATED MATTERS) AMENDMENT ACT, 32 OF 2007.**

The previous section provided a broad outline of the legal definition of sexual abuse and the extent to which the Act covers aspects of both contact sexual abuse and non-contact sexual abuse, as found in literature. Although the Act makes reference to behaviour that constitutes non-contact sexual behaviour, these behaviours that constitute an offence are limited to a select few. As pointed out above, the Act (in article 19, 21 and 22) refers to behaviour that is described by literature as non-contact sexual abuse. The behaviour described in the Act is, however, limited to the following:

- a) exposure of a child to pornography;

- b) exposure of a child to a sexual offence;
- c) exposure of a child to adult sexual activity;
- d) exposure of a child to self-masturbation; and
- e) exposure of a child to the genital organs, anus or breasts of a person.

Although the inclusion of these behaviours in the Act as an offence is positive, the exclusion of other non-contact behaviours described in literature, such as sexual comments to a child, fetishism and voyeurism, can be seen as a shortcoming in the Act.

In practice it has been experienced that there is often a link between non-contact sexual behaviour and the sexual grooming of the child. It is important, though, that health care professionals note that the Act makes no reference to any connection between non-contact sexual behaviour or offences and the sexual grooming of the child. In practice, the onus would therefore rest on the forensic investigator to prove that the motive underlying these offences (Art 19, 20, 21) was the sexual grooming of the child. Regardless of the fact that the Act fails to highlight the connection between non-contact sexual behaviour and grooming, it is important that professionals understand the dynamics of non-contact sexual abuse as possibly forming part of the process of sexual abuse. In practice, the authors have experienced that non-contact sexual abuse often forms part of the grooming process of a child leading up to sexual violation and/or later sexual penetration of the child. It should, however, also be noted that a progression in behaviour is not always found (Faller, 2003:23; Spies, 2006: 45).

The authors are of the opinion that in cases where non-contact sexual abuse, as described by the Act, is indeed found to be present at the time of the sexual abuse of the child and/or preceding the sexual abuse of the child, these non-contact behaviours should inherently constitute the sexual grooming of a child.

### **3.3 DEFINING GROOMING WITHIN THE FRAMEWORK OF THE CRIMINAL LAW (SEXUAL OFFENCES AND RELATED MATTERS) AMENDMENT ACT, 32 OF 2007**

A critical analysis of the definition of sexual abuse and other behaviour that is seen as a sexual offence in the Act, revealed that the Act does not make a clear link between non-contact sexual behaviours and the sexual grooming of a child. Yet, as pointed out above, the grooming of a child forms an inherent part of most incidents of sexual abuse of a child. It is therefore important that professionals working in the field of sexual abuse have a clear understanding of what grooming entails, both from a legal and a psycho-social perspective.

In general terms, grooming has been defined as “*to prepare or train for a particular purpose or activity*” (OED:395). In the framework of sexual abuse, the “*grooming*” of a child would therefore refer to preparing and/or training a child for the purpose of sexual abuse or sexual activities with the child. In the Act, two new offences have been created in section 18, namely promoting the sexual grooming of children and the sexual grooming of children (Minnie, 2009:555). Sexual grooming of a child is described in the legal framework as the use of an article, pornography, publication or film with the intention to facilitate the commission of a sexual act with or by a child. Sexual grooming of children in the legal framework is also seen as any act committed by a person with the intention to encourage, persuade, facilitate and/or diminish or reduce any resistance or unwillingness of a child, in order to ultimately engage the child in a sexual act [Criminal Law (Sexual Offences and Related Matters) Amendment Act, 32 of 2007]. In light of the above description in the Act, the authors are of the opinion that grooming can therefore be seen as the premeditation of the eventual sexual abuse of a child.

The inclusion of the offence of sexual grooming of a child in the Act begins to acknowledge the important role grooming plays in the sexual abuse of children (Minnie, 2009:545), but the authors are of the opinion that the Act does not take into account the full impact that grooming has on the child. The limitations of the Act with regard to grooming will be highlighted in the next paragraph.

### **3.4 A CRITICAL ANALYSIS OF THE DEFINITION OF GROOMING AS DESCRIBED IN THE CRIMINAL LAW (SEXUAL OFFENCES AND RELATED MATTERS) AMENDMENT ACT, 32 OF 2007**

According to the authors, the term *grooming* can be used to describe the perpetrator's actions during the preparatory stage of sexual abuse. Although the inclusion of sexual grooming in current legislation is a huge step in the right direction, current definitions of grooming fail to connect non-contact sexual behaviours (*the offence of compelling or causing a child to witness pornography, a sexual offence, sexual act or self-masturbation*) with the possible grooming of a child. The authors are of the opinion that where these non-contact sexual behaviours were present prior to and/or during the sexual abuse of the child, the Act should make provision that these behaviours inherently be seen as constituting the sexual grooming of a child. Because the Act fails to do this, it is the responsibility of health care professions to illustrate to the court the progression in behaviour, in cases where it exists, and to highlight how in certain cases the presence of non-contact sexual behaviour can constitute the sexual grooming of the child.

Another shortcoming in the Act pertaining to the sexual grooming of a child relates to the question of premeditation. The Act does not clearly state whether the sexual grooming of a child is seen as premeditation leading to the eventual sexual violation and/or penetration of the child. Yet, where the sexual grooming of a child has been present prior to the eventual sexual violation and/or penetration of a child, it should be seen as premeditation. The very essence of the definition of grooming, both in psycho-social and legal terms, suggests the presence of premeditation. As grooming is not described by the Act as indicative of premeditation, the question that arises is whether the sexual grooming of a child is considered by the court as aggravating circumstances when a person is found guilty of sexual violation and/or penetration of a child.

According to Minnie (2009:555), the Act is limited in the scope of behaviours that are regarded as grooming, and various behaviours which have been recognised by practitioners and academics as grooming, are not included in the provisions of section 18 (2) of the Act. The grooming process of the child is furthermore not limited to the sexual grooming of the child, as referred to in a legal definition, but also includes the emotional grooming, or establishing of an emotionally rewarding relationship with the child. Although this is a difficult aspect to address in the legal framework, legislation fails to consider that offenders may groom a child not only

sexually but also emotionally. In some cases, grooming is an even more extensive process which is not limited to the sexual and emotional grooming of the child but which also includes the grooming of the child's parents and even the broader community. Grooming of the child's parents or primary caretakers and the broader community is often done with the intention to diminish or reduce the parents' or the community's resistance, in an effort to ultimately engage the child in a sexual act (Hollely & Minnie, 2008:2; McAlinden, 2006:339; Minnie, 2009:556).

Although the Act makes provision for the sexual grooming of a child as a sexual offence, it includes various stipulations that apparently disregard the effect of grooming on a victim. An example of this is the age of consent, which is 18, except where consensual sexual acts are described. Where consensual sexual acts are described, the age of consent is between 12 and 16. Children under the age of 12 are thus deemed by the Act as being incapable of consenting to any act of sexual penetration and/or sexual violation (Minnie, 2009:545).

The Act determines that where a child over the age of 12 consents to a sexual act, the perpetrator of such an act will be guilty of a consensual sexual act. This is interpreted as a less serious offence and therefore a lesser sentence will be applicable. The question that arises, then, is whether only children under the age of 12 are susceptible to grooming, bearing in mind that if a child of 12 years or older has been exposed to an emotional and sexual grooming process, that child's ability to give consent to a sexual act would surely be affected. Health care professionals need to take note that where a child has been exposed to sexual grooming, regardless of their age, it is the responsibility of that professional to highlight the impact of the grooming process on the child's ability to give consent to the court.

As pointed out above, the Act places much emphasis on the age of consent. A further question that therefore arises, is whether age alone plays a role in determining whether or not a child can give consent to a sexual act. Factors that influence the ability of a child to give consent will be discussed more in-depth in the section to follow.

### **3.5 THE ISSUE OF CONSENT AS COVERED BY THE CRIMINAL LAW (SEXUAL OFFENCES AND RELATED MATTERS) AMENDMENT ACT, 32 OF 2007.**

Section 1(2) of the Act defines the term *consent* as follows: “*consent means voluntary or uncoerced agreement*”. The issue of consent is further addressed by the Act by excluding children under the age of 12 from being able to give consent to an act of sexual violation and/or sexual penetration, in that section (1)(3)(d) includes children under the age of 12 in the group who is considered to be incapable of appreciating the nature of a sexual act (Minnie, 2009:545). The Act further determines that the sexual exploiting of children (section 17) and the exposure of a child to pornography (section 19) constitute offences, regardless of whether or not a child has consented to these acts. Minnie (2009:544) points out that the practical implication of this is that a person charged with any of these offences will not be able to raise consent as a valid defence.

However, the Act does not allow the same provisions where a child is compelled or in some way caused to witness sexual offences, sexual acts or self-masturbation of the perpetrator while the child is observing. Hence, a valid defence in these cases could rest on the fact that a child consented to witnessing these acts. It is therefore necessary to take a more critical look at the issue of consent.

### **3.6 CRITICAL ANALYSIS OF THE ISSUE OF CONSENT**

In the authors' opinion, the definition in the Act of a mentally disabled person provides good guidelines for when a person is able to provide consent – unfortunately, in the Act these defining factors only apply to cases where mentally disabled people are involved. In the Act, the ability of a child to give consent is determined solely by the age of the child, while other factors that play a role in the child's ability to consent, are not taken into account. Factors like the child's level of maturation, the impact and role of grooming and the difference in power and status between the offender and the child, for example, are not taken into account by the Act.

It is important that health care professionals dealing with cases of alleged sexual abuse have knowledge of and insight into the dynamics of abuse, so that they may understand that age

alone cannot determine ability to give consent. In a case of sexually abusive behaviour where there is a difference in status between the perpetrator and the child, the question that immediately arises is whether a child is able to give informed consent for an action of which he/she has inferior knowledge to a person who is older, wiser, bigger and in an authority position over him/her (Delany, 2005:3; Spies, 2006:44).

Zabow and Kaliski (2006:371) highlight four elements that are considered as central to a person's ability to give consent. These elements include:

- Competence;
- voluntariness;
- full disclosure of information; and
- the possibility to withdraw consent.

Competence of decision-making requires an assessment of the person's understanding and capacity to make decisions regarding the situation at hand (Zabow & Kaliski, 2006:371). According to the authors, the child's capability to understand what he/she is consenting to is undermined not just by age but also by the grooming process as well as the fact that the perpetrator does not fully disclose all information as to what the sexual abuse entails. Zabow and Kaliski (2006:373) explain that consent goes hand in hand with the disclosure of information: *"No-one can make a reasonable decision without being provided with all the relevant information about the procedure or process to which he or she will be consenting to."*

Therefore, situations where children give consent, agree to cooperate, or even willingly and actively participate, are still abusive. Although this aspect is covered by the Act in as far as it acknowledges that certain sexual acts are considered as an offence (sections 17 & 19), regardless of whether the child did give consent, very few of these behaviours are unconstrained by the issue of consent. For example, it is unclear why exposing a child to pornography is treated as an offence, regardless of whether the child gave consent; while in acts such as exposing a child to sexual offences, sexual acts or self-masturbation, consent is accepted as a viable defence. The Act is not consistent in this respect, because a child, who is regarded as unable to consent to being exposed to pornography, should also be deemed unable to consent to witness sexual acts.

It is the opinion of the authors that health care professionals working in the field of sexual abuse should be knowledgeable not only about the legal parameters defining consent but also about those factors that have an influence on a child's ability to give consent. As indicated in the above discussion, the legal parameters defining consent are limited; but regardless of whether a child has given consent to a sexual act or not, it is important to note the professional's obligation to report sexual acts with a child to authorities.

### **3.6.1 Provisions in the Criminal Law (Sexual Offences and Related Matters) Amendment Act, 32 of 2007 in terms of the obligations to report commissions of sexual offences against children**

Within the general provisions of the Act, sections 54 (1)(2), reference is made to the obligation of any person to report knowledge that a sexual offence has been committed against a child. The failure to report such knowledge is treated as an offence that can lead to either imprisonment or a fine. In terms of the reporting of knowledge, suspicion or reasonable belief that a sexual offence has been committed against a mentally disabled person, section 54(2)(c) further determines that if a person reports such suspicions and/or reasonable belief in good faith, that person shall not be liable in terms of any civil or criminal proceedings for making such a report.

In section 54, however, a clear distinction is made between section 54(1) pertaining to children and section 54(2) pertaining to a person who is mentally disabled. With regard to section 54(1), referring to children, the Act limits the obligation of reporting to *knowledge* that a sexual offence has been committed. Section 54(2), pertaining to a mentally disabled person, makes provision for not only the reporting of knowledge but also the obligation to report any reasonable belief and/or suspicion that a sexual offence has been committed. A clear distinction is also made in terms of the civil or criminal liability of reporting information pertaining to sexual abuse in the case of a child, as opposed to a person with mental disabilities. The question that arises is why this clear distinction is made between children and persons with mental disabilities.

### **3.6.2 A critical analysis of the obligations stipulated in the Criminal Law (Sexual Offences and Related Matters) Amendment Act, 32 of 2007 to report commissions of sexual offences against children.**

A distinct differentiation is made in the Act between a child and a person with mental disability, specifically in terms of the general provisions of the Act on the obligation to report sexual offences against children and in terms of civil and criminal liability when someone fails to report these matters. In the sections to follow, each of these aspects will be critically analysed. The Act clearly states that in the case of children, professionals and members of the public are only obligated to report *knowledge* of sexual abuse. Yet, in the case of a person with mental disabilities, the Act specifies that *knowledge, suspicions and/or reasonable belief* that a mentally disabled person is being sexually abused, should be reported to authorities [Criminal Law (Sexual Offences and Related Matters) Amendment Act, 32 of 2007]. Often, professionals and/or members of the public only have a suspicion or a reasonable belief that a child is being sexually abused, although no concrete knowledge exists. Yet, within the general guidelines of the Act, neither professionals nor members of the public are in these cases obliged to report the matter.

By differentiating between a child and a mentally disabled person in terms of the public's obligation to report suspicions or a reasonable belief that a child is being abused, the dynamics of sexual abuse such as grooming and the child's ability to give consent are disregarded. Although it is acknowledged that there is a difference between a child and a mentally disabled person, the definition of a mentally disabled person in the Act should surely also apply to children when the dynamics of sexual abuse are taken into account.

In chapter one of the Act, a mentally disabled person is defined as "*a person affected by any mental disability, including any disorder or disability of the mind to the extent that he or she at the time of the alleged commission of the offence in question was:*

- *able to appreciate the nature and reasonably foreseeable consequences of such an act, but unable to act in accordance with that appreciation;*
- *unable to resist the commission of any such act; or*
- *unable to communicate his or her unwillingness to participate in any such act".*

In view of the above definition of a mentally disabled person, the authors are of the opinion that children – due to their age and cognitive capabilities – are often also incapable to appreciate the nature and foreseeable consequences of a sexual act. The Act indirectly addresses the child's inability to consent to a sexual act, by stating that children under the age of 12 are incapable of understanding the nature of sexual activities and are therefore incapable of consenting to any act of sexual violation and/or penetration (Minnie, 2009:545). Yet, despite this recognition, children are still being placed in a disadvantaged position because the public is not obliged to report suspicions of a child being sexually abused.

The protection that the Act provides against civil or criminal liability of a person who in good faith reports suspicions of and/or reasonable belief of sexual abuse is, again, limited to cases involving persons with a mental disability. In the experience of the authors in private practice, however, people are often hesitant to report suspicions of sexual abuse, as they fear civil proceedings against them by the alleged perpetrator. This concern is now being addressed by the Act in terms of the mentally disabled person and the Act will hopefully provide the public with the necessary assurance that they cannot be held liable for acting in what they believe is the best interest of a mentally disabled person. However, this protection remains limited to cases where the victim is mentally disabled – the Act does not provide the assurance that people reporting suspicions and/or knowledge of sexual abuse of a child cannot be held liable in terms of civil or criminal proceedings. It therefore needs to be established why this clear distinction is made between children and people with mental disabilities.

### **3.6.3 Other shortcomings in the Criminal Law (Sexual Offences and Related Matters) Amendment Act, 32 of 2007 that have relevance for the health care professional working in the field of sexual abuse.**

Other shortcomings in the Act that is relevant for the professional working with children, who have been sexually abused, include a lack of clearer definitions of certain terminology in the Act. The first term that is not clearly defined, relates to the obligation to report *knowledge* of sexual abuse. Above, it was explained that members of the public as well as professionals are under a legal obligation to report knowledge of sexual abuse of a child. Yet, it is not clear what constitutes knowledge of sexual abuse. The Act provides no definition or guidelines to the public or the professional about when information can be considered as knowledge of sexual abuse. In general terms, knowledge is defined as “*The sum of what is known. An awareness gained by experience of a fact or situation.*” (OED:500). In the authors' opinion, knowledge of

sexual abuse would include a verbal disclosure made by a child to another person and/or professional as well as a positive medical exam that confirm sexual abuse. Unfortunately, verbal disclosures as well as positive medical exams are often not present in cases of sexual abuse, and this leaves many children vulnerable to further abuse. It is therefore of the utmost importance that a clearer guideline is set for health care practitioners in terms of when a case should be reported to the authorities.

The second term in the Act that is not clearly defined relates to when a person is deemed to be a perpetrator. The Act refers to a perpetrator as “*a person who commits certain acts deemed as an offence within the act*”, but no clear definition is provided of the terminology “person” in terms of age and/or other defining factors. The only reference to age is made under the general provision of the Act, where it is described that where both the accused parties who are consenting to sexual violation, are children, the age difference between them may not exceed two years.

Where both the perpetrator and the child are minor children, factors such as the motivation and/or intent of the alleged perpetrator should be taken into account when a child is considered as a perpetrator. In the experience of the authors, young children who have been sexually abused often involve other children (with or without a two year age difference) in sexual acts that can be considered abusive, although in such cases it is often not the intent of the “*perpetrator*” to abuse. Rather, an abused child’s repeating of sexual abusive acts with others is intended to make sense of the own abusive experience, and/or an attempt to gain a sense of control over a situation in which the abused child had no power and control (Potgieter, 2000:22; Ryan, 2000:43). The motivation and/or intent of the perpetrator as a factor for determining whether an act should be considered as abusive or not, poses various difficulties. The first and possibly the most difficult aspect in this regard are proving the motive of a perpetrator. Nonetheless, the authors are of the opinion that intent should be considered, especially where acts of sexual violation among children are concerned. Clearer guidelines in the Act about when sexual violation among children should be regarded as a criminal offence could provide professionals with the necessary guidelines to determine when these incidents should be reported criminally.

Minnie (2009:543) concludes that the objectives of the Act are to enact all matters relating to sexual offences in a single statute, to criminalise all forms of sexual abuse or sexual

exploitation and to expand or extend statutory sexual offences. The new Criminal Law (Sexual Offences and Related Matters) Amendment Act, 32 of 2007, is a vast improvement on the common law offences and previous Sexual Offence Act, 23 of 1957, and it succeeds in its attempt to address all matters relating to sexual offences in a single statute. Nevertheless, there are still areas in the Act that fail to address the specific vulnerabilities of children in the sexual sphere.

Complementary to the Act are the sections of the new Children's Act, 38 of 2005, pertaining to sexual offences against children. The sections of the new Children's Act, 38 of 2005, pertaining to sexual abuse and complementary to Criminal Law (Sexual Offences and Related Matters) Amendment Act, 32 of 2007, will be discussed in the section to follow.

#### **4. CRITICAL ANALYSIS OF THE SECTIONS IN THE CHILDREN'S ACT, 38 OF 2005, THAT COMPLEMENT THE SEXUAL CRIMINAL LAW (SEXUAL OFFENCES AND RELATED MATTERS) AMENDMENT ACT, 32 OF 2007**

The object of the Children's Act, 38 of 2005, is to give effect to certain rights of children and to set out principles relating to the care and protection of children. The Children's Act, if implemented correctly, will provide children in South Africa with the legal framework that will safeguard them against violation of their human rights and that will promote their overall well-being and safety (Kassan & Mahery, 2009:185).

In the Children's Act, the provisions pertaining to the reporting of sexual abuse of children may be regarded as complementary to the Criminal Law (Sexual Offences and Related Matters) Amendment Act, 32 of 2007. As pointed out above, one of the weaknesses of the latter Act is that the compulsory reporting of a sexual offence against children is limited to the reporting of *knowledge* of sexual abuse. Section 110(1) of the Children's Act, 38 of 2005, and section 54(1) of the Criminal Law (Sexual Offences and Related Matters) Amendment Act, 32 of 2007, are complementary to these provisions in the latter Act and determine that certain individuals are obliged to report the sexual abuse of a child.

In these sections of the Children’s Act, 38 of 2005, as well as the Criminal Law (Sexual Offences and Related Matters) Amendment Act, 32 of 2007, there is an obligation on a person (both professionals and members of the general public) who:

- On reasonable grounds conclude that a child has been sexually abused (Criminal Law (Sexual Offences and Related Matters) Amendment Act, 32 of 2007 (54)(1)); and/or
- Deals with a child in circumstances that gives rise to the suspicion that a child is being abused (Children’s Act, 38 of 2005), to report such conclusions and/or suspicions.

The Children’s Act (38 of 2005) makes a further distinction between professionals who “*must*” report versus any person who “*may*” report. Thereby placing a greater onus on professionals who on reasonable grounds have concluded that a child has been sexually abused.

According to Kassan and Mahery (2009:222), in order for a person to conclude that a child has been sexually abused, reasonable grounds would include more than mere suspicion, but rather several factors must be present that justify the conclusion of possible abuse. The Children’s Act, 38 of 2005, therefore provides the necessary provisions to enable professions and others to report suspicions of sexual abuse, although the Children’s Act is not very clear on what the factors justifying these suspicions would be. The authors are, however, of the opinion that a constellation of factors – such as behaviour symptoms, including sexualised behaviour, a child playing out age-inappropriate sexual knowledge, as well as tentative disclosures of abuse and possible hearsay evidence by a third party – when seen together, could justly be considered as suspicions of possible abuse that should be reported.

## **5. CONCLUSIONS AND RECOMMENDATIONS**

The Criminal Law (Sexual Offences and Related Matters) Amendment Act, 32 of 2007, represents a huge step in the right direction in terms of protecting children against sexual abuse and enabling the judicial system to effectively prosecute sexual offenders. There are, however, several shortcomings in the Act that need to be addressed. These shortcomings are summarised below:

- A clearer and broader definition is necessary of non-contact sexual behaviours that form part of sexual abuse.

- Non-contact sexual behaviours need to be clearly linked to grooming and in the event where these behaviours formed a part of the abusive experience, the presence of these acts should constitute grooming.
- The elements defining a mentally disabled person in the Act, with regard to their inability to give consent, should also apply to children in cases of sexual abuse, by taking into account the effect of grooming and the dynamics of sexual abuse.
- The issue of consent, as covered by the Act in terms of what a child under the legal age can consent to, should be broadened to include not only the exposure of a child to pornography but also the exposure of a child to sexual offences, sexual acts or self-masturbation by the perpetrator while the child is observing.
- The same obligation that rests upon any person to report suspicions of abuse of a mentally disabled person should also apply with regard to suspicions of abuse of a child. This implies that anyone who reports suspicions of abuse of a child in good faith must be protected by the Act against civil or criminal liability.
- Clearer guidelines in the Act about when sexual violation among children is considered as a criminal offence could provide professionals with the necessary guidelines in terms of when these incidents should be reported criminally.

The critical analysis of various aspects of legislation pertaining to sexual abuse made it clear that the professional working in the field of sexual abuse is tasked with a very big responsibility. In light of the shortcomings of legislation, the authors would like to highlight the following responsibilities of professionals in the field:

- It is the responsibility of health care professionals to equip themselves with extensive knowledge, not only pertaining to the relevant legislation in case of alleged sexual abuse, but also pertaining to the dynamics of abuse.
- Health care professionals have a responsibility to educate the courts on how the presence of non-contact sexual behaviour can in certain cases constitute the sexual grooming of the child, as well as on the possible impact of grooming on a child.
- It is the opinion of the authors that health care professionals working in the field of sexual abuse should be knowledgeable not only about the legal parameters defining consent but also about those factors that have an influence on a child's ability to give consent.
- The Criminal Law (Sexual Offences and Related Matters) Amendment Act, 32 of 2007, as well as the Children's Act, 38 of 2005, place a legal obligation on professionals and members of the public to report knowledge of sexual abuse, as well as a reasonable belief

and/or suspicions of sexual abuse, where such a belief or suspicion is based on a constellation of various factors.

Health care professionals should not only be knowledgeable about legislation relevant to sexual abuse, but should also be aware of the shortcomings in legislation, so that they can take the responsibility to act in the best interest of the child – either by promptly reporting matters of alleged sexual abuse or by speaking on behalf of children, educating the court and others where legislation falls short.

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**ARTICLE 2**

**REDEFINING CHILD SEXUAL ABUSE: FROM A LEGAL TO A  
PSYCHOSOCIAL PERSPECTIVE**

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**ABSTRACT**

*In order to effectively help traumatised children to achieve positive outcomes, one must have a clearly defined methodology, underpinned by theory and based on an integrated approach. The first step towards this is clearly to redefine the phenomenon of child sexual abuse. As sexual abuse is both a legal and a psychosocial phenomenon, the authors are of the opinion that a more integrative definition is necessary in the South African context. The information in this article is therefore aimed at providing health care professionals with an integrative definition that takes into account both the South African legal definition of sexual abuse and the underlying psychosocial factors associated with it.*

**1. INTRODUCTION**

The incidence of the sexual abuse of children is reaching new statistical highs in South Africa. According to a research study conducted in 2009 on the incidence of child sexual abuse in South Africa by the social welfare arm (Helpende Hand [Helping Hand]) of the trade union Solidariteit (Solidarity), an average of 60 cases of child rape per day are reported in the country (Solidariteit, 2009:1). The study, further found that an average of 88 per cent of all child rape cases are never reported to the authorities. If the full picture of child rape cases per day were then to be extrapolated it would indicate that the incidence of the rape of children in South Africa would in fact be an average of 530 cases occurring per day. In other words, using this figure we can assume that in South Africa, one child is raped every three minutes (Solidariteit, 2009: 1).

Bearing these shocking statistics in mind, social workers, psychologists and other health care professionals are faced with the often daunting task of addressing the effects of abuse on children. One of the prerequisites for effectively addressing this impact is a solid knowledge base and understanding of the phenomenon of the sexual abuse of children. If social workers, psychologists and other health care professionals fail to understand and appreciate the

experience and effects of sexual abuse, they will fail to make effective therapeutic interventions. The authors concur with Tomlinson and Philpot's (2008:11) perspective that, in order to effectively help traumatised children to achieve positive outcomes, one must have a clearly defined methodology, underpinned by theory and based on an integrated approach.

Although a diversity of literature is available on the field of sexual abuse, it would appear that the definition of sexual abuse focuses on either the legal definition or the psychosocial definition of sexual abuse. The Criminal Law (Sexual Offence and Related Matters) Amendment Act, 32 of 2007, represents a huge step in the right direction in terms of protecting children against sexual abuse and enabling the judicial system to effectively prosecute offenders. There are, however, several shortcomings in the Act, with specific reference to the legal definition of sexual abuse. The legal definition of sexual abuse, as expressed in the Act, falls short when it comes to both non-contact sexual behaviour, as well as a comprehensive definition of grooming as integral parts of sexual abuse. The shortcomings in the legal definition of sexual definition will be discussed under the summary of the legal definition.

In attempting to truly understand the sexual abuse of children, a definition of abuse further needs to incorporate the dynamics exclusive to the phenomenon of child sexual abuse. As sexual abuse is both a legal and a psychosocial phenomenon, the authors are of the opinion that a more integrative definition is necessary in the South African context. The first step in developing a clearly defined methodology as the foundation to an integrated approach, therefore lies in redefining the phenomenon of the sexual abuse of children. The information in this article is therefore aimed at providing health care professionals with an integrative definition that takes into account both the South African legal definition of sexual abuse and the underlying psychosocial factors with which it is associated in addressing sexual abuse cases.

## **2. THE AIM AND OBJECTIVES OF THE ARTICLE**

The aim of this article is to redefine sexual abuse from a legal to a psychosocial perspective. In order to do this the article will:

- Summarise the legal definition of childhood sexual abuse within the South African context;
- Critically evaluate current definitions of sexual abuse from a psychosocial perspective;
- Formulate a new integrative definition of sexual abuse that encompasses both legal and psychosocial factors pertaining to child sexual abuse.

## **3. A LEGAL AS OPPOSED TO A PSYCHOSOCIAL PERSPECTIVE ON SEXUAL ABUSE**

The sexual abuse of children encompasses a wide spectrum of acts about which professionals often disagree as to both when and whether certain sexual acts are abusive. When attempting to define sexual abuse the following components must be considered:

- Legal definition of sexual abuse;
- Types of sexual behaviour;
- Parameters of both abusive and non-abusive sexual encounters; and
- Psychosocial definition of sexual abuse.

For the purposes of this article, a summary of the legal definition of sexual abuse will be provided. For a more thorough discussion of the legal definition, the reader is referred to Aucamp, Steyn and Van Rensburg (2012: 1-10). The focus of this article, in terms of defining sexual abuse, will be on the psychosocial components of a definition of sexual abuse

### 3.1 SUMMARY OF THE LEGAL DEFINITION OF SEXUAL ABUSE AND TYPES OF SEXUAL BEHAVIOUR

From the legal point of view the perpetrator of sexual abuse is defined by the Criminal Law Sexual Offences and Related Matters Amendment Act, 32 of 2007, as any person who engages a child ('person under the age of 18') with or without the consent of the child, in a sexual act. '*Sexual act*' is defined as an act of sexual penetration or an act of sexual violation. '*Sexual penetration*' can be seen as any sexual form of penetration to any extent whatsoever by the genital organ, any body part and/or object by one person into, or beyond, the genital organs, anus or mouth of another person (Criminal Law Sexual Offences and Related Matters Amendment Act 32 of 2007).

The terms sexual penetration and sexual violation, as described in the Act, provide healthcare professionals with the legal definition of what is often referred to in sexual abuse literature as contact sexual abuse. In the literature, the definition of contact sexual abuse is, however, broader than the legal definition, insofar as it is described as sexually abusive behaviour where there is direct or indirect contact between the child's and the perpetrator's bodies (Faller, 2003:21-22; Potgieter, 2000:19).

A very considerable number of sexually abusive behaviours as described in literature can be seen as non-contact sexual abuse. This is seen as sexually abusive behaviour whereby there is no direct contact between the child's body and that of the alleged perpetrator, and thus involves other forms of sexually abusive behaviour in which actual physical contact is excluded (Faller, 2003:21-22; Potgieter, 2000:19). Non-contact sexually abusive behaviour that constitutes an offence within the Act is limited to the following:

- a) the offence of compelling or causing a child to witness pornography and;
- b) the offence of compelling or causing a child to witness a sexual offence, a sexual act or self-masturbation (Criminal Law Sexual Offences and Related Matters Amendment Act 32 of 2007: (3) (19a,b & c.); (21,1, 2 & 3)). Note that this Act criminalises all these sexual abuse behaviours.

Although the Act does make reference to behaviours that literature would describe as non-contact sexual abuse, it does not treat these behaviours as sexual abuse, but rather as the

offence of compelling or causing a child to witness certain acts, which surely would be treated as a lesser offence.

Although the Criminal Law Sexual Offences and Related Matters Amendment, Act 32 of 2007 is a great advance on previous legislation in this regard, literature on sexual abuse illustrates the shortcomings in the Act by providing health care professionals with a far broader definition of sexual abuse. Such a definition is needed when it comes to non-contact sexual behaviours that often form an aspect of sexual abuse and grooming. These non-contact sexual behaviours should further be clearly linked to grooming. In the event of these behaviours forming part of the abusive experience, the presence of these acts should constitute grooming.

Health care professionals should not only be knowledgeable about legislation relevant to sexual abuse, but should also be aware of the shortcomings in the legislation, so that they can take on the responsibility of acting in the best interests of the child, either by promptly reporting matters of alleged sexual abuse or by speaking on behalf of children, and educating the court and others on the areas in which legislation falls short (Aucamp, Steyn & Van Rensburg: 2012:9).

### **3.2 DEFINING SEXUAL ABUSE FROM A PSYCHOSOCIAL PERSPECTIVE**

Although the Criminal Law Sexual Offences and Related Matters Amendment Act (32 of 2007) provides a solid explanation of which contact and non-contact behaviours can be seen as sexual offences against children, definitions of sexual abuse, as found in some literature, seem to encompass other common components that are not included in the legal perspective.

From psychosocial literature on sexual abuse, certain common components can be identified when attempting to define sexual abuse. These components can also be seen as the parameters defining abusive as opposed to non-abusive behaviour. These parameters include:

- behaviour where the motivation of the perpetrator is their own sexual pleasure or gratification;
- difference in status between the perpetrator and the victim;

- lack of mutual consent (Draucker, 2002:3; Delany, 2005:3; Van Dam, 2006:48; Wickham & West, 2002:3).

The first step in attempting to formulate a comprehensive psychosocial definition of sexual abuse begins with a critical study of the various parameters defining abusive behaviour.

### **3.2.1 Motivation of the perpetrator as a factor defining behaviour as abusive**

One of the first parameters found in literature defining behaviour as sexually abusive is the motivation underlying the alleged offender's behaviour (Draucker, 2002:3; Delany, 2005:3; Van Dam, 2006:48; Wickham & West, 2002:3). In the authors' opinion, the motivation of the perpetrator is a very important factor in deciding whether or not behaviour can be seen as abusive. Often an action, such as touching a child's genitals, could be seen as abusive or non-abusive, depending on the perpetrator's motivation.

If a parent is putting ointment on a child's genitals because the child has a rash this surely cannot be seen as sexually abusive, as the parent's intention is to help the child by soothing the rash. Yet if the same parent were to put ointment on a child's genitals in order to stimulate the child sexually, the same behaviour would be seen as abusive.

However, the perpetrator's motivation as a factor determining whether or not an act can be seen as abusive poses various difficulties. The first, and possibly the most difficult aspect of this, is proving the perpetrator's motive. In certain cases of sexual abuse, this might be clearly indicated. For example, if there has been sexual penetration. However, in other forms of contact and non-contact, abusive sexual behaviours are often not that clear cut. In order to prove the motive of the alleged perpetrator, social workers, psychologists and other health care professionals will have to consider the broader context in which the behaviour has occurred, as well as examining alternative explanations for the behaviour.

The motivation of the perpetrator often lies embedded in a psychological dynamic that is more complex than just sexual needs. Weiland (1997:12) maintains that distortion of thoughts often occurs whereby the perpetrator confuses his own needs with the needs of the child. The thought distortions of the perpetrator often results in him or her believing they are meeting the

emotional needs of the child, through meeting their own sexual and emotional needs. The child's needs in the sexually abusive exchange are therefore secondary to those of the perpetrator (Draucker, 2002:3; Weiland, 1997:12; Wurtele & Kenny, 2012:538). Spies (2006a:17-18) concurs and explains that the adult often turns to the child for nurturance and comfort further expecting the child to meet the adults unfulfilled emotional and sexual needs. The motivational drive behind child sexual offending is complex and regardless of various research, the question 'why' still cannot be fully answered (Gibson & Vandiver, 2008:35; Van Niekerk, 2007:101).

When behaviour is to be defined as sexually abusive, health care professionals ought to take into account all alternative hypotheses explaining both the behaviour and the motivation of the perpetrator. The motivation of the perpetrator can never lessen the harm done to a child through sexual abuse, yet it brings with it important information that can play a role in both sentencing and intervention planning of the perpetrator. Thorough assessment of the perpetrator, offending behaviour and rehabilitation potential therefore should form an integral part of child protection work (Van Niekerk, 2007:100).

### **3.2.2 Difference in status between the perpetrator and victim as a factor in defining behaviour as abusive**

The previous section debated the motivation of the perpetrator as one of the parameters defining sexual abuse. The second parameter highlighted in literature as important when defining sexual abuse refers to the difference in status between the perpetrator and the victim. This difference is a factor in defining behaviour as abusive, and includes the following:

- difference in developmental stages;
- an age difference of five years;
- difference in cognitive abilities;
- superior knowledge about sex; and/or
- power difference (Delany, 2005:3; Draucker, 2002:3; Van Dam, 2006: 48; Wickham & West, 2002:3).

When any of these factors are present, it can be argued that there is a difference in status which results in inequality between the perpetrator and the victim.

In the event of sexual abuse where the perpetrator is an adult, inequality is present in terms of all five of the above aspects that determine a difference in status. Sgroi, Blick and Porter (1982:9) maintain that the subordinate position of the child against the power and authority of the adult perpetrator enables the perpetrator to coerce the child into sexual compliance (Goodyear-Brown, Fath & Myers, 2012:4). Summit (as quoted by Garrison, 1998) concurs that no child is ready to deal with abuse by a trusted adult on whom they are entirely dependent. The basic subordination and powerlessness of children in their relationship with adults further contribute to their helplessness in abusive relationships. According to Summit (as quoted by Garrison, 1998) it is this helplessness that contributes to the later entrapment and eventual accommodation of the abuse by the child, as described in the Child Abuse Accommodation Syndrome. The authors are of the opinion that, in the case of an adult perpetrator, the power position of the perpetrator over the child includes not only the power of an adult position of authority, but also adult emotional power over the child brought about by grooming. This is not to overlook an adult perpetrator's physical power over the child owing to adult size and strength.

However, a difference in status becomes more difficult to determine when sexually inappropriate interaction takes place between two children. Inequality caused by a difference in status can exist even among children, and one of them can be in a subordinate position because of the greater physical size of a peer. Furthermore, children in different developmental stages have different cognitive abilities, which can place one child at a disadvantage in terms of his knowledge and understanding of a sexual act proposed by an older, yet still minor child. Goodyear-Brown *et al.*, (2012:4) explain other situations that may result in a difference in status or power, maintaining that even hierarchical differences in social standing in a peer group may arguably add to the coercive nature of a sexual encounter. In the case of sexual play between children, or even sexually inappropriate exploration, the motivation is seldom sexual in nature. The purpose of highlighting these factors is not to label the child initiating the act as the offender or perpetrator, but rather to call attention to the fact that such a child's experience may be one of abuse giving rise to the same actions that are often reported by another child as sexual abuse (Goodyear-Brown *et al.*, 2012:5). As the occurrences of sexually abusive behaviour perpetrated by young children are on the increase, it is important for health care professionals to critically review those factors that can be seen as a difference in status amongst children, even amongst children of the same age, and to realise the possible effects on the children involved.

The previous discussion directs the attention to the Constitutional Court Verdict with regards to Sections 15 and 16 of the Criminal Law (Sexual Offence and Related Matters) Amendment Act, 32 of 2007 that criminalise consensual sexual acts between adolescents. The Constitutional Court, on the 3 October 2013, found that Sections 15 and 16 of the Act is unconstitutional as it infringes on adolescents rights to privacy and dignity. However, non-consensual acts between children of any age still remains illegal and prosecutable (Gender Health & Justice Research Unit, 2013). Regardless of the decriminalisation of adolescent consensual sex, practitioners still need to consider variables of inequality when working with adolescents and guard against the assumption that all adolescent sexual encounters are consensual. The greatest challenge practitioners will face is educating law enforcement and the courts on inequality and the role this plays in both non-consensual and consensual adolescent sexual encounters.

When sexual abuse involves inequality, a stronger party (the alleged offender), for any of the above reasons, is forcing a weaker party (the child) to consent to sexual activity (Zabow & Kaliski, 2006:277). In psycho-legal terms, this can constitute undue influence imposed on the child's ability to consent. The issue of consent as a factor defining behaviour as sexual abuse will be discussed in the following section.

### **3.2.3 Lack of mutual consent as a factor defining behaviour as abusive**

The inequality or difference in status that influences a child's ability to give consent has been highlighted. Consent is seen in some literature as a further factor in distinguishing between abusive and non-abusive behaviour (Draucker, 2002:3; Delany, 2005:3; Van Dam, 2006:48; Wickham & West, 2002:3). In a review of psycho-legal literature on the issue of consent, Potonick and Pienaar (2006:272) state that, in order for an individual to give consent, the following prerequisites for valid consent are to be followed:

- that the subject is informed;
- that the subject is competent; and
- that the subject is not unduly influenced (voluntariness).

The first prerequisite for a valid consent thus lies in the assumption that consent must be informed. The implication is that a child must have full knowledge and understanding of the

nature of what he/she is consenting to, the significance of the sexual encounter, and the benefits, risks and reasonable alternatives for what he/she is consenting to (Potonick & Pienaar, 2006:272; Zabow & Kaliski, 2006:371).

The second prerequisite for a valid consent lies in the competency of the child to consent to a sexual act. The issue of a child's competency to consent to a sexual act is addressed by the Criminal Law Sexual Offence and Amendment Act (32 of 2007) insofar that Section (1)(3)(d) includes children under the age of 12 in the group who are seen as incapable in law of appreciating the nature of a sexual act and are therefore not deemed competent to consent to such an act (Minnie, 2009:545). Beauchamp and Childress (2001:76) state that a person is competent to make a decision if they have the capacity to:

- understand the information;
- make a judgement about the information in the light of their values;
- intend a certain outcome; and
- freely communicate their wishes.

Owing to the nature of their developmental abilities and levels of maturity, children are in no position to make a judgement about the appropriateness of a suggested sexual act. Their limited field of experience and their knowledge of social values regarding sexual abuse mean that they are unable to make an informed decision about sexual abuse. When considering helplessness as described by Summit (as quoted by Garrison, 1998) in the Child Abuse Accommodation Syndrome (CSAAS), it is clear that no child has equal power to say no or to anticipate the consequences of sexual involvement with an adult. The essence of helplessness as described in the CSAAS stands in stark contrast to valid consent. Furthermore, children who are sexually abused are not given due notice of the intended abuse, nor are they informed of the intended outcome of either a process of sexual grooming or the outcome or effect of the sexual interaction(s). It is therefore clear that children usually do not have the capacity to conform with or meet any of the above criteria in an abusive situation.

The last prerequisite for valid consent is voluntariness, which implies that the subject is not unduly influenced. According to Potonick and Pienaar (2006:277), this occurs when a stronger party influences a weaker party to the latter's detriment by using factors such as isolation, dependence, powerlessness, fear and deception. Truly voluntary consent can therefore be

given only in the absence of these conditions. In child sexual abuse, and with specific reference to helplessness and entrapment as described in the CSAAS (Summit in Garrison, 1998), most, if not all, of these conditions are present.

The authors are further of the opinion that, in order for a child to give consent voluntarily, he or she must be sure that, should they withhold their consent, they would not suffer any negative consequences. Zabow and Kaliski (2006:371) concur, emphasising that one of the core elements impacting on a person's ability to give consent is the individual's right to withdraw consent at any given time. In the researchers' experience, this very seldom applies, since there is often an element of threat or bribery issued to obtain and maintain a child's apparent consent to the abusive act.

Abusive sexual behaviour refers to interaction in which there is a difference in status between the perpetrator and the child. Subsequently, the question that immediately arises is that of consent to an action of which he or she knows less than a person who is older, wiser and physically bigger and in a position of authority over him or her (Delany, 2005:3; Finkelhor, 1995:54; Spies, 2006b:44). For this reason, situations in which children give consent, agree to cooperate, or even willingly and actively participate, are still abusive.

Further, it is important for health care professionals to be aware of the factors that influence a child's ability to give consent, so that, if necessary, this can be highlighted and explained to the child and his or her caregivers in a therapeutic process. Health care professionals also need to understand and make a clear distinction between consent as opposed to cooperation or willingness as a result of difference in status. The child could also have been sexually and emotionally groomed. The authors maintain that cooperation and willingness to comply do not inherently imply that a child has consented to a sexual act.

#### **3.2.4 Concluding the parameters that define behaviour as sexual abuse**

Considering the various parameters defining sexually abusive behaviour, it is clear that an enormous responsibility rests on the shoulders of health care professionals when they are faced with the question of whether or not certain behaviour can be considered abusive. The authors are of the opinion that the various parameters cannot be viewed in isolation, but should

rather be seen as an interlinking set of factors that, when viewed holistically, could assist professionals in determining whether or not certain behaviour can be seen as abusive.

It is vital for health care professionals always to view behaviour within the broader context in which it occurred. It is also important for alternative hypotheses that explain this behaviour, as well as that of the alleged perpetrator, to be taken into account when the motive underlying the behaviour as a determining factor in sexual abuse is considered. Health care professionals should further be informed about the various factors that can constitute inequality, especially in cases where both the victim and the perpetrator are minor children. A sound knowledge base of the CSAAS and the characteristics depicting the abusive reality is vital for all health care practitioners working with child sexual abuse.

#### **4. REDEFINING SEXUAL ABUSE FROM A PSYCHOSOCIAL PERSPECTIVE**

As stated earlier, most definitions of sexual abuse found in literature focus on either the legal definition of sexual abuse or the psychosocial definition of abuse. As far as the South African context is concerned, the authors would like to redefine sexual abuse from a psychosocial perspective that integrates the legal parameters of behaviour that can be seen as abusive. The components that redefine child sexual abuse will be discussed to best explain the behaviours and situations that constitute this phenomenon.

The first component of a comprehensive definition of child sexual abuse is the legal definition of sexual abuse as outlined in the Criminal Law (Sexual Offence Amendment Act), 32 of 2007. This aspect, as summarised in the above definition, was extensively discussed earlier in this article.

When redefining the sexual abuse of children, the health care professional needs to take the categories and dynamics in the Child Sexual Abuse Accommodation Syndrome (CSAAS) into account. CSAAS, as described by Roland Summit during 1983 (as quoted by Garrison, 1998:3), reflects the compelling reality of sexual abuse for the victim. The CSAAS describes five categories, two of which are preconditions for the occurrence of sexual abuse. The remaining three categories are sequential contingencies which take on increasing variability

and complexity. The five categories as described by Summit include secrecy, helplessness, entrapment and accommodation, delayed conflicted disclosure and retraction (Garrison, 1998:3-5). The characteristics of this syndrome, especially secrecy, helplessness and entrapment, corroborate the parameters that define sexually abusive behaviour.

After taking into account the legal definition of abuse and the reality of the characteristics of the abusive situation for the victim, the next aspect for consideration when attempting to redefine sexual abuse is the experience of the victim in this situation. Traumagenic dynamics, as described by Finkelhor and Brown (1985:530-541), illustrate the effect that the various trauma dynamics in conjunction with each other has on the child's unique experience of abuse. Four different traumagenic dynamics are identified:

- a) **Traumatic sexualisation:** The first dynamic explains how sexuality is shaped often in a dysfunctional and inappropriate manner through secondary gains and reward offered by the abuser for sexually inappropriate behaviour.
- b) **Stigmatisation:** The second dynamic operates on receiving negative messages within the abusive experience. These messages of badness, worthlessness, shame and guilt may be communicated overtly by the abuser or covertly through the secrecy of the abuse.
- c) **Betrayal:** Betrayal occurs when the child realises that someone they trust and depend upon is harming them. Betrayal may occur early on in abuse, but in the authors' experience the realisation of betrayal, especially amongst young children, often sets in much later.
- d) **Powerlessness:** A number of aspects of child sexual abuse play a role in powerlessness, not least being the repeated overruling and undesired invasion of the body (Finkelhor & Brown, 1985:530-541).

The traumagenic dynamics are generalised dynamics not necessarily unique to sexual abuse. It is the conjunction of these four dynamics in one set of circumstances that makes the trauma of sexual abuse unique and therefore different from other childhood traumas.

Faller (2003:22) highlights the fact that that the victim's perception of an abusive act is of great importance when it comes to whether or not their experience of the act will be traumatic. (Gil, 2006:6; Spies, 2006b:45; Wickham & West, 2002:3). The child's unique experience or perception of an abusive incident is, in the authors' opinion, a vital component in the formulation of a psychosocial definition of sexual abuse. However caution should be taken

that the absence of trauma or trauma symptoms is not mistaken or used to disconfirm allegations of abuse. Goodyear-Brown, Fath and Myers (2012:14) refer to various research studies conducted over the last 10 years, all of which have found that a significant number of sexually abused children (as many as 40 %) are asymptomatic and thus show no symptoms associated with sexual abuse.

Following the discussion of the components that constitutes child sexual abuse the authors would like to conclude by redefining sexual abuse as follows:

- *Exposure of a child to sexually inappropriate stimuli, that can include but are not limited to sexual penetration, sexual violation and compelling a child to witness sexual acts (Criminal Law Sexual Offence Amendment Act, 32 of 2007);*
- *where the behaviour falls within the parameters defining sexually abusive behaviour that includes lack of mutual consent, inequality and a sexualized motive;*
- *correlation with the characteristics of secrecy, helplessness, entrapment and eventual accommodation of the abuse; and*
- *where the child's experience of the abuse is shaped by traumagenic dynamics of traumatic sexualisation, betrayal, powerlessness and stigmatisation, resulting in symptoms of abuse-related trauma. The absence of trauma and symptoms of abuse related trauma does not, however, mean that sexual abuse did not take place.*

## **5. CONCLUSION**

It is vital that, in working with children who have been sexually abused, it should not be the legal definition alone that is considered when defining an experience as abusive, but a more psycho-social definition should be considered. Although the legal definition of sexual abuse provides health care professionals with the legal parameters of what is considered prosecutable it falls short in capturing the full range of abusive behaviour, as well as the dynamics that forms an integrated part of child sexual abuse. Most psychosocial definitions of sexual abuse incorporate a wider range of behaviour that can be considered abuse, as to what is stipulated as such in the Criminal Law (Sexual Offences and Related Matters) Amendment Act, 32 of 2007. Psychosocial definitions, however, fail to truly capture the dynamics of sexual abuse when limited to a range of behaviours that are considered abusive. The phenomenon of the sexual abuse of children, and thus a definition of sexual abuse, is much more extensive

than just a list of abusive behaviour but includes fundamental dynamics such as grooming, individual experiences and the effect of abuse on the individual child.

In order to effectively help sexually abused children and effectively prosecute offenders, health care professionals and law enforcement officers must have a clearly defined understanding of child sexual abuse. The authors definition of sexual abuse takes into consideration, not only the legal definition, but incorporates the characteristics of the reality of the abusive situation as set out in the Child Abuse Accommodation Syndrome, and also considers the conjunction of the four traumagenic dynamics evident in the effect of an abusive experience on a child. Through the proposed comprehensive definition of child sexual abuse, all role players, in service delivery to sexually abused children, are educated on all the variables that play a role in establishing whether or not an act can be considered abusive. The proposed definition promotes an understanding of the effect of abuse on the child as an integral facet of child sexual abuse. The inclusion of both the reality of the abusive situation and the effect of the abusive experience is necessary in the assessment of victim impact, therapeutic intervention and sentencing of offenders as indispensable components of child protection work. Bearing in mind that the sentencing of offenders should never be determined by victim impact alone.

A one sided approach limited to either the legal definition or a psychosocial definition listing a range of behaviours that can be considered sexually abusive will no longer suffice in effectively addressing the phenomenon of the sexual abuse of children. Effective child protection work begins with health care professionals, law enforcement officers and the public having a clearly defined understanding of the sexual abuse of children. The proposed definition of sexual abuse lays the foundation for a comprehensive understanding of child sexual abuse – the first step in answering the call to protect and effectively help sexually abused children.

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# **ARTICLE 3**

## **AN ECOLOGICAL PERSPECTIVE ON THE EFFECT OF CHILDHOOD ABUSE**

### **ABSTRACT**

*Sexual abuse is a phenomenon with far-reaching effects. This article will provide a holistic look at the effects of sexual abuse from an ecological systems perspective. The effect of sexual abuse on the child as the focus of the microsystem will be highlighted, as well as the effects on the parents or the child's caregiver as the meso system. The authors will attempt to highlight the interactive dynamics between the different systems and will explain how each system can contribute to either mitigating or exacerbating the effects of abuse on the child.*

### **1. INTRODUCTION**

Over the last several decades, health care professionals have witnessed a dramatic increase in knowledge of the effect of trauma on children and adolescents. It is indisputable that sexual abuse has a multi-faceted effect on the child and his functioning (Colarusso, 2010:3; Karakurt & Silver, 2014:80; McFarlane & Yehuda, 2007:157; Van der Kolk & MacFarlane, 2007:15-16). Although there is agreement amongst authors when it comes to the effect of sexual abuse on the child, most of them list possible symptoms of sexual abuse when referring to this effect. However, practitioners fall short when they know only the "signs or indications" associated with sexual abuse, and lack understanding of the underlying psychological dynamics that cause them and the effect's hereof.

### **2. PROBLEM STATEMENT**

The effect of sexual abuse on the child is clear when studying the list of symptoms that abused children can experience. Symptoms associated with sexual abuse are often extensive, but are nonetheless well documented (Currie & Widom, 2010:111; Karakurt & Silver, 2014:80; Saunders, 2012:186; Yonas, Lewis, Hussey, Thompson, Newton, English & Dubowitz, 2010:43). The initial effects of sexual abuse may result in children suffering from one or several

of the following symptoms: anxiety, depression, poor self-image, isolation, awareness of sexuality inappropriate to their chronological age and sleep disturbances, to name but a few (Colarusso, 2010:3-8; Currie & Widom, 2010:111; Karakurt & Silver, 2014:80; Levine & Kline, 2007:39-80; Mannarino, Cohan, Deblinger, Runyon & Steer, 2012:232; Simon, Feiring & McElroy, 2010:229; Yonas *et.al.*, 2010:43). Over time, sexual abuse can result in a cluster of psychological symptoms associated with post-traumatic stress disorder, such as problems in affect regulation, exaggerated startle response, intrusive recollections and persistent avoidance of associated stimuli (Colarusso, 2010:5; De Bellis, Woolley & Hooper, 2013:178-179; Gaskill & Perry, 2012:36-37; Karakurt & Silver, 2014:80; Simon *et al.*, 2010:229).

The authors are wary of focusing on the various symptoms exhibited by sexually abused children, as concern with symptomology poses various dangers. The term symptom can be defined as a sign or indication of an underlying physical or psychological disorder, disease, psychological problem or undesirable situation (New Dictionary of Social Work, 1995:64; Oxford Dictionary, 2006:922). When focusing on symptoms, practitioners lose sight of the child's individual experience and interventions become concentrated on reducing the symptoms of abuse instead of addressing the dynamics underlying these symptoms (Gil, 2006:59; Van der Kolk & McFarlane, 2007:17; Van der Kolk, McFarlane & Van der Hart, 2007:419). A further danger in focusing only on symptoms is that practitioners fall into the trap of using symptomology to determine whether or not a child has been sexually abused. Goodyear-Brown, Fath and Myers (2012:14) refer to various research studies conducted over the last 10 years, all of which have found that a significant number of sexually abused children (as many as 40 %) are asymptomatic and thus show no symptoms associated with sexual abuse.

The effects of sexual abuse do not begin and end with the child. The child forms part of a broader system, which is affected by the abuse, and its effects (Colarusso, 2010:5; Gil, 2006:17; Karakurt & Silver, 2014:80-81; Webb, 2011:12-13,16). An ecological systems perspective provides the professional with a holistic, multi-layered approach to understanding the effects of child sexual abuse.

### **3. AIM OF THIS ARTICLE**

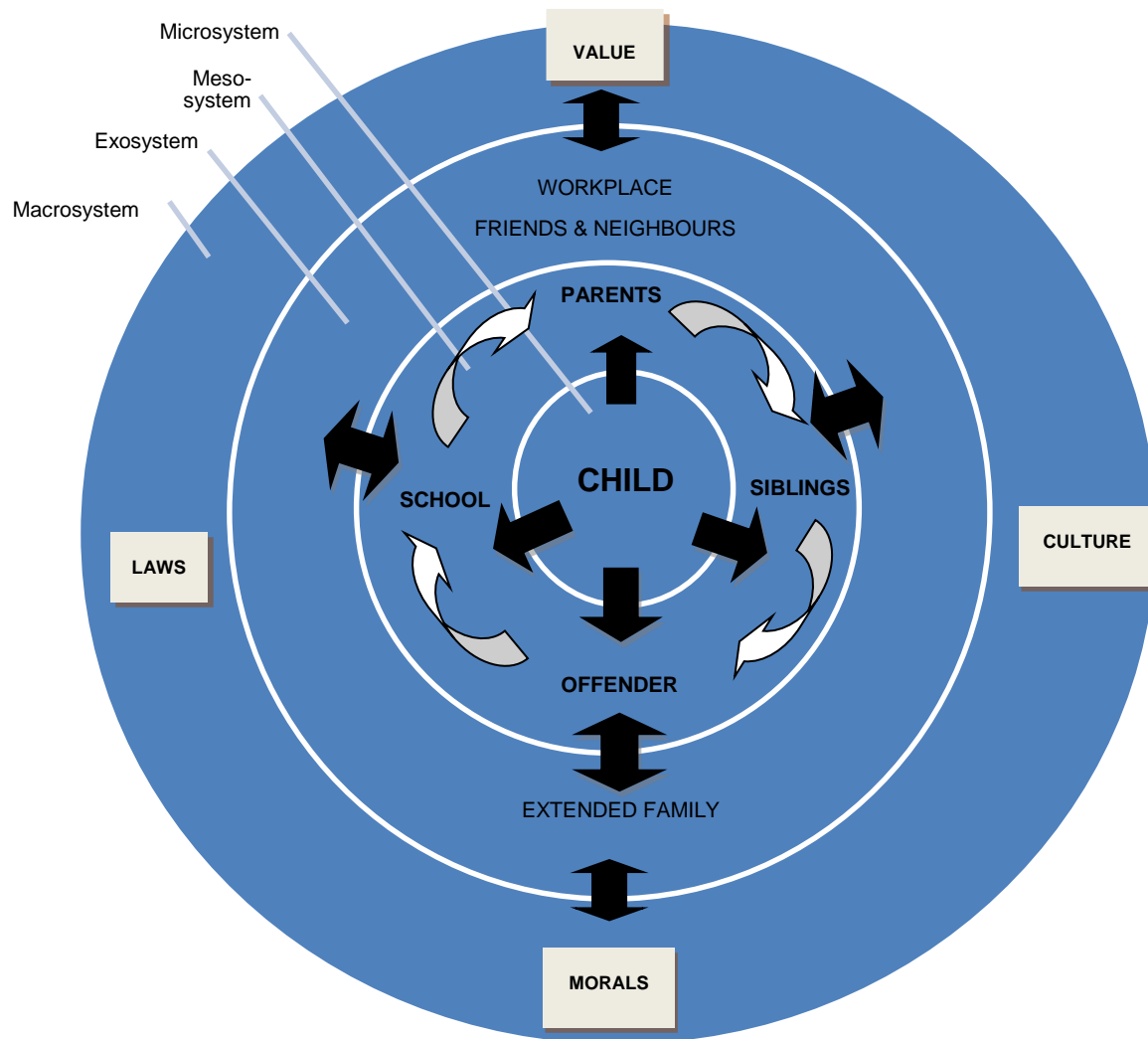
The aim of this article is to provide an ecological perspective on the effect of child sexual abuse on the child. In order to achieve this aim the following objectives are set:

- To describe the multi-facet effect of sexual abuse on the child; and
- To outline various factors that plays a role in determining the child's individual experience of trauma.

### **4. EFFECT OF SEXUAL ABUSE ON THE CHILD**

Sexual abuse has the potential to cause psychological harm to children in all areas of their functioning (Colarusso, 2010:7; De Bellis, Woolley & Hooper, 2013:171; Karakurt & Silver, 2014:80; Spies, 2006:52; Webb, 2011:336). Comprehensive lists of symptoms delineating the effect of sexual abuse on the child are widely available in literature. However, listing the various symptoms does not help practitioners truly understand how the child has been affected in all the spheres of functioning. Sexual abuse has a multi-faceted effect on the child in this respect, so a multi-level approach is necessary if the effect of sexual abuse on the child is to be properly understood (Karakurt & Silver, 2014:81; McFarlane & Yehuda, 2007:157; Van der Kolk & McFarlane, 2007:15-16; Webb, 2011:18). The different areas of the child's functioning affected by sexual abuse do not exist in isolation but are essentially inter-dependent and interactional (Karakurt & Silver, 2014:81; Pynoos, Steinberg & Goenjian, 2007:350; Webb, 2011:61,338). The Bronfenbrenner ecological systems approach is helpful in understanding the effect of sexual abuse on the child, as it provides an interactive model that includes all the systems in which children function, as well as the interaction between the various systems (Bronfenbrenner, 1994:39-40; Karakurt & Silver, 2014:82; Saywick & Williams, 2006:371; Yonas *et al.*, 2010:44). Bronfenbrenner (1994:39) argues that the ecological environment is conceived as a set of nested structures, each inside the other, like Russian Dolls. All the parts of the structure are connected with each other and interaction occurs among the members of the system as well as between the different systems. Each of the systems is interdependent and interactive, so the effect of abuse in one system will have a widespread effect in the other systems (Karakurt & Silver, 2014:81; Yonas *et al.*, 2010:44). Bronfenbrenner (1994:39) refers to this reciprocal effect as bi-directional influences, which are considered to be strongest within the micro-system (Karakurt & Silver, 2014:81; Pynoos, *et al.*, 2007:350; Webb, 2011:61,338).

The effects of sexual abuse on the child from an interactive ecological systems model perspective are shown in Figure 1.

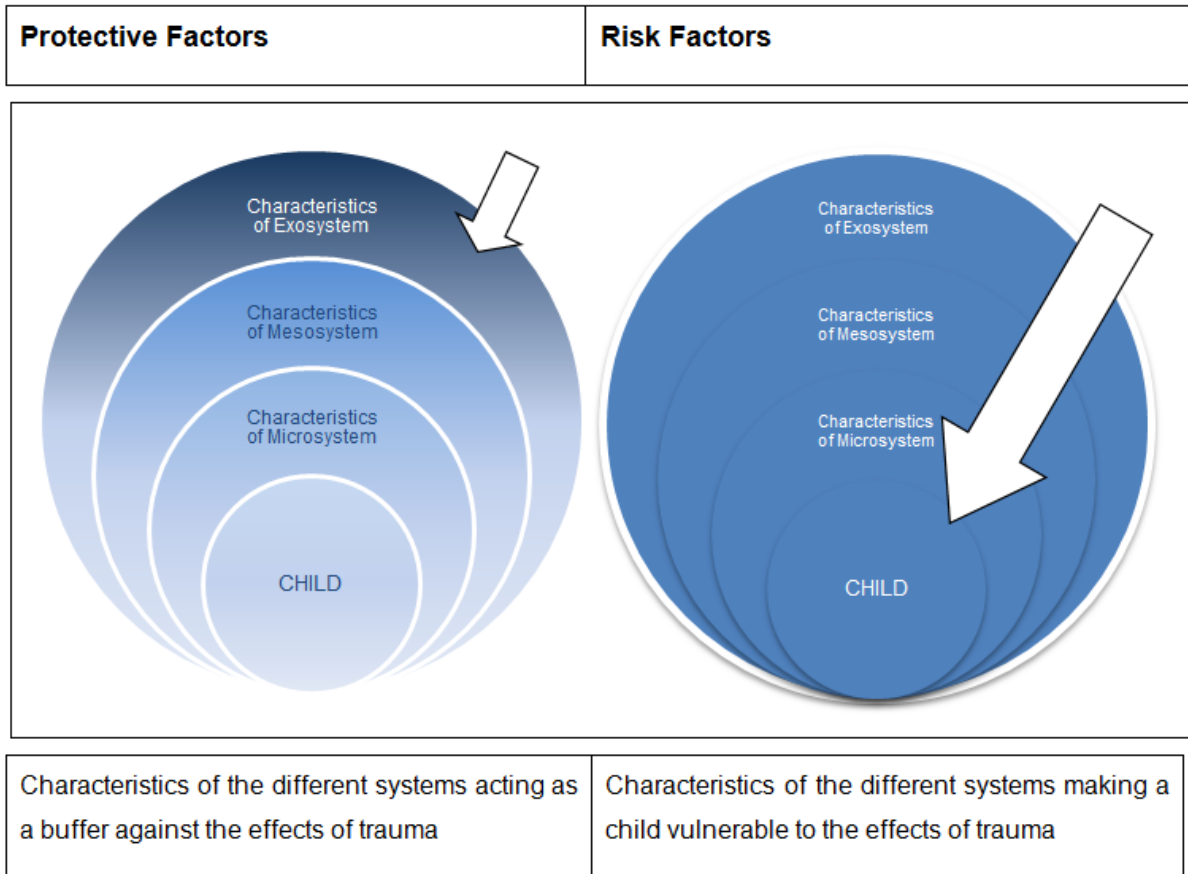


**Figure 1: Ecological systems view of the effect of sexual abuse consisting of interdependent and interacting categories**

The environments or systems consist of a microsystem at the inner core, which reflects individual and interpersonal relationships through face-to-face interaction in the individual's life. At the center of the microsystem, we find the child and the individual effect of sexual abuse in three spheres: (a) Developmental Effect; (b) Neurological Effect; (c) Behavioural Effect.

The mesosystem encapsulates the microsystem and represents, inter alia, the interactional and reciprocal effect of abuse on the child and his primary caregivers and vice-versa. Next follows the exosystem, which represents the larger social system, in which the child does not function directly. The exosystem, however, does interact with other systems or individuals within the microsystem and may therefore indirectly affect the child. Lastly the macrosystem holds the overarching beliefs, resources and customs of the specific culture or community (Bronfenbrenner, 1994:39-40). The culture, customs and beliefs of the macrosystem also interact with and affect the microsystem.

Trauma resulting from sexual abuse is an individualized experience, and various factors that play a role in the child's individual experience of trauma, are described in literature (Colarusso, 2010:3; Easton, Coohy, Rhodes & Moorthy, 2013:212; Gil, 2006:7-8; Karakurt & Silver, 2014:88; Levine & Kline, 2007:72; McFarlane & Yehuda, 2007:157; Pynoos *et al.*, 2007:338; Spies, 2006:49-52; Van der Kolk & MacFarlane, 2007:7; Weiland, 2006:2-5). The various resources that an individual brings to a situation, such as individual resources (for example, temperament) or situational resources (for example, support of caregivers) determine how an event is appraised and thus experienced (Easton *et al.*, 2013:212; Gil, 2006:7; Wurtele & Kenny, 2012:557). From an ecological perspective, each system possesses characteristics that play a role in the individualized effect of sexual abuse related trauma. Figure 2 provides an outline of how the individual characteristics of each system in an ecological systems perspective can act as protective or risk factors in mitigating the effect of sexual abuse.



**Figure 2: Ecological perspective on the individual characteristics of the different systems and their role in mitigating the effect of child sexual abuse.**

Davies (2011:61) defines protective factors as factors in either the child or the environment that mitigate risk by reducing stress and providing opportunities for growth, and/or strengthening coping capacities. In turn, risk factors can be described as conditions such as vulnerabilities in the child, parenting or socio-economic factors that compound the levels of stress and thus vulnerability experienced (McFarlane & Yehuda, 2007:157-158; Yonas *et al.*, 2010:44). Risk factors are further increasingly dangerous, as their number increases because their effects interact with and potentiate one another (Davies, 2011:65).

The extent of the abuse effect in each system is clearly influenced by both the risk and protective factors associated with the micro-, meso- and macrosystems. The effect of sexual abuse will be discussed concurrently with the ecological systems perspective looking at the microsystem with the child as focus, the mesosystem and the macrosystem, as well as the influence of the characteristics of each system on the effect of child sexual abuse.

## **4.1 THE MICROSYSTEM**

The microsystem includes the child and the close interpersonal relationships that form a part of his daily life (Bronfenbrenner 1994:39). When looking at the effect of sexual abuse on the microsystem, professionals have to first consider the direct effect of sexual abuse on the individual child as the center of the microsystem.

### **4.1.1 Effect of sexual abuse within the microsystem, with the child as focus.**

Avoiding symptoms associated with sexual abuse as the focal point, the effect on the child must include the dynamics of this abuse in his internal functioning. This would include the neurobiological effect of trauma on the brain, the developmental effect of the abuse and the resulting behavioural symptoms associated with child sexual abuse.

#### ***4.1.1.1 Neurobiological effect of sexual abuse***

The neurobiological effect of sexual abuse has received a great deal of attention in recent years (De Bellis *et al.*, 2013:17; Gaskill & Perry, 2012:29-37; Gil, 2006:16-17; Weiland, 2006:14-19). The importance of the neurobiological effect of trauma related to sexual abuse is explained by Levine and Kline (2007:4), who maintain that: "Trauma is not in the event itself, rather trauma resides in the nervous system." Despite the rapid advances in the field of neurobiology and trauma, there has been a tendency among professionals to overlook the importance of the neurobiological effect of trauma on children (Pynoos *et al.*, 2007:350). In attempting to understand the effect of sexual abuse and applying the basic principles of intervention with the child, it is imperative to have an understanding of neurobiology (De Bellis *et al.*, 2013:180; Gaskill & Perry, 2012:45; Gil, 2006:16).

The scope of this article does not allow for the thorough discussion necessary if one is to fully understand the neurobiological impact of sexual abuse-related trauma. However, a summary of the most important features includes the understanding that trauma induces a total brain response insofar as all the parts of the brain are affected by the survival reaction (De Bellis *et al.*, 2013:172). Fear and related traumatic reminders associated with child maltreatment are processed through the thalamus, activating the amygdala. The amygdala is responsible for signaling neurons in the prefrontal cortex, hypothalamus and hippocampus, which indirectly causes elevated cortisol response. Increased activity in the brainstem is activated, resulting

in increased sympathetic nervous system activity (heart rate, blood pressure, metabolic rate and alertness). Within the dynamics of sexual abuse, these reactions often persist over time, impairing the brain's prefrontal cortex and executive functions (De Bellis *et al.*, 2013:172; Gaskill & Perry 2012:33).

The hippocampus, the area of the brain that plays a central role in learning and memory, can deteriorate if it is bombarded with high levels of stress hormones. This results in memory impairment. The longer the exposure to trauma, the higher the abnormal concentrations of stress hormones (norepinephrine/epinephrine), resulting in symptoms associated with PTSD. The presence of both PTSD symptoms and high cortisol levels is associated with the reduction of the hippocampus over time, which may contribute to memory impairments (De Bellis *et al.*, 2013:172).

Excessive traumatic experiences can bring about profound alterations in the regulation and functioning of many body systems. Just as the use-dependent process of the brain can create positive learning it can also create negative learning and memory. Owing to the trauma of abuse, the cortex, limbic system and brainstem will all create altered memories based on the traumatic experience, thereby changing the brain's prior homeostatic states. (Fishbein, Warner, Krebs, Trevarthen, Flannery & Hammond, 2009:299; Gaskill & Perry, 2012:30-36). Children experiencing such alterations in the brain will often express these alterations in academic problems, emotional or relationship problems, hypersensitivity to future stress, the inability to self-regulate, sensory-motor problems or physiological problems (Cashmore & Shackel, 2013:23; De Bellis *et al.*, 2013:171-173; Gaskill & Perry, 2012:30-36; Pynoos *et al.*, 2007:350-352; Weiland, 2006:5-15). An understanding of the role of neurobiology in trauma and knowledge of the treatment options that are potentially helpful in the process of neurobiological restoration is essential (Cashmore & Shackel, 2013:23; Gaskill & Perry, 2012:30; Gil, 2006:17).

#### **4.1.1.2 Developmental effect of sexual abuse on the child**

Sexual abuse-related trauma, especially when repeated, has the potential to cause defense adaptations that can interfere with later development (Cashmore & Shackel, 2013:18; Colarusso, 2010:2; Davies, 2011:77). Sexual abuse has the potential to impact on normal development in the following ways:

<b>Developmental sphere effected</b>	<b>Underlying dynamics contributing to negative developmental effect</b>
Cognitive development	Pre-occupation with trauma and survival resulting in minimized energy to accomplish other activities essential for optimum development.
	Persistent high arousal and dissociative tendencies overshadows and interferes with other brain activities such as curiosity, concentration and motivation to learn.
Social development	Constricted play and stigmatization as described by Traumagenic Model adds to social isolation and impacts negatively on social development.
Normal sexual development	Sexual abuse steals the child's processes of normal and healthy sexual development, bringing an awareness of sexuality long before the child is ready to discover it on his own. This aspect is accurately encapsulated in the Traumagenic Model of Finkelhor and Brown (1985:633) by the term traumatic sexualization.

**Table 1: Summary of the effect of sexual abuse on child development**

(Colarusso, 2010:5; Davies, 2011:77; De Bellis *et al.*, 2013:178; Fishbein *et al.*, 2009:299; Gaskill & Perry, 2012:30-36; Levine & Kline, 2007:259; Pynoos *et al.*, 2007:350-352; Van der Kolk, 2007:198).

There has been increasing focus on the effect of trauma that occurs during critical developmental periods in which both cognitive and socio-emotional development might be compromised. It is therefore imperative for practitioners to recognize the fundamental interrelationship between trauma and normal development (Colarusso, 2010:9; Pynoos *et al.*, 2007:332; Tangeman & Shelby, 2012:433). The authors maintain that the effect of sexual abuse related trauma should extend beyond the effects on a single domain of development to include an understanding of its effects on the relationships between the different areas of development. Crucial to an understanding of the effect of abuse on the child is knowledge of normative development. This would assist practitioners in accurately understanding the effect of abuse related trauma and safeguarding against inaccurate assumptions (Colarusso, 2010:3; Poole & Wolfe, 2009:121).

#### ***4.1.1.3 The effect of sexual abuse on the child's behaviour***

The effect of sexual abuse on the child's behaviour includes all of that behaviour resulting from the sexual abuse, whether directed at the self or at others (Yonas *et al.*, 2010:44). As previously stated, the authors are wary of listing behavioural symptoms associated with sexual abuse, as the same behaviour is often also typical of a large percentage of non-abused children (Goodyear-Brown, Fath & Myers, 2012:14; Poole & Wolfe, 2009:101). The behavioural symptoms with which children present vary from child to child according to intensity and frequency, based on a variety of factors (Colarusso, 2010:3; Fishbein *et al.*, 2009:299). The following behaviour is generally associated with children who have been sexually abused: fear and anxiety; sleep disturbances and nightmares; generally heightened emotionality and temper tantrums; aggression; age inappropriate sexualized behaviour; problems with self-esteem and self-image; somatic complaints and bodily concerns; social withdrawal; inability to concentrate and behaviour similar to ADD/ADHD behaviour (Colarusso, 2010:5; Fishbein *et al.*, 2009:299; Hewitt, 2012:127; Karakurt & Silver, 2014:80; Kendall-Tackett, 2012:49-62; Levine & Kline, 2007:70-71; Yonas *et al.*, 2010:43).

The outline of possible behaviour associated with childhood sexual abuse serves as a piece of the puzzle in understanding the effect of sexual abuse on the child. Although practitioners do need an understanding of the potential effect of sexual abuse on the child's behaviour, the authors caution against careless assumptions of abuse based purely on behaviour (Gurley, Kuehnle & Kirkpatrick, 2009:129; Poole & Wolfe, 2009:10).

### **4.1.2 Characteristics of the micro system influencing the effect of sexual abuse on the child**

Each system consists of unique characteristics that can pose as either risk or protective factors in mitigating the effects of child sexual abuse. Characteristics of the microsystem include factors “in” the child, or child characteristics, which influence the child’s vulnerability or resilience against trauma (Davies, 2011:62; Fishbein *et al.*, 2009:299; McFarlane & Yehuda, 2007:158; Simon *et al.*, 2010:230; Webb, 2011:84). Child variables influencing the effect of sexual abuse on the child include temperament, age and the developmental phase, as well as previously formed internalizations or working models.

#### ***4.1.2.1 Temperament***

Temperament refers to biologically-based personality traits that affect the child’s orientation to the world (Davies, 2011:68). The characteristics embedded in temperament act as a filter through which events are experienced. Extremes of temperament can increase both the risk for traumatization and the reaction to trauma, which can intensify the social, emotional and behavioural problems associated with child sexual abuse (Brittz, 2007:47; Davies, 2011:68; Finkelhor, Omrod, Turner & Holt, 2009:317; Nader, 2008:148; Weiland, 2006:4).

#### ***4.1.2.2 Age and developmental phase***

An advance developmental level is considered a protective factor, mitigating the effect of child sexual abuse, as the older the child, the better he will be able to appraise, interpret and cope with the distressing events. Childhood trauma is the most damaging to younger children because the central nervous system and cognitive functions have not yet fully matured. Because of this developmental disadvantage, the child is often overwhelmed by the trauma and its effects (Colarusso, 2010:2; Davies, 2011:62; Finkelhor *et al.*, 2009:325; Fishbein, *et al.*, 2009:312; Levine & Kline, 2007:72; Nader, 2008:139; Spies, 2006:50).

### ***4.1.2.3 Previously-formed working model, internalizations and/or core belief system***

These concepts refer to a cognitive map or mental schemata consisting of assumptions or beliefs that the child internalizes regarding the self, adults or caregivers and the world in general. Although most people cannot verbalize the content of their working models, they nonetheless determine how an individual makes sense of their experiences and what actions they are likely to take in the face of stress or trauma (Davies, 2011:22; Karakurt & Silver, 2014:81; Thomlinson & Philpot, 2008:57-58; Van der Kolk, MacFarlane & van der Hart, 2007:431; Weiland, 2006:2-5). Working models consisting of positive experiences of self and caregivers can contribute to mitigating the harmful effects of child sexual abuse. However, in the same way a child with working models consisting of negative experiences of self may respond to trauma by projecting his existing working model onto the traumatic experience, thereby reinforcing existing models and destructive patterns of thought and behaviour (Davies, 2011:23). Despite clear indications in literature as to the extent to which various child variables can mitigate the harmful effect of sexual abuse in a child's life, practitioners are cautioned to not just assume that the presence of these factors did indeed contribute to this. Rather, a holistic look at all the variables that play a role is important.

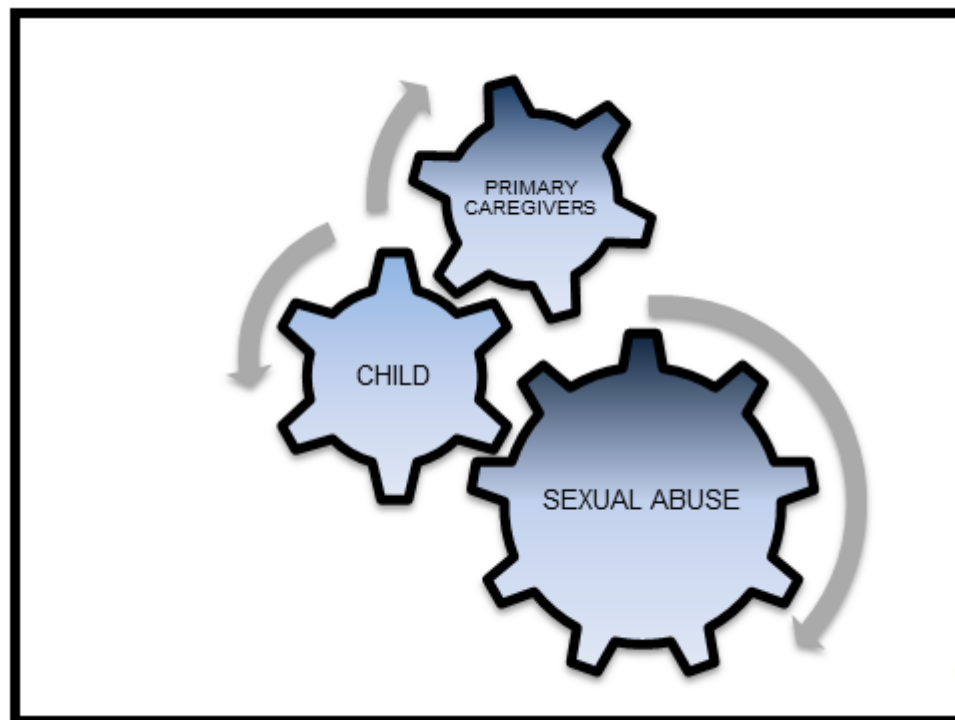
The system of which the child forms a part is the next interactive component in the effect on the child of sexual abuse. While the child's family forms part of the microsystem, the relationship and connection between the child and the family members are seen as the mesosystem. The effect of sexual abuse on the mesosystem is the next area to be discussed.

## **4.2 THE MESOSYSTEM**

The mesosystem refers to the linkages, processes and effects that two or more systems within the microsystem have on one another (Bronfenbrenner 1994:40). Relationships or systems with whom the child interacts directly therefore form part of the mesosystem and should be included in a holistic consideration of the effects of sexual abuse. The most prominent role players who interact with the child, and who will be discussed as part of the mesosystem include the family and the school.

#### 4.2.1 Family as a roleplayer within the mesosystem

When the family is viewed as a system, a problem for one member affects the whole family. In trying to encompass all the ramifications of the effect of sexual abuse on the child, the ecological systems perspective helps the practitioner to understand the reciprocity between the various systems, as illustrated in Figure 3.



**Figure 3: The effect of sexual abuse on the child-caregiver mesosystem**

First, parents and caretakers themselves are at risk of developing traumatic stress response after the disclosure of abuse (Hewitt 2012:130). Learning of the sexual abuse of one's child is generally a conflicting and confusing event. Shock, disbelief, protectiveness, ambivalence, anger and sorrow are just a sample of the emotions experienced by parents whose children disclose abuse. Evidence further strongly suggests that both non-offending mothers and fathers experience significant distress and are faced with various crises following the sexual abuse of their child (Gil, 2006:122-123; Hewitt, 2012:130; Levy-Peck, McCurley & Wolfe, 2009:2).

Owing to the predominant transactional patterns associated with families (Webb, 2011:32), research indicates that the reaction by parents, caregivers or significant others has a

significant effect on the child and the extent to which he will cope with the effects of sexual abuse (Cashmore & Shackel, 2013:11; Karakurt & Silver, 2014:80; Levy-Peck *et al.*, 2009:2; Yonas *et al.*, 2010:43). Even when parents or caregivers believe the child and are supportive, their own emotional reaction to the abuse disclosure can be misinterpreted by the child, especially the young child. This reaction can exacerbate his feelings of guilt and sense of responsibility. Parents and caregivers are often faced with the daunting task of dealing with the child's behavioural and emotional responses resulting from sexual abuse. The authors have found that this is a task for which parents are often ill-equipped. Owing to the effect of sexual abuse, the child and his behaviour often place extra demands on parents.

The authors are of the opinion that there is no single "right way" for a non-offending parent to react to the news that his or her child has been sexually abused. What is important is that professionals realize that sexual abuse does not affect only the child. Considering the idea of the mesosystem, the child is directly affected by the interaction in the mesosystem, where he is personally engaged. Bronfenbrenner (1994:39-40) refers to this reciprocal effect between the child and the parents as bi-directional influences.

#### **4.2.2 The school as a role player in the mesosystem**

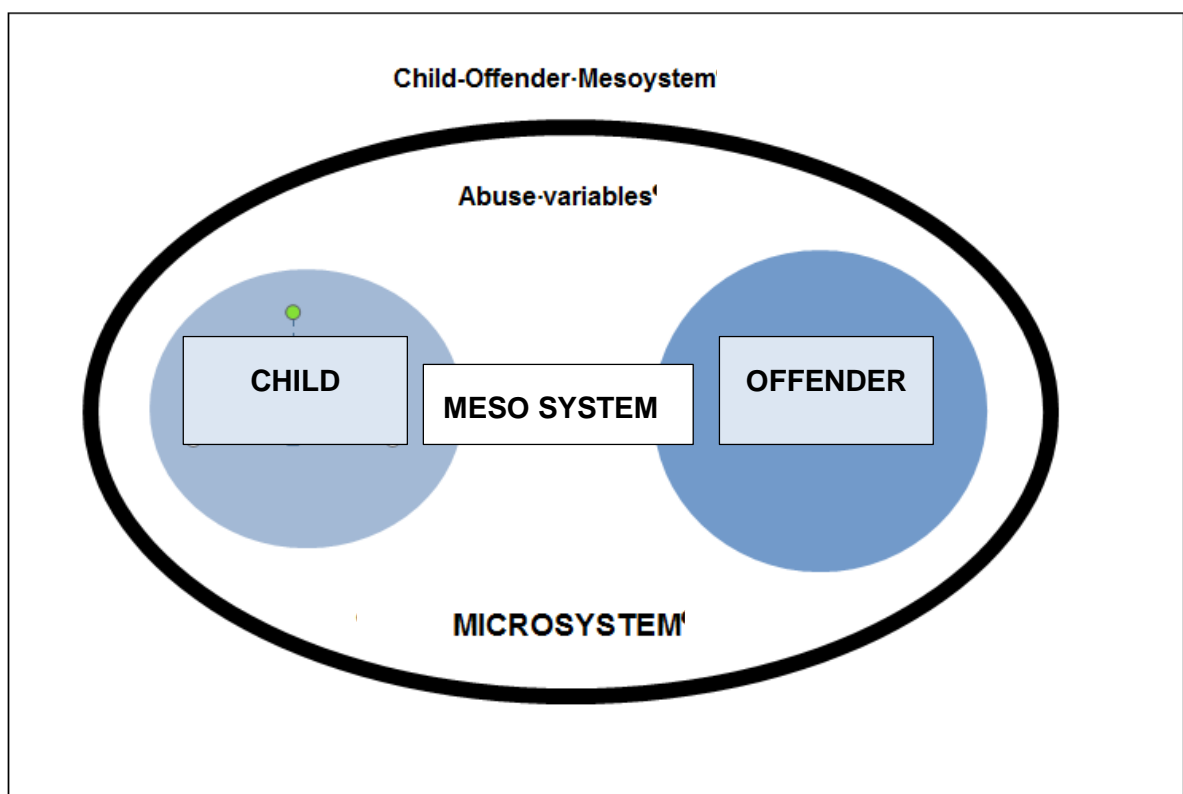
Schools are often considered to be *in loco parentis* (in place of parents), as children spend the majority of their day in the school environment amongst peers and teachers. Next to parents the school can be considered as having the greatest influence on a child's life (Webb, 2011:199). When considering the bi-directional influences within the mesosystem, that is, the reciprocal influence between the various role players within the microsystem, it is obvious that the school environment will also be affected. Webb (2011:199) states that it is both logical and essential to consider this, because of the shared responsibility for the child.

Considering the developmental effect of sexual abuse on the child highlights the first area in which both the child and the school are affected. Because learning requires mental energy and emotional stability, the effect of sexual abuse on the child both developmentally and behaviourally affects the school (De Bellis *et al.*, 2013:180; Gil, 2006:54; Hewitt, 2012:127; Levine & Kline, 2007:70-71; Spies, 2006:53-58; Webb, 2011:200). In the authors' experience, schools are often ill- equipped to deal with developmental and behavioural problems and are

often completely nonplussed by a child's behaviour in the school context. When teachers deal with it incorrectly, the effect of abuse is exacerbated for the child.

### 4.2.3 The abuser as role player within the mesosystem

The dynamics of the sexually abusive relationship place the abuser in the microsystem, as he is someone with whom the child has direct contact. Through the emotional and personal grooming and sexual interaction, a unique child-offender mesosystem is formed. The dynamics within the mesosystem include individual characteristics exclusive to it, which play a role in the child's unique experience of the abuse (Cashmore & Shackel, 2013:11; Gil, 2006:8; Heitritter & Vought, 2006:31). The child-offender mesosystem from an ecological systems perspective is illustrated in Figure 4.



**Figure 4: The child-offender mesosystem in child sexual abuse**

(Gil, 2006:8; Greenwald, 2005:10-11; Heitritter & Vought, 2006:33-35; Levine & Kline, 2007:73; Spies, 2006:50-51;).

Figure 4 outlines how both the offender and the child form part of the microsystem, as the offender is someone with whom the child has direct contact. Various abuse variables which form the connection between the offender and the child are seen as the mesosystem within the abuse context. The most prominent connection in the mesosystem is the child's relationship with the offender. At the heart of this variable lies the traumagenic dynamic of betrayal, as outlined in the traumagenic model by Finkelhor and Browne (1985). Betrayal experienced as part of the relationship with the offender is described by Finkelhor and Browne (1985:530-541) as the dynamic that occurs when the child realizes that someone whom they have trusted and depended on is harming them. This dynamic is considered to be one of the factors contributing to the child's unique experience of the abuse. Trust in the relationship between a child and an offender can therefore be considered an abuse variable in the mesosystem and plays a large role in determining the effect of abuse on the child (Karakurt & Silver, 2014:82; Heitritter & Vought, 2006:33; Spies, 2006:51). However, practitioners cannot simply assume that the impact of sexual abuse will be more severe when perpetrated by a relative or family member. The authors concur with Heitritter and Vought (2006:33) that the nature of the relationship between the child and the offender should be assessed, and understood through the eyes of the child, to determine the child's experience and the subsequent trauma following the betrayal of this relationship.

Powerlessness as traumagenic dynamic seems to be at the heart of the duration of abuse, the extent of abuse and the presence of threat and force (Karakurt & Silver, 2014:84). The longer a child is exposed to sexual abuse and the resulting trauma the more severe will be the effect (Greenwald, 2005:14; Levine & Kline, 2007:73; Spies, 2006:50). An individual may still have the coping mechanisms for dealing with a single traumatic sexual event, but when abuse is repeated, the child's normal coping mechanisms are eroded, forcing him to develop other strategies for survival (Colarusso, 2010:2; Heitritter & Vought, 2006:35; McFarlane & De Girolamo, 2007:130). Child abuse that continues over a period of time therefore has much greater potential to disrupt coping mechanisms, than in the case of a single circumscribed traumatic event (McFarlane & De Girolamo, 2007:130). Repeated abuse over time has the potential to exacerbate the child's feelings of hopelessness and helplessness and to disrupt his sense of security, thereby exacerbating the dynamics of his powerlessness (Karakurt & Silver, 2014:85).

One of the central variables that is often considered crucial in determining the effect of sexual abuse on the child is the nature of the sexual activity or the extent of the abuse to which the

child has been exposed (Gil, 2006:8; Heitritter & Vought, 2006:33; Spies, 2006:50). There is consensus in literature that a perpetrator who takes the child further along the progression of sexually abusive interactions, and/or does more physical damage to the child, has the potential to create a more residual effect (Greenwald, 2005:10; Heitritter & Vought, 2006:34; Howe, 2005:203; Spies, 2006:50). Nevertheless, the authors are of the opinion that the effect of abuse is not determined solely by the extent of the abuse; various other factors are at play and should be considered in relation to the effect of abuse on a specific child. Traumatic sexualization, stigmatization and the level of powerlessness experienced by the child are all factors that play a role in determining the effects of abuse on a child.

Within the field of psychology and trauma recognition it is recognized that some events have a more intense psychological toxicity than others. One of the characteristics of events that have a more intense probability of causing harm are those with the capacity to create fear and an intense sense of threat (McFarlane & Girolamo, 2007:131). Spies (2006:51) states that the presence of threat will create anxiety and fear in the child which in turn may exacerbate feelings of helplessness (McFarlane & Girolamo, 2007:131; Karakurt & Silver, 2014:85). The fear and helplessness associated with threat, force and violence in the child's sexual abuse experience, often demand more from the child's coping mechanism than mere adaptation. When normal coping mechanisms are overwhelmed, the child often has to resort to dissociative responses to defend himself against his state of helplessness and terror (Van der Kolk, Van der Hart & Marmar, 2007:314). In the authors' opinion, the presence of threat, force and violence can add to the traumagenic experience of powerlessness that can aggravate the potentially harmful effect of sexual abuse on the child.

Research, as outlined in the previous discussion, indicates that abuse by a person with whom the child shares a trusted relationship, and sexual activities that are more long-lasting and are accompanied by force or threat, all seem to be related to the degree of trauma experienced by the victim. In concurrence with Webb (2011:13), the authors are of the opinion that simplistic, single-cause explanations no longer suffice for a multi-system, multi-faceted phenomenon such as child sexual abuse. Taking into account the traumagenic dynamics of Finkelhor and Browne (1985:530-540), together with an ecological systems view, a more integrated and holistic understanding of the effect of abuse is ensured.

### **4.3 THE EXOSYSTEM AND MACROSYSTEM**

The micro- and mesosystems are encapsulated in the exosystem and macrosystem, which represents the larger social system in which the child does not function directly. The exosystem contains the relationships and influences between systems in the microsystem (e.g. interaction between the school and parents) as well as broader societal structures, such as the justice system. Even though these role players do not necessarily interact with the child directly, they do interact with systems or individuals within the microsystem, so they may indirectly affect the child. The macrosystem holds the overarching beliefs, resources and customs of the specific culture or community (Bronfenbrenner, 1994:39-40).

Those in the exosystem who can potentially play a role in the effect of sexual abuse include, inter alia, the school, the parents' work and the parents' support system. The degree to which these role players are able to support parents influences how they cope with the reality and subsequent effects of sexual abuse on their child (Cashmore & Shackel, 2013:11). In the authors' practical experience, they have found that parents often choose not to inform the school, their friends or even their extended family about the abuse, owing to the high level of stigmatization surrounding child sexual abuse that still exists in communities. In parents' attempts to protect their child against stigmatization, they are often left without valuable support which could have assisted them in this time of crisis.

Health-care professionals, law enforcement and the criminal justice system are all systems within society that deal with the sexual abuse of children on a daily basis. When conceptualizing sexual abuse from a systems perspective, society has to recognize that abuse affects many individuals and systems in profound ways. One of the effects of sexual abuse on the macrosystem includes vicarious trauma for professionals who deal with child sexual abuse. Research indicates that professionals working in fields dealing with traumatic subject matter demonstrate high levels of secondary trauma and burnout (Morrison, Quadara & Boyd, 2007:14). In the authors' experience, the effects of sexual abuse are not limited to social workers or psychologists, who work directly with abused children, but police officers, state prosecutors and presiding officers are often just as affected.

Within the macrosystem community beliefs can either protect children or put them at risk. The overarching beliefs regarding sexual abuse in the community are often influenced negatively

by false allegations, syndromes such as parental alienation or cultural practices that lead to a callous response or disbelief in the systems that are essentially responsible for protecting and supporting children (Wurtle & Kenny, 2012:542). Children often experience secondary victimization through their experiences of the response by the criminal justice system and healthcare providers (Morrison, Quandara & Boyd, 2007:3). When children are not believed, are exposed to repeated questioning or are refused therapy while awaiting the finalisation of criminal procedures, their trauma is exacerbated.

If we conceptualize sexual abuse as simply an issue of private trauma, the social costs of sexual abuse are rendered invisible. Child sexual abuse has a ripple effect that not only affects the child in the microsystem, but also moves beyond those close to the child, affecting the community and wider society (Cashmore & Shackel, 2013:22; Morrison *et al.*, 2007:26). The role players in the macrosystem and the effect of abuse on the broader community and its systems can, in turn, contribute to either mitigating or exacerbating the effect of the abuse on the child. The complexity of the effects of sexual abuse brings with it the realization that it will no longer be enough for practitioners to continue privatizing the effects of sexual abuse by limiting them to the child and, perhaps, the mesosystem. Greater awareness of the ripple effect of sexual abuse on all the systems, and sequentially on the child, is needed to effectively address the holistic, multi- faceted effect of child sexual abuse.

## **5. SUMMARY AND CONCLUSIONS**

Practitioners working with children need information on the factors that play a role in negotiating trauma, but knowledge of these factors should lead to understanding the need for an individual case-to-case assessment or evaluation of each child as a prerequisite for therapeutic intervention. Gil (2006:17) concurs, maintaining that no child exists in a vacuum. Therefore, when practitioners work with children, they must understand the social and familial context in which they are operating, so that they can assist in whatever ways are necessary. The authors concur with Webb (2011:5) in maintaining that the complex interplay between children and their social environments make it essential to consider simultaneously a child's temperamental and developmental status, and the surrounding familial context, including the risk and protective factors of his or her social environment. The process of therapeutic intervention should therefore begin with a complete understanding of all the factors that have

contributed to the child's current problem situation and experience, so that the practitioner can formulate, propose and implement an appropriate intervention (Webb, 2011:59).

Sexual abuse has the potential to affect the child on multiple levels of functioning. Focus on symptomology alone will not suffice when studying the effects of sexual abuse on children. A holistic, multi-factorial or systems understanding is necessary when attempting to fully understand the effect of sexual abuse on the child. An ecological systems perspective on the effects of sexual abuse avoids a simplistic focus on symptomology, thereby directing therapeutic interventions to addressing the "roots" and not just the "fruit" associated with sexual abuse related trauma. The variety of factors described in literature clearly indicates the need for practitioners to acknowledge and evaluate the individual effects of abuse on the child prior to starting therapeutic interventions. However, this can only be done once the practitioner understands the variables that contribute to exacerbating the effect of abuse (risk factors) or to the child's resilience (protective factors) to withstand its possible harmful effects. Sexual abuse is a complex life experience that includes various dynamics, risk and protective factors. It is neither a diagnosis nor a disorder (Colarusso, 2010:5). It is time for health-care professionals to consider the complexity of the effects of sexual abuse from the perspective of a complex systems perspective that encapsulates the life experience of all the role-players involved.

According to Kagan (2004:40), therapy means to face the pain of the past and recover the promise of the future by helping children to face, master and change the story of their lives. In order to initiate the process, we need to begin by fully understanding the "story" and how it has affected the child and his family.

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## ARTICLE 4

# A STRUCTURED PLAY THERAPY INTERVENTION MODEL TO MITIGATE THE EFFECTS OF CHILDHOOD SEXUAL ABUSE

### ABSTRACT

*As health care professionals are faced with the phenomenon of sexual abuse on increasing levels, the need for effective intervention to address the potentially harmful effects of abuse has never been greater. This article will provide an outline of a structured play therapy intervention model to mitigate the effects of childhood sexual abuse. The various phases of the model and underlying objectives are discussed. The authors will also highlight the empirical study that was undertaken regarding the proposed model and the feedback from research participants.*

### 1. PROBLEM STATEMENT

Childhood sexual abuse in South Africa has become an increasing phenomenon facing health care professionals. A study conducted by Solidariteit (2009:1) found that, in South Africa, a child is raped every three minutes. As statistics for sexual abuse reach new highs so does the need for knowledge and skills for effectively addressing the effects of abuse-related trauma. Over the last several decades, health care professionals have witnessed a dramatic increase in knowledge of the traumatic effects on children and adolescents. While a good deal of research and attention have been given to the effects of sexual abuse in childhood, appropriate ways of helping the children recover have been slower to evolve (Gil, 2006:53; Saunders, 2012:186).

While the need for therapy increases, few interventions address the effects of sexual abuse and the need(s) of the abused child holistically. Gil (2006:53) cites Prior (1996), who summarizes the problem by stating that clinicians are struggling to find their way, with little to guide them and certainly no comprehensive model with which to work. Few approaches to therapy with abused and traumatized children have been studied enough to justify calling them

evidence-based approaches (Gil, 2006:53; Turner, McFarlane & Van der Kolk, 2007:527). One approach that is considered to be evidence-based is Trauma Focussed Cognitive Behavior Therapy (TF-CBT), which is currently at the forefront of empirically-based treatment (Allen & Crosby, 2014:49; Saunders, 2012:193). TF-CBT is a components-based, relatively brief treatment model that incorporates trauma-sensitive interventions with cognitive behavioural, family, and humanistic principles and techniques (Allen & Crosby, 2014:49).

TF-CBT has been found effective in the treatment of sexually abused children, and has various theoretical and practical strengths and some limitations in the use of TF-CBT for children has been identified. Gil (2012:254) emphasize that it is important to note that children have difficulty articulating their abuse or addressing it directly. In addition evidence also suggests that traumatic memories are embedded in the right hemisphere of the brain, which is not really receptive to verbal strategies. Van der Kolk (2007:289) states, in this regard, that the very nature of trauma memories is to be dissociated, and to be stored initially as sensory fragmentary memory that has no linguistic components. Clients can often express their internal states more effectively through physical movement, psychodrama, symbolic language, creativity and play (Gaskill & Perry, 2014: 186; Gil, 2012:254; Stien & Kendall, 2004:137).

Many other treatment methodologies for treating abused children are described by various authors. Yet in concurrence with Gil (2012:252) and Gaskill and Perry (2014:186-187), many of these specify a particular treatment strategy or emphasize only certain dimensions of play. The foundation for a therapeutic model for mitigating the effects of childhood sexual abuse lies in an appreciation not only of the underlying theory of childhood sexual abuse, but also of what the experience of sexual abuse means to the victim (Briere, 2006:vii; Gaskill & Perry, 2014:187; Tomlinson & Philpot, 2008:11). In order for psycho-social interventions to be effective, we need an integrated approach that understands all aspects pertaining to child sexual abuse and also addresses everything to do with the child's functioning: that is, the behavioural, emotional and relational functioning, as well as cognition as an integrated and interdependent whole (Gaskill & Perry, 2014:193).

## **2. THE AIM AND OBJECTIVES OF THE ARTICLE**

The aim of this article is to outline the research study on the proposed structured play therapy intervention model to mitigate the effects of child sexual abuse. To reach the aim of this article, the following objectives are set:

- To give an outline of the research methodology underlying the study;
- To discuss the problem analysis and project plan;
- To outline the intervention model for mitigating the effects of child sexual abuse;
- To discuss the research findings on the proposed model.

## **3. RESEARCH METHODOLOGY**

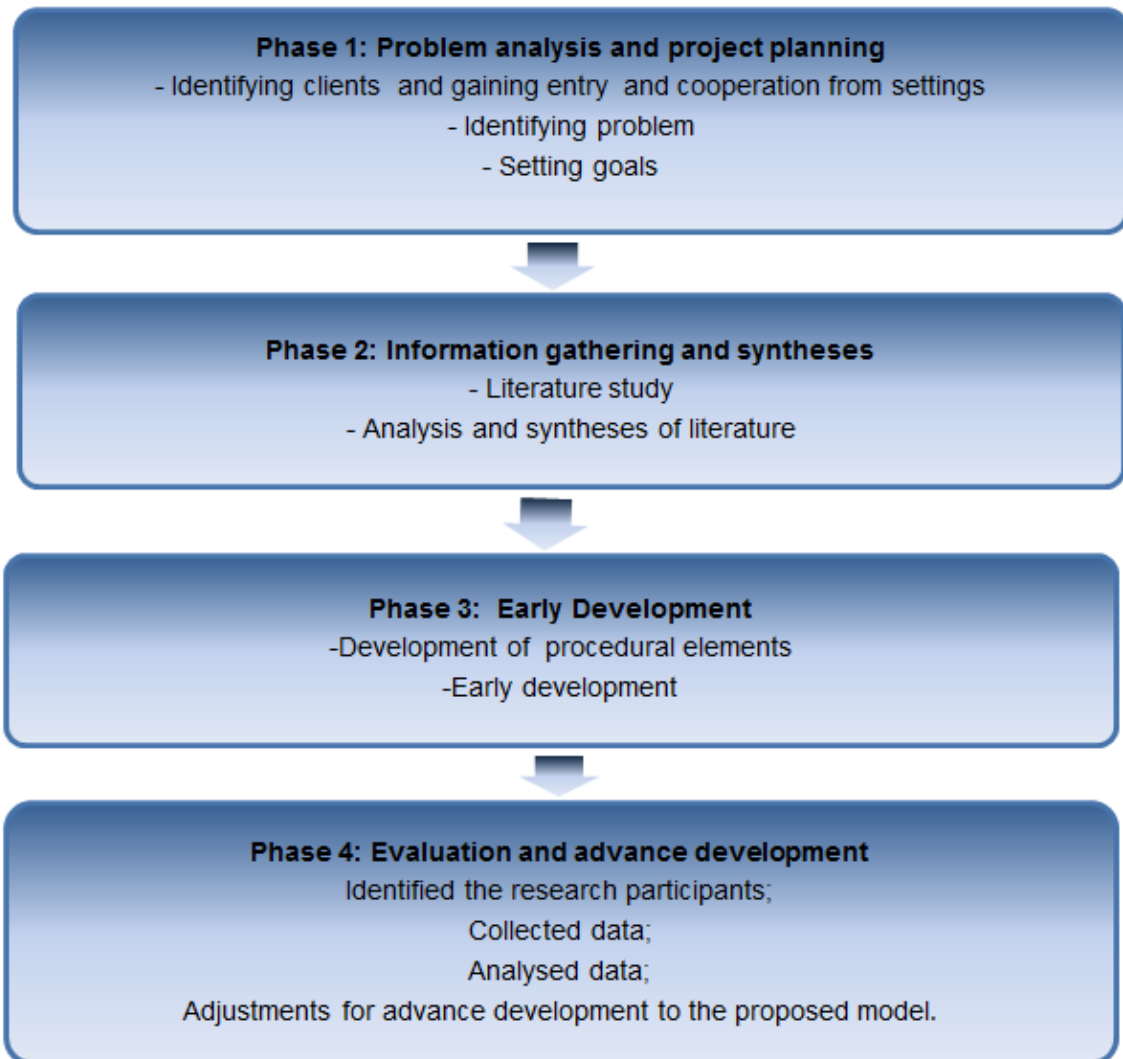
### **3.1 THE RESEARCH DESIGN**

For the purposes of this research, the authors employed a qualitative research design involving intervention research. Intervention research sets out systematic procedures for designing, testing and evaluating the scientific technology needed and disseminating proven techniques and processes to professionals in the community (De Vos & Strydom, 2011:475; Fraser, Richman, Galinsky & Day, 2009:4; Melnyk & Morrison-Beedy, 2012:1). Intervention research design usually follows a phased developmental sequence which is set out in Table 1.

<b>PHASE</b>	<b>DESCRIPTION OF PHASE</b>	<b>PROPOSED COMPONENTS</b>
Phase 1	Problem analysis and project planning	1.1 Identifying and involving clients, 1.2 Gaining entry and cooperation from settings, 1.3 Identifying concerns of the population, 1.4 Analysing concerns or problems identified 1.5 Setting goals
Phase 2	Information gathering and syntheses	2.1 Use of existing literature and sources of information 2.2 Studying natural examples 2.3 Identifying functional elements of existing models
Phase 3	Design	3.1 Designing and specifying elements of an intervention model and procedures
Phase 4	Evaluation of the proposed model	4.1 Identifying participants 4.2 Collecting data 4.3 Analysing data
Phase 5	Advance development and dissemination	5.1 Advance development 5.2 Dissemination

**Table 1: Outline of the phases of intervention research as adapted to the specific research study (De Vos & Strydom, 2011:476-489)**

The procedure followed by the researcher in the said research study is outlined in Figure 1.



**Figure 1: Outline of the process of intervention research followed in the specific study**

## **3.2 PROCEDURE**

### **3.2.1 Phase 1: Problem analysis and project planning**

The first step in the problem analysis and project planning involved identifying and involving the clients (De Vos & Strydom, 2011:477). Identifying clients and gaining entry and cooperation from various settings followed as a natural result of the author's existing involvement in the field of child sexual abuse. Following on from the practical experience of the authors and their involvement with role players on various levels, the need for guidelines and an integrative approach to addressing the effect of sexual abuse of children was identified. The authors subsequently set the following goals:

- To conduct a thorough literature study on the various aspects of child sexual abuse;
- To develop a structured play therapy intervention program to mitigate the effects of sexual abuse; and
- To evaluate the effectiveness of the above-mentioned program.

### **3.2.2 Phase 2: Information gathering and synthesis**

The second phase of the research study was aimed at acquiring knowledge to identify functional elements from existing information sources that can be used in the design of the intervention program (De Vos & Strydom, 2011:480). The research study started off with an in-depth literature study on various aspects of sexual abuse. From the literature study, it became clear that very few, evidence-based intervention models exist that holistically address the effects of sexual abuse (Gaskill & Perry, 2014:185-187; Gill, 2012:252; Saunders, 2012:191).

### **3.2.3 Phase 3: Development of procedural elements and early development**

The third phase involved specifying the procedural elements of the intervention and early development of the intervention model (De Vos & Strydom, 2011:482-483). Owing to ethical concerns, there was no pilot test of the proposed model with a sexually abused child. The procedural elements for the intervention were identified through the literature study and served as the guideline for the early development of the proposed intervention model. During this phase, a prototype of the intervention model was developed. The proposed intervention model is outlined under point 4.

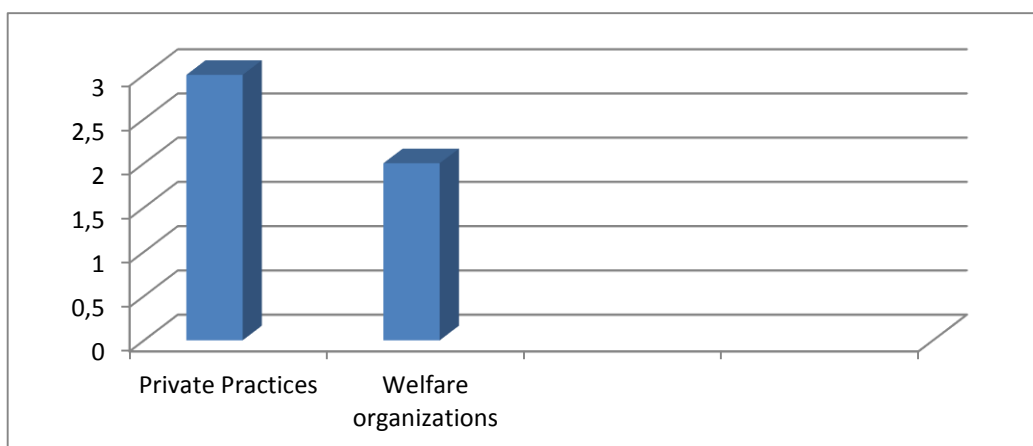
### **3.2.4 Phase 4: Evaluation and advance development**

The fourth phase involved the evaluation of the prototype and advanced development. Because the program was not applied in a setting where children are involved, the program was evaluated by experts in the field of child sexual abuse by means of the Delphi Technique. The Delphi Technique is described by Hsu and Sandford (2007:1) as “a method for gathering data from participants within their domain of expertise”. The Technique consists of up to four rounds of data collection. During this phase, with the incorporated use of the Delphi technique, the authors:

(a) **Identified participants** who are experts in the field of trauma and therapy with children by means of non-probability sampling, specifically purposive sampling. When using the Delphi technique, the selection of subjects is dependent on the different disciplines of expertise relevant to the specific research project (Hsu & Sanford, 2007:3; O'Manthuna, 2012:80). The criteria that guided the researcher in purposive sampling included the requirement that social workers or psychologists should have at least two years' experience in either the field of child sexual abuse or therapy with traumatized children. The exclusion criteria included no practical experience in direct work with sexually abused or traumatized children.

Over 30 participants were initially identified and contacted, offering a brief outline of the purpose of the research study (*Addendum 1*). Of the initial 30+ participants identified, a total of 20 prospective participants indicated their willingness to participate in the research study. In the second round of the data collection, these 20 prospective participants were given an outline of the research model together with a question schedule on the model. Only 10 participants completed the question schedule and participated in the research study. As participation in the study was voluntary the researchers respected the non-comments as part of the choice not to participate.

**Figure 2** outlines the extent to which participants represented social workers and psychologists, from both the private and the welfare sectors.



**Figure 2: Outline of the representation of various sectors in the field**

The psychologists and social workers represented practitioners in both private practice and the welfare sector. Of the ten participants, a total of six (60%) were in private practice and four (40 %) were working in various welfare organizations. The inclusion of practitioners from both sectors meant that the group of participants were a better reflection of the greater population.

**(b) Data collection** was conducted by means of a semi-structured question schedule and the use of the Delphi Technique (Hsu & Sanford, 2007:3). The prototype of the model (Addendum 2), together with a question schedule (*Addendum 3*) to guide the participants' review of the prototype, was made available to all the 20 participants. The question schedule made use of open questions, allowing participants to answer questions adequately and thoroughly, thereby adding richness to the detail obtained. The researchers decided on the use of a question schedule, as the participants identified were practising over a wide geographical area. The use of a question schedule also afforded the participants the opportunity of studying the proposed therapeutic model and completing the question schedule in their own time.

The Delphi Technique consists of several rounds of data collection and the number of Delphi iterations largely depends on the level of consensus achieved and the extent to which clarification of the data provided is needed (Hsu & Stanford, 2007:3). In the first round participants worked through the question schedule which was then returned to the researcher. The researcher collected all the data, and returned a summarized statement of the position of the whole group to each participants. Participants during the second round then had the opportunity to elaborate or comment on aspects where their original stance differed from the majority of feedback. Data analysis revealed not only high levels of consensus during the initial rounds of the Delphi technique, but also sufficient clarification by the participants of aspects where there was no consensus.

**(c) Data analysis** was performed according to Marshall and Rossman's (2011:1) thematic content analysis approach. It therefore consisted of organizing the data by entering it into a software program. Next the authors studied all the entries to identify specific recurrent themes, patterns and categories relevant to the specific questions posed (Marshall & Rossman, 2011:1). The emerging themes were then coded and correlated with the

relevant literature. Finally, the authors looked at alternative explanations, described them and demonstrated why the explanation offered was the most plausible.

Made the necessary **adjustments for advanced development** to the proposed model.

### **3.3 ETHICAL ASPECTS**

Ethical considerations should be seen as an integral aspect of good research. Although the nature of intervention research can, in essence, be ethical, the manner in which the goals of the research are obtained should also meet ethical standards. O'Mathuna (2012:75) explains the essence of ethics by stating that the most important determinant of ethical research is the researcher's ethics and personal integrity. The proposed research study was submitted to the Ethical Review Board of NWU. The approval number allocated was NWU – 00037 – 07 – S7.

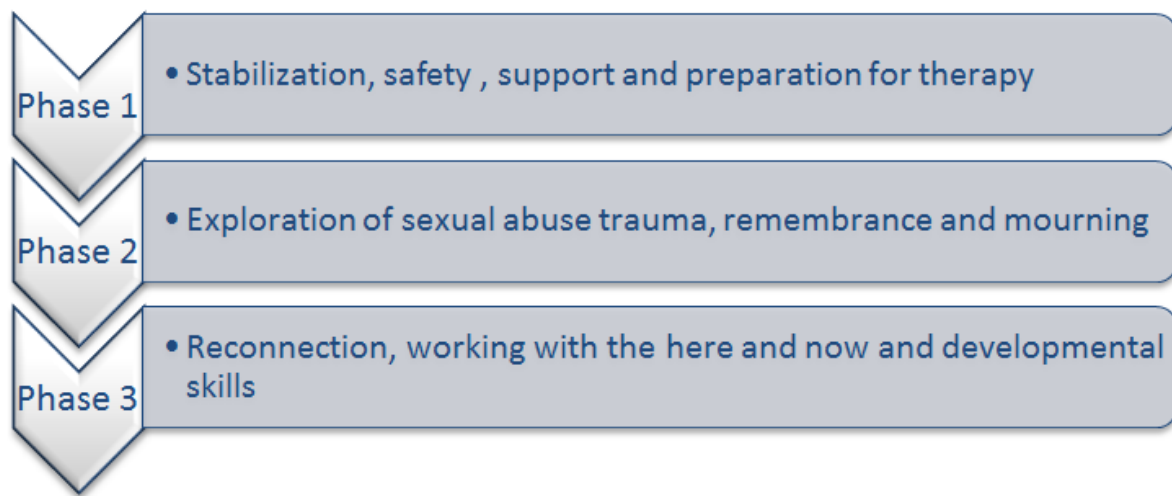
O'Mathuna (2012:81) states that the way in which research participants are recruited should show evidence of respect for others, their privacy and their right to confidentially and informed consent (Cotrell & McKenzie, 2011:111-115). All the participants were initially contacted to obtain permission to use their personal information and contact details, and to send them information on the proposed research study, after which they would have the option of contacting the researcher if they were interested in taking part in the research study. The potential participants were assured of confidentiality, in that their identity would be kept confidential by not revealing their names at any stage, or to any person. All the research participants took part voluntarily in the research after they had received adequate information on the goal of the investigation, the procedures, advantages and potential disadvantages. They were informed that they would be free to withdraw from the research at any given moment. No response from them after the first round of the Delphi Technique was seen as their decision not to participate and this was respected.

As part of the authors' ethical responsibility to the discipline of science, all research findings are correctly and accurately reported as are any problems encountered during the research study.

#### 4. OUTLINE OF THE PROPOSED THERAPEUTIC MODEL

The proposed model consists of three interlinked and interdependent phases. A phased approach supports the notion that fully effective treatment is likely to require a strategically staged, multi-model treatment model (Karakurt & Silver, 2014:81; McFarlane & Yehuda, 2007:157; Van der Kolk & McFarlane, 2007:15-16; Webb, 2011:18).

The phases of the proposed model are outlined in Figure 3.



**Figure 3: Outline of the phases of the proposed model**

The three phases of the model are interlinked and follow on consecutively, one after the other. The individual child and the complexity of the interacting factors play a role in that the specific child's trauma experience determines the length of time each child needs to successfully move through each phase of therapy. It should further be noted that, depending on the individual needs of each child, the unique trauma experience, developmental phase and support system, not all children will necessarily need all three phases of therapy at a specific time (Briere, 2006:ix; Saunders, 2012:178; Webb, 2011:18).

Although any effective therapy will involve the core elements as illustrated by this model, the timing, context, the intensity and the order of attention varies from child to child. When following the therapeutic model as a phased process, it should therefore always be an individualized process that accords with the specific needs of the child in question (Gil, 2006:xiii; Geldard & Geldard, 2013:7; Saunders, 2012:177-178). That said, it is necessary to

understand the core therapeutic goal and objectives that underscore the proposed model before the different phases are discussed.

#### **4.1 CORE THERAPEUTIC GOAL AND OBJECTIVES OF THE MODEL**

The central goal of the proposed therapeutic model is to enhance children's capacity to resolve abuse-related trauma and empower them to cope and function effectively. Ultimately therapy must reduce the effects of child abuse and restore the effective, healthy functioning of the child (Gaskill & Perry, 2012:40; Goodyear-Brown, 2012:297; Tomlinson & Philpot, 2008:72). Stemming as they do from the goal, the therapeutic objectives of the proposed model can be seen as a road map that directs the therapist towards ultimately achieving the best possible outcomes for the child.

Taking into account the child's individual symptoms, needs, strengths, vulnerabilities and personality (Briere, 2006:ix), the different phases of the model, the fundamental objectives (Fitzgerald & Cohen, 2012: 205; Geldard & Geldard, 2013:6; Gil, 2006:55-62; Tomlinson & Philpot, 2008:72; Van der Kolk, McFarlane & Van der Hart, 2007:419; Webb, 2011: 291) and the focus areas of each phase are illustrated in Table 2:

<b>PHASE</b>	<b>FUNDAMENTAL OBJECTIVE</b>	<b>FOCUS AREAS</b>
<b>1</b> Stabilization, safety, support and preparation for therapy.	To help the child learn how to regulate emotions and promote acceptance, and direct expression of feelings in healthy and supportive relationships.	1.1 Creating a safe and predictable environment; 1.2 Motivating for therapy; 1.3 Teaching grounding and affect modulation; 1.4 Formation of healthy and supportive relationships.
<b>2</b> Exploration of sexual abuse trauma, remembrance and mourning.	Desensitize traumatic memories and enhance integrative functioning; correct faulty belief systems and enable the child to achieve some level of congruence regarding thoughts, feelings and behaviours.	2.1 Telling the trauma story; 2.2 Reframing the abuse experience; 2.3 Re-experiencing the trauma in the power position; 2.4 Addressing secondary losses.
<b>3</b> Reconnection, working with the here and now and developmental skills.	Changing learned behaviour patterns and/or behaviour that have negative consequences.	3.1 Reinforcing healthy and supportive relationships; 3.2 Equipping the child with skills in problem solving and communication; 3.3 Reinforcing techniques in grounding, affect modulation and constructive expression of emotions; 3.4 Explaining in a child-friendly manner the concept of forgiveness; 3.5 Reinforcing personal boundaries; 3.6 Working on positive body and self-image; 3.7 Discussing the possible need for follow-up therapy in future.

**Table 2: Link between different phases of the model, the fundamental objectives and focus areas of each phase.**

The outline of the model in Table 2 provides a more detailed view of the various aspects implied with each of the fundamental objectives of the different phases. The next step in outlining the model is to highlight the theoretical foundation and core elements of each of the proposed phases.

## **4.2 THEORETICAL FOUNDATION OF THE DIFFERENT PHASES OF THE PROPOSED THERAPEUTIC MODEL**

Knowledge of theory, research and best available evidence-based practice is essential when attempting to address the effect of childhood sexual abuse on children (Saunders, 2012:194). Although individual differences and preferences do exist and different approaches are endorsed by different experts, most clinicians arrive at similar conclusions on the phases of treatment and the areas that justify attention (Allen & Crosby, 2014:49). Basing their opinion on their analysis of the literature, the authors concur with various other authors that an integrated approach might serve children best in the goal to enhance their capacity to resolve abuse-related trauma and empower children to cope and function effectively (Gil, 2012:252; Goodyear-Brown, 2012:298; Karakurt & Silver, 2014:81; McPherson, Scribano & Stevens, 2012:36; Tomlinson & Philpot, 2008:11; Webb, 2011:18).

In an integrated, phased approach to therapy, most authors agree that the first step towards helping children resolve abuse-related trauma is establishing stability.

### **4.2.1 Phase 1: Stabilization, safety, support and preparation for therapy**

During the first phase of therapy, the aim is to help the child gain a sense of control over their emotions through grounding and affect modulation, and to provide them with a sense of security (in both circumstances and relationships) prior to the exploration of abuse specifics (Van Eys & Truss, 2012:161; Fitzgerald & Cohen, 2012:205; Gil, 2012: 251; Goodyear-Brown, 2012:297; Levine & Kline, 2007: 382). The motivation underlying this is to better equip the child to deal with and tolerate the possible distressing affect when abuse exploration begins.

According to Tomlinson and Philpot (2008:71), an integrative approach should be based on the involvement of all role players; on openness, not secrecy; on communication, not

avoidance; and on predictability, not inconsistency. Bearing this in mind, the first phase of therapy, with the support and assistance of parents or caregivers, includes the following: creating a safe and predictable environment; motivating for therapy and providing information; teaching grounding and affect modulation techniques to the child and caregivers; and the formation of healthy, supportive relationships.

Therapy does not take place as something separate from children's everyday lives, so a child should not be treated in isolation from the wider context (Tomlinson & Philpot, 2008:71). The authors are of the opinion that by involving parents or caretakers in this phase of therapy, therapists are not only equipping them with the necessary knowledge and skills but also at the same time are avoiding the trap of accepting the idealized role of becoming the child's savior (Fitzgerald & Cohen, 2012:205; McPherson, Scribano & Stevens, 2012: 36; Webb, 2011: 147).

#### ***4.2.1.1 First Focus Area: Creating a safe and predictable environment***

Before attempting to address the child's trauma, one of the prerequisites for therapy is safety (Van Eys & Truss, 2012:161; Fitzgerald & Cohen, 2012:205; Gil, 2012: 251; Goodyear-Brown, 2012:297; Van Der Kolk & McFarlane, 2007:17). In order for children to work through traumatic experiences, they need to feel safe. Only once this has been achieved can memories and emotions enter the consciousness and be accessed, acknowledged and processed (Fouché & Yssel, 2006:248; Gaskill & Perry, 2014:186). Children can relax only once they feel safe, both in the therapeutic relationship and in their daily lives. A child's safety includes the following: feeling safe in their own bodies, safety from further abuse and thus the abuser, safety from secondary losses (Van Eys & Truss, 2012:161; Malchiodi, 2012:346). In the authors' opinion, safety is not experienced only when the child is physically safe but perceived safety, which is a subjective experience of the child is just as important (Van Eys & Tuss, 2012:161). The safer, more contained and trusting we feel, the more we are able to allow the painful and difficult emotions to be contemplated.

When raising the concept of safety in sexual abuse cases, health care professionals are quick to assume that safety involves no contact with the alleged offender. While this is certainly true in some cases, safety from further losses is often not considered. While safety from further abuse is paramount, this should be achieved by taking into account the dynamics of sexual

abuse and thus the child's relationship with the alleged offender. When safety from further abuse needs to be established, it should be done by also attempting to minimize secondary losses for the child.

Predictability is an essential component in providing children with a sense of safety and security. Tomlinson and Philpot (2008:75) argue that every part of a child's life, even his home environment, is seen as having therapeutic potential. Therefore even the home environment, whether with primary caregivers or within substitute care, should be structured in such a way that the needs of the child are addressed and thus complement the aspects worked on during therapy. In the author's opinion predictability must be created in two spheres: the child's home environment and the therapeutic process. Predictability in the child's day-to-day functioning and home life lies in a set routine, consequent discipline, predictable, consistent adult behaviour and a place that the child can call home (Pringle, 2006:37). Predictability in therapy lies in understanding what therapy entails and thus what to expect, as well as the time and place scheduled in the therapy (Gil, 2012:259).

Creating a safe and predictable environment for the child will therefore include:

- Ensuring the child's safety from further abuse;
- Protecting the child from perpetrators and unsupportive adults by enforcing boundaries and safety limits;
- Maintaining or re-enforcing predictable daily structures in the child's life through set routine, rules, boundaries and predictable adult behaviours;
- Minimizing further losses in the child's life, as far as possible; and
- Providing a child with predictability in terms of therapy in that the child knows the reason why he is there, when he will be coming, what he can expect from therapy and the therapist.

#### ***4.2.1.2 Second Focus Area: Motivation for therapy and providing information***

Various authors highlight the importance of educating parents and children on trauma and its effects during the introductory phases of therapy (Fitzgerald & Cohen, 2012:205-206; Gil, 2012:258; Stien & Kendal, 2004:144-145). This aspect is seen by the authors as the motivation for therapy which includes a child-friendly explanation of the effect of trauma on the child as well as an outline of the recovery process. The goal is thus to empower the child and parents or caregivers, by providing a motivation as to why therapy is necessary and thus the reasons why the child is with the therapist. This not only demystifies the process for parents and children alike, but also counteracts dissociative tendencies and empowers the child and parents to understand the roots of what the child is experiencing (Fitzgerald & Cohan, 2012:205; Stien & Kendall, 2004:139). Gil (2012:258) stresses that, although intensive exploration of abuse is contraindicated before stabilization is achieved, it is important to acknowledge the abuse at this stage.

#### ***4.2.1.3 Third Focus Area: Teaching grounding and affect modulation techniques to the child and parents***

The treatment of abused and traumatized children typically begins with techniques that are aimed at reducing stress and helping children find new ways of regulating their emotions and calming themselves (Allen & Johnson, 2012: 80; Fitzgerald & Cohan, 2012: 208-209; Gaskill & Perry, 2014:186; Malchiodi, 2012:345; Van Der Kolk, McFarlane & Van der Hart, 2007:426). In the author's opinion, this is a crucial component of therapy that the child needs to master before any trauma work can be attempted. Children need to be empowered with the necessary skill in affect modulation and expression of emotions prior to entering into their trauma so that the symptoms do not become overwhelming (Gaskill & Perry, 2014:186; Malchiodi, 2012:345; Van der Kolk, McFarlane & Van der Hart, 2007:426). Gaskill and Perry (2012:40) explain that, until state regulation or healthy homeostasis is established at the brainstem level, higher brain-mediated treatments (trauma focussed work) will be less effective.

Affective ways of helping children gain a sense of control over overwhelming emotions involve the development of skills that include the ability to express emotions, cognitive coping strategies, relaxation techniques and grounding techniques (Fitzgerald & Cohan, 2012:208-21; Goodyear-Brown, 2012:303). Levine and Kline (2007:138) describe grounding as follows:

*“Grounding is a feeling of a solid connection to the earth that enables a child to be directly connected to his or her body sensation.”* Primary process communication, such as eye contact, face-to-face gazing, touch, physical movement and rhythm are the modalities recognized by the brainstem aiding in the grounding process (Gaskill & Perry, 2012:42). Grounding thus reconnects the child to the here and now through body sensation, calming the brainstem and limbic areas of the brain and counteracting being overwhelmed by trauma-related emotions or sensations (Gaskill & Perry, 2012:42; Levine & Kline, 2007:138; Wieland, 2006:23).

The use of sensory stimuli in the grounding process, such as stroking a small stuffed animal with a specific smell associated with a special time can be used to help children relax and can be used as a safety object. Empowering rhymes and stories that include movement and bodily sensation can also be helpful in facilitating the grounding process. The therapist can orientate the child in the here and now by using the child’s senses to ground the child so that it can realize that the child is not in the trauma situation; e.g. *“Take my hands and feel how warm they are. As you feel my hands notice where your feet touch the floor, notice your breathing. Now let’s see where you are (describe surroundings, focussing on the child’s senses). You are safe”*. Repeating a word, sound, phrase or muscular activity, breathing exercises or an art activity involving repetitive skills like stringing beads, can be used to activate the relaxation response of the limbic system (Fitzgerald & Cohan, 2012: 208-211; Gaskill & Perry, 2012:42; Goodyear-Brown, 2012:302; Malchiodi, 2012:345-346;116; Wieland, 2006:23-28).

When teaching children grounding techniques, it is important to equip parents/caregivers to assist by facilitating practical techniques. Parents can help facilitate grounding techniques through eye contact, face-to-face gazing and physical contact. Verbal facilitations from parents, such as: *“I am here to support you when you are upset by helping you find better ways of expressing and dealing with what you are feeling (emotions or bodily sensations)”* can support this process.

Equally important as teaching the child and parents or caregivers various techniques in grounding, is equipping them with skills in expressing emotions and affect modulation. Techniques for affect modulation include breathing techniques, constructive rocking

movements that calm the limbic system (a rocking chair or sitting on a parent's lap and being rocked) and progressive relaxation techniques. In order to help children with the healthy and constructive expression of emotions, practitioners need to help them identify and label their emotions through the use of various techniques, such as making emotional faces or using a gingerbread man with different colours to make squiggles and shapes for various body parts to indicate different feelings. Children need to be taught how to express emotions through constructive activities, such as hitting with newspapers, drawing angry pictures, keeping an emotional journal or diary or using an emotional weather chart or barometer. Emotional awareness and constructive expression of emotions are facilitated by therapist and parents alike, by employing techniques such as *modelling* (modelling constructive expression of emotions to the child through role play and by expressing own emotions in a constructive manner) and mirroring (reflecting to the child his behaviour and emotions that have been observed and helping him to label the emotions and their cause) (Fitzgerald & Cohan, 2012:208-209; Fouché & Yssel, 2006:251; Gil, 2012:259; Malchiodi, 2012:346; Wieland, 2006:23-28). If a child can be supported and helped to gain a sense of control over his emotions through grounding and affect modulation prior to the exploration of abuse specifics, he will be better equipped to deal with and tolerate distressing affect when abuse exploration begins.

#### ***4.2.1.4 Fourth Focus Area: The formation of healthy supportive relationships***

Traumatized children need a new set of interpersonal experiences. They must learn that people are not always a source of pain, but can actually provide comfort and support (Bratton, Ceballos, Landreth & Costas, 2012:321; Gaskill & Perry, 2014:181). Levine and Kline (2007:114) add a further component to the importance of forming healthy relationships by explaining that the child's ability to self-regulate affective states is shaped by the interactions he has with each of his caregivers. The child's brain and nervous system do not develop separately but as an interactive dynamic with the various external relationships, of which primary caregivers are the often the most influential (Goodyear-Brown, 2012:304; Karakurt & Silver, 2014:80; Wieland, 2006:28).

The formation of healthy and supportive relationships refers to both the therapeutic relationship and the parent-child or caregiver-child relationship. The formation of healthy supportive relationships is achieved by involving parents and/or caregivers in all four aspects

of phase 1 and by equipping parents with the knowledge and skill relating to all the aspects of therapy (Brattom *et al.*, 2012: 322; St. Amand, Bard & Silovsky, 2008: 152; Fitzgerald & Cohan, 2012:207; Goodyear-Brown, 2012:304). If parents and/or carers can contain and handle children and help them understand and regulate their arousal, children begin to feel competent and clear about their own ability to handle themselves well when they feel under stress or emotionally upset (Goodyear-Brown, 2012:304). Research suggests that children's adjustment following a traumatic event, such as sexual abuse, is more dependent on parental response than the characteristics of the abuse itself (Bratton *et al.*, 2012:322). Thus, if parents understand what to expect and are equipped with the knowledge and skills to support the child, this can be conducive to the therapeutic process and mitigate the long-term effect of sexual abuse.

#### **4.2.2 Phase 2: Exploration of sexual abuse trauma, remembrance and mourning**

The middle stage of treatment involves the exploration of childhood sexual abuse experiences. This phase aims to facilitate the integration of trauma memories into autobiographic memory so that eventually these memories will cease to trigger the implicit memory system and the child will be able to remember without re-experiencing the full extent of the original psychological arousal or emotions (Fitzgerald & Cohan, 2012:212; Gil 2012: 259; Machloldi, 2012:347; Van der Kolk, McFarlane & Van der Hart, 2007:428). Goodyear-Brown (2012:306) emphasises that the therapist's ability to act as a container, strong enough and safe enough to handle the trauma content without being overwhelmed, will invite the child to share more. The exploration and processing of the trauma is necessary.

Becoming aware of and experiencing the affective and cognitive aspects of the trauma that helps to lessen dissociative tendencies; and returning to the trauma and processing feelings, cognitions and beliefs related to the experience help to make the trauma less powerful and overwhelming (Fitzgerald & Cohen, 2012:211-213; Gil, 2012:259-260; Goodyear-Brown, 2012:307; Machloldi, 2012:347).

Although memory work is critical in helping traumatized children recover, the therapist must proceed in a structured, deliberate yet cautious manner. Briere (1996:146) refers to this cautious yet deliberate process as the “therapeutic window”. The therapeutic window can be seen as that psychological place during treatment where appropriate therapeutic interventions are cast. Such an intervention is neither so non-demanding as to be useless (*structured and deliberate*) nor so evocative or powerful (*cautious*) that the client’s delicate balance between trauma and avoidance is tipped toward the former (Fitzgerald & Cohen, 2012:212; Goodyear-Brown, 2012:307; Levine & Klein, 2008:125,129). The focus of this phase is therapeutic intervention at the appropriate time that is neither so non-demanding as to be ineffective nor as evocative or overwhelming as to re-traumatize the client. Therapists would miss the therapeutic window if they avoided exploring the abuse or when exploration is too intense or too fast to allow the child to adequately process the trauma (Briere, 1996:146; Gil, 2012: 258).

Throughout this phase, therapists will continuously assist children in owning their emotions; expressing them constructively and making use of grounding and affect modulation when emotions are overwhelming. The positive emotional experience of discharging emotions in the context of a supportive relationship serves to inhibit and counter-condition the fear associated with the trauma (Fitzgerald & Cohan, 2012:212; Goodyear-Brown, 2012:306). The second phase of therapy includes: telling the trauma story; reframing the abuse experience; re-experiencing the trauma in the power position; and addressing secondary losses.

#### ***4.2.2.1 First focus area: Telling the trauma story***

The primary goal of the second phase of therapy is to gradually expose the child to the abuse experience, and help him face and make sense of that and the associated emotions at a pace that is safe, manageable and not overwhelming. During this phase, the traumatic material is told and retold until it becomes an integrated aspect of the self and takes on new meaning as part of a socially shared autobiographical history (Fitzgerald & Cohan, 2012:211; Malchiodi, 2012:347; Van der Kolk, McFarlane & Van der Hart, 2007:430). The retelling of the trauma is designed to help the trauma victim realize that their trauma memories and reactions are not dangerous and do not need to be avoided (Fitzgerald & Cohan, 2012:212; Fouché & Yssel, 2006:258; Gil, 2012:260).

When telling the trauma story, memory work is more effective when the child uses several sensory modalities to process the memories (Gil, 2012:254; Goodyear-Brown, 2012:307; Malchiodi, 2012:248-350). Because abuse memories are coded both verbally and through the sensorimotor system, exposure and desensitising must include both systems (Gil, 2012:254; Goodyear-Brown, 2012:307-308). Telling the trauma story thus involves helping children to tell their trauma story with the use of dolls, puppets, a sand tray, role play, art work, and other forms of playing out the trauma. The role of the therapist is to facilitate the child's telling of the trauma story through focussed exploration, at the same time setting boundaries that contain the child and his emotions through continuous grounding and affect modulation (Fitzgerald & Cohan, 2012:212; Fouché & Yssel, 2006:252; Levine & Kline, 2007:122).

Goodyear-Brown (2012:308) explains that, owing to the neurochemical release that often occurs during trauma, the brain's ability to integrate the sensory aspects of the trauma with the logical narrative is often affected. Children are thus often able to talk about what happened without ever experiencing a connection between the verbal narrative and the somatic or affective content (Goodyear-Brown, 2012:308; Malchiodi, 2012:349). Exploring sensations and emotions therefore forms an integral part of memory work. Sensory and emotional expression through the use of various art forms have been found to be central to trauma recovery owing to both the sensory qualities and the experiential nature of the creative process (Malchiodi, 2012:349). A variety of techniques and media such as the use of body diagrams, clay, drawing and painting can be used to identify bodily sensations, express emotions and integrate these into the trauma narrative (Fitzgerald & Cohan, 2012:211-213; Goodyear-Brown, 2012:308; Levine & Kline, 2006:138; Malchiodi, 2012:349).

#### ***4.2.2.2 Second Focus Area: Reframing the abuse experience for the child***

Reframing the abuse experience involves identifying cognitive distortions and false attributions that children have revealed in their trauma narratives (Goodyear-Brown, 2012:308; Stien & Kendall, 2004:156). Merely uncovering memories is not enough, as memories need to be modified and placed in their proper context by providing a child with corrective information to assist in forming a new, more accurate narrative and meaning for their trauma experience (Fitzgerald & Cohan, 2012:212; Gil, 2012:260; Goodyear-Brown, 2012:308; Van der Kolk & McFarlane, 2007:19).

If the child is to start shifting negative internalizations or inaccurate cognitions about the abuse, then therapists have to assist in replacing dysfunctional cognitions with more accurate and optimal thoughts. Reframing the abuse experience and subsequent inaccurate internalizations or cognitions can be facilitated by reframing the abuse experience in terms of responsibility and blame; providing information (bodily responses and grooming) that is age and abuse appropriate to the child; normalizing thoughts and feelings; and by reconstructing circumstances surrounding the abuse by asking various questions that focus on the difference in size between the offender and the child, difference in age, the impact of threat and fear and the child's lack of knowledge (Fitzgerald & Cohan, 2012:213; Fouché & Yssel, 2006:254; Gil, 2012:260; Wieland, 2006: 28-32).

#### ***4.2.2.3 Third Focus Area: Re-experience of the trauma in the power position***

The therapeutic value of exploring the child's trauma is strengthened when it is attached to other empowering experiences, such as being safe and feeling physically strong, powerful and capable (Van Der Kolk & McFarlane, 2007:19). In order to recover from trauma the child has to do what he could not do in the trauma situation and emerge as victor. Allowing a child to re-experience their trauma in the power position is about allowing him to emerge as the victor or hero, thus restoring his sense of control through positive endings in traumatic play (Fouché & Yssel, 2006:259; Levine & Kline, 2007:13; Wieland, 2006:35). The miniaturization through play materials of people and dynamics that previously seemed overwhelming to the child can allow for a sense of mastery and control when re-experiencing trauma in a power position (Goodyear-Brown, 2014:307). The process of providing positive endings to traumatic play can be further facilitated by using focused questions highlighting what the child would like to change about the abuse, whom the child would like to have with the child to help, allowing the child to play out any thoughts or emotion toward the perpetrator and bringing new-found knowledge and skills into the trauma story to change the outcome (Goodyear-Brown, 2012:306; Levine & Kline, 2007:174-175; Wieland 2006:18-21).

#### ***4.2.2.4 Fourth Focus Area: Addressing secondary losses***

It is inevitable that sexually abused children will experience many losses. Levine and Kline (2007:2004) accurately sum it up when they state that: "*It is possible to have grief without trauma, it is not possible to have trauma without grief*". Only once a child's trauma has been

resolved can buried grief reactions emerge and be addressed (Levine & Kline, 2007:206). Grieving these losses should be integral to the therapeutic process (St. Amand *et al.*, 2008:153; Rymaszewska & Philpot, 2006: 33; Tomlinson & Philpot, 2008:68). The child can experience a wide variety of secondary losses, which can include, amongst others, loss of trust; the loss of a relationship with significant others; the loss of a relationship with the alleged offender; changes in circumstances and the way of life; loss of positive body awareness; loss of innocence; loss of choice and control; loss of “*what might have been*” if the abuse had never taken place (Rymaszewska & Philpot, 2006: 33-34; Tomlinson & Philpot, 2008:68).

For children who have been sexually abused, the loss and grief they experience is a complicated dynamic for adults and therapists to understand (Tomlinson & Philpot, 2008:68). As with any other form of grief, the therapist has to realize that no two children’s grief processes are alike. Nevertheless, it is important for therapists to educate themselves on the common features of the stages of grief, especially in children (Perkins, 2007:27). William Worden (1983), as cited in Perkins (2007:67), was the first to identify the four tasks of mourning. Although there is usually no death of a loved one involved in the sexually abused child’s array of losses, the authors are of the opinion that it is still relevant to address the four tasks of mourning (Worden, 1983). The authors have amended the tasks of mourning to address the possible losses experienced by the sexually abused child as the following:

- to accept the reality of the loss;
- to work through the grief;
- to adjust to an environment in which the person, relationship or previous circumstances are absent; and
- to withdraw emotional energy and reinvest it in healthy and safe relationships (Gil, 2012:260; Perkins, 2007:67).

Grieving experienced for the losses can be facilitated by using a variety of media such as a sand tray, drawing, building a collage, writing letters and using a memory box (Gil, 2012:260; Perkins, 2007:67-77; Webb, 2011: 242-244; Wieland, 2006:20).

Once the child has successfully worked through the trauma and losses associated with sexual abuse, the focus can be shifted to the here and now. This signals the end of the second phase of the therapy and the need to work on addressing learned behaviour patterns and new skills to optimize the child’s healthy functioning.

### **4.2.3 PHASE 3: RECONNECTION, WORKING WITH THE HERE AND NOW AND DEVELOPMENTAL SKILLS**

The third phase of therapy is aimed at changing learned behaviour patterns and optimizing the child's normal development. The focus is on restoring age-appropriate social contact, re-establishing boundaries, establishing prevention strategies and reinforcing healthy supportive relationships (St. Amand *et al.*, 2008:153; Fitzgerald & Cohen, 2012:199; Gil, 2012:260; Goodyear-Brown, 2012:308; Malchiodi, 2012:350).

One of the focus areas in this phase is that of reinforcing healthy relationships in the child's daily life. Not only are healthy, supportive relationships a factor in building a child's resilience in recovering from trauma, but they also play an integral role in the child's future healthy functioning and safety (Goodyear-Brown, 2012:304; Malchiodi, 2012:350; Urquiza & Blacker, 2012:287). Although this aspect is addressed in the first phase of the therapy, it is important to reinforce relationships with supportive and caring adults prior to the termination of the therapy. This phase of therapy aims to assist the child in re-attuning with adults and caregivers, thereby reinforcing safety and security, providing emotional regulation skills within the context of relationships and renewing positive expectations for attachment relationships and future friendships (Goodyear-Brown, 2012:304; Gil, 2012:260; Malchiodi, 2012:350; Urquiza & Blacker, 2012:287).

Not all healing takes place in therapy and even after the completion of trauma work children often still need support, reassurance and skills reinforcement from their family (St. Amand *et al.*, 2008:153; Fitzgerald & Cohan, 2012:225; Urquiza & Blacker, 2012:287). In the author's opinion, supportive, healthy relationships and, at best, secure attachments foster change and continued growth in children long after therapy has been terminated.

During the final phase of therapy, children need to be equipped with skills in problem solving, thought-stopping procedures and crafting more helpful cognitions. Techniques in grounding, affect modulation and constructive expression of emotions need to be reinforced, thereby equipping the child to handle any future difficult situations more effectively (Goodyear-Brown, 2012:308; Fitzgerald & Cohan, 2012: 215-225). Other areas that might need to be addressed include: explaining in a child-friendly manner the concept of forgiveness and forgiveness as an on-going process; reinforcing personal boundaries; working on a positive body and self-

image; and discussing the possible need for follow-up therapy in the future (Fitzgerald & Cohan, 2012: 215-225; Fouché & Yssel, 2006:256, 260-261; Gil, 2012:260).

After working through the different phases of therapy, the final aspect to be addressed is the issue of termination. Termination of therapy is considered when all the needs and subsequent areas of the child's functioning that have been affected by sexual abuse have been addressed and provided for. This is often determined through feedback from the various role players involved in the child's life, and thus through continuous evaluation and assessment (Fitzgerald & Cohan, 2012:216). Goodyear-Brown (2012:309) refers to termination as an intentional process that should celebrate the child's work and results in a meaningful way.

## **5. DISCUSSION OF RESEARCH RESULTS**

After the early development and design of the proposed therapeutic intervention model, the model was made available for the participants to evaluate. The process of identifying participants their composition was previously discussed (see point 3.2.4 (a) & (b)). The participants received an outline of the proposed therapeutic model (*Addendum 2*) and a question schedule (*Addendum 3*) to assist them in critically evaluating the proposed model. Open questions were formulated on each phase of the proposed model in order to extensively evaluate all the core components of the different phases. The first aspect on which participants were required to comment was the proposed therapeutic goals of the model.

### **5.1 OUTLINE OF THE AIM AND THERAPEUTIC GOALS OF THE PROPOSED INTERVENTION MODEL**

#### **5.1.1 Feedback from participants on the therapeutic goals of the proposed intervention model**

All the 10 participants agreed that the therapeutic goals of the proposed model were relevant and addressed the needs of the child who had been sexually abused. Although the majority of the participants felt that the outlined goals and objectives were sufficient, three additional objectives emerged from the participants' feedback. These are:

- To strengthen the child's personal boundaries;
- To create a relationship of trust and safety between the child and the therapist; and
- To identify areas of dysfunction or need for the child that are related to sexual abuse.

Although these additional objectives are not specifically mentioned in the outline of the goals and objectives of the proposed model, they are indirectly implied by the objectives and are thoroughly addressed in the various phases of the proposed model. It could, however, be constructive to describe the outlined objectives of the proposed model more thoroughly by specifically mentioning all the implications in the set objectives, as discussed in the various phases of the model.

## **5.2 PHASE 1: STABILIZATION, SAFETY, SUPPORT AND PREPARATION FOR THERAPY**

The feedback from the participants on phase 1 will be discussed in the following paragraphs.

### **5.2.1 Feedback from participants on the first phase of therapy**

The participants reviewed the relevance and importance of the first phase of the therapy. They all agreed on the importance of the first phase of therapy, which focuses on stabilization, safety and preparation for therapy. Some of the comments on the importance of the first phase included the following: Participant # 6 maintained that *"It is the basic first thing that should be in place before the therapist will be able to start with therapeutic intervention"*; and participant # 1 remarked *"The first phase of therapy is imperative. In practice I have experienced it time and again that if a child does not experience the necessary safety and predictability progress in therapy is jeopardized"*.

Participant # 5 maintained that the first phase of therapy depends on whether or not a legal process is pending. The authors, however, disagree. The first phase of therapy does not address the child's trauma directly, so it does not address the child's memories of sexual abuse. Instead, it focuses on equipping the child with the necessary skills and social support for dealing with the effect of the trauma on the child's functioning. In the authors' opinion, all

children, whether or not awaiting the finalization of a criminal process could benefit from this phase of therapy, with no possibility of contamination by abuse-related information.

After the discussion on the necessity of the first-phase of therapy research, participants were asked to comment on the four focus areas of this phase.

### **5.2.2 The importance of creating a safe and predictable environment for the child as part of the first phase of therapy**

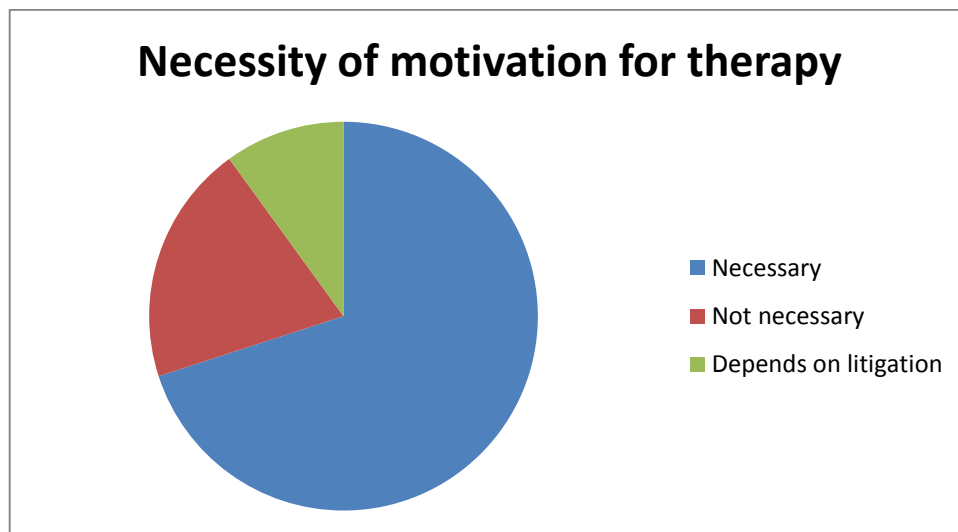
The feedback from all the 10 participants concurred with various authors that, when attempting to address the child's trauma, one of the prerequisites for therapy is safety (Van Eys & Truss, 2012: 161; Fitzgerald & Cohen, 2012:205; Gil, 2012: 251; Goodyear-Brown, 2012:297; Levine & Kline, 2007: 382). Seventy percent (70%) of the participants highlighted the child's experience of safety and predictability as a pre-requisite for moving on to the second phase of therapy and for effective progress in the therapy.

The following core components as part of a safe and predictable environment emerged from the findings: structure and limits; emotional security; and experiencing control. Participant # 3 summarized the importance of providing emotional security to a child through a safe and predictable environment by saying that: *"An abused child usually loses trust in adults as well as in his/her own judgement. Creating a safe environment enables the child to relax and start dealing with his trust issues. Predictability helps creating and reinforcing trust and credibility. Everything that happens as the therapist predicted, strengthens their bond, strengthens the therapists' credibility and helps the child to start trusting another human being"*.

Participant # 5 highlighted that recovery in traumatized children is best facilitated by a nurturing, safe environment that also includes appropriate structure, limits and predictability. Three of the 10 participants, # 8, # 6 and # 4 highlighted the importance of the child's experiencing a sense of control in the therapeutic setting. The child's experience of control was consistently linked to the degree of predictability the child experienced within the therapeutic environment. The majority of the participants maintained that creating a safe and predictable environment for the child would enhance the therapeutic relationship.

### 5.2.3 Participants' feedback on motivating the child for therapy in a developmentally sensitive manner

The next question raised in the empirical study was whether a child should be motivated for therapy by explaining the necessity for therapy in a developmentally sensitive manner. Figure 4 illustrates the participants' point of view on the necessity of motivating a child for therapy.



**Figure 4: Necessity of motivation for therapy**

The above figure indicates that seventy percent of participants agreed with the authors on the importance of motivating a child for therapy. Their reasons for supporting this stance included that it added to predictability; minimized resistance; contributed to trust in the therapeutic relationship; and gave the child a sense of control.

Two participants, # 4 and # 10, felt that the motivation for therapy was necessary only if the child presented with resistance. Other than this, motivation for therapy was not necessary. Although the authors agree that motivation for therapy is especially crucial in cases where children present with resistance, they think that all children, regardless of their age or whether they present resistance, can benefit from this aspect. By providing a motivation as to why therapy is necessary and thus the reasons why the child is there, parents and children alike are empowered by knowledge and a sense of predictability and thus control (Fitzgerald & Cohan, 2012: 206-207; Gil, 2012:258).

On the same point of discussion Participant #5 cautioned against the motivation for therapy, stating that this is dependent on the stage of the litigation process. The authors concur with the caution, especially when a criminal case is still pending. The therapist should always proceed with caution in all aspects of the therapeutic relationship so as not to contaminate the child's information, thereby possibly influencing the child's authentic testimony. This comment relates to the next point on which the participants were asked to comment, which was whether or not the therapist should acknowledge the abuse when the therapy started.

#### **5.2.4 Participants' feedback on whether or not the therapist should acknowledge the abuse when the therapy started**

Flowing from the discussion on motivating the child and parents for therapy, it is proposed that the therapist should acknowledge to the child that he or she is aware of the abuse, as part of the motivation for therapy. Seventy percent (70%) of the participants agreed that it is important that the abuse is acknowledged at the beginning of therapy and cited the following motivations as to why this is important: it indirectly gives the child permission to talk about the abuse; it minimizes later denial of the abuse; it communicates acceptance of the child, regardless of the abuse; it opens the door for the child to canalize emotional energy into the therapeutic process instead of hiding or suppressing the abuse; and it contributes to trust and openness in the therapeutic relationship.

Three participants, #7, #6 and # 5, felt that the abuse should not be acknowledge at the start of the therapy. Participant # 6 stated: *" No, I think the abuse can only be handled effectively after a relationship of trust has been built. When a child feels safe, he will disclose the abusive events and in doing it at his own time, the child will feel more empowered, respected and in control"*. In consensus with the comment by Participant # 6, the other two participants preferred to work with the information the child provided, acknowledging the abuse only once the therapists regarded the child as ready.

The authors want to highlight that acknowledging abuse does not imply exploring it. In acknowledging it, the therapist is creating an open and trusting relationship with the child, still respecting the child to disclose the detail of the abusive events only once he is ready.

### **5.2.5 Research participants' feedback on the use of techniques and skills in grounding, affect modulation and constructive expression of emotions**

All of the participants agreed on the importance of teaching both children and caregivers skills in grounding, affect modulation and constructive expression of emotions. Participant #10 explained the value of this by stating: *"It gives a child a toolkit to contain painful memories and emotions in and outside the therapy room."*

Other reasons cited by participants (#8, #4 and #2), which corroborated the importance of this aspect of therapy, included that it is empowering for the child; if a child was not equipped with these skills, he would experience trauma work as overwhelming and could be re-traumatized in the second phase of therapy; it provides the child with a feeling of control and mastery over negative emotions; and enhances the development of his sense of self.

Participant #5 cautioned that the different techniques should be used on a scale of readiness of the child. The authors agree that any technique and or skill introduced in therapy should take the child's unique process, age and level of readiness into account. Even though the proposed therapeutic model suggests a structured and thus more directive approach to therapy, the therapist should never lose sight of the individual needs of the specific child.

### **5.2.6 Feedback from participants on the importance of establishing healthy supportive relationships in the child's life**

The participants all agreed on the importance of establishing healthy, supportive relationships in the child's life, prior to exploring the child's sexual abuse trauma. The feedback from participants on the reasons why this is important concurs with literature, which highlights the following underlying motivation for the formation of healthy relationships. According to Participant #7, it can enhance the child's experience and perception of safety. Participant #8 mentioned that healthy, supportive relationships assist with behavioural change, as they act as a buffer against the effect of trauma and the development of PTSD symptoms. Other reasons cited by Participants #9, #8, #6 and #5 included that supportive connections promote resilience; they help or teach the child to self-regulate; and they help the child to internalize new messages about himself, about adults and about the world. It would therefore be helpful to replace the negative messages which the child internalized during the trauma.

### **5.2.7 Overall evaluation and feedback on the first phase of therapy**

After the participants had evaluated and commented on the different focus areas of the first phase of the therapy, they were asked to comment on this phase in general. The overall evaluation of the first phase focussed on the strengths and weaknesses of this phase and any aspects that participants felt needed to be added at this stage.

The strengths of the first phase of therapy the participants noted included the following: Participant #4 selected the clear and transparent way in which therapy and the reasons for it are explained, while Participants #6, #4 and #3 commented on the focus placed on establishing healthy and supportive relationships.

Sixty percent (60%) of the participants (#11, #10, #8, #7, #6 and # 2) identified the teaching of techniques and skills in grounding and affect modulation as the greatest strength of the first phase of the therapy. The shortcomings of the first phase cited by Participants #8 and #9 centred mainly on the practical issues of building healthy and supportive relationships. Practical issues of implementation were pointed out relating to children who have been removed from their parents' care and placed in alternative care and/or parents who show little insight or motivation to cooperate with the therapist.

Participant #8 described very accurately the situations with which practitioners are faced in practice. One situation is that of children remaining with their primary caregivers after an abusive incident with either both caregivers or at least the non-offending caregiver as a support person while going through the therapeutic process. The other reality is that of children being removed from parental care and placed in a place of safety, foster care or other form of alternative statutory care. In these cases, children face multiple losses, and the reality is often that they do not have an adult or carer in their lives who can act as a support person.

The formation of healthy and supportive relationships refers to both the therapeutic relationship and the parent-child or caregiver-child relationship. In cases where parents or primary caregivers cannot be involved, the therapist should try to identify a support person in

the child's life who can give the child the necessary level of support throughout the therapeutic relationship. If no such adult is available, the therapist's role will become paramount. In the authors' experience, when a healthy, supportive relationship is provided for the most part by the therapeutic relationship, it takes longer to achieve the objectives of the first phase of the therapy. The value of the therapeutic relationship in establishing the necessary support for a child cannot be underestimated (Tomlinson & Philpot, 2008:72).

Participant #10 suggested that building a relationship of trust with the therapist should be added as an objective for the first phase of the therapy. In the light of the importance of this relationship for the effectiveness of the therapy, this can be considered a shortcoming of this phase, and should therefore be included.

### **5.3 PHASE 2: EXPLORATION OF SEXUAL ABUSE TRAUMA, REMEMBRANCE AND MOURNING**

The focus areas of Phase 2 will be described in the following paragraphs.

#### **5.3.1 Research participants' feedback on the importance of helping the child tell his trauma story**

Participants were asked to give their opinion on whether or not it is important to help the child tell his trauma story in an attempt to mitigate the effects of sexual abuse. Nine out of the ten participants (90%) agreed that this was an important feature that should form part of the therapeutic process. The participants' motivation of the importance of this aspect can be summarized as follows: it helps to integrate trauma-related information with the autobiographical memory (participants #2, #8 and #9); it helps the therapist to identify any cognitive adjustments that need to be addressed (participant #4); and telling the trauma story helps the child regain control (participant #6).

Participant #10 quoted Kagan (2004:173), explaining that traumatized children think only in terms of the present and, unless the past is addressed, there is no hope for the future. Kagan (2004:173) maintains that traumatized children may have learned that the past is too hard or dangerous to confront. The child frequently carries on as if the problems or trauma did not

exist. While this gives the child a means of “*survival*”, it often leads to maladaptive coping and functioning and possible dysfunctional behaviour. By assisting the child to tell the trauma story, practitioners help the trauma victim realize that their trauma memories and reactions are not dangerous and do not need to be avoided (Fitzgerald & Cohen, 2012:211-212; Fouché & Yssel, 2006:258; Gil, 2012:60).

Participant #5 offered the opinion that recounting the trauma story should depend on the child’s age, the trauma experienced, the symptoms displayed by the child, such as anxiety, as well as the child’s readiness. The authors are, however, of the opinion that, regardless of the child’s age or the type of trauma, children can benefit from telling their trauma story in a safe and contained environment. It is of paramount importance that the child is emotionally ready to tell his trauma story. It is therefore the therapist’s responsibility to continuously evaluate the child’s emotional readiness prior to facilitating the narration of the child’s trauma story (Briere, 2006:ix; Levine & Klein, 2008:126; Webb, 2011:60; Wickham & West, 2002:14).

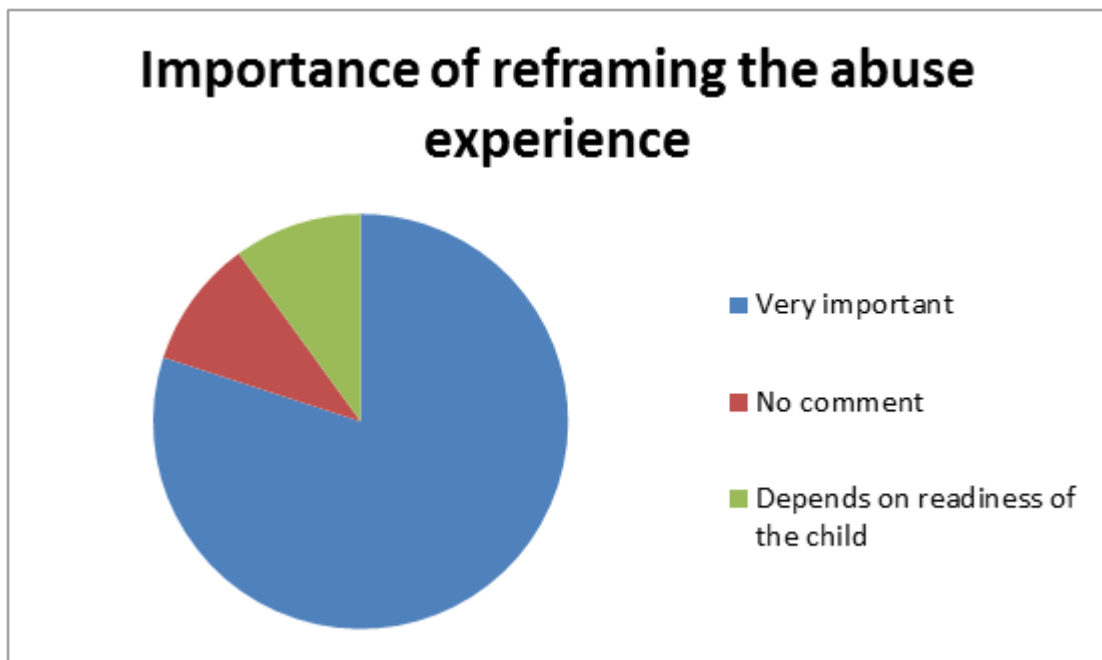
As part of the empirical study, the participants were next asked to comment on the therapist’s role in facilitating the child’s narration of the trauma story. Participants were given the outline of the therapist’s role as suggested by the proposed model (Addendum 2), both in facilitating the trauma story and in exploring the sensations and emotions involved in memory work.

### **5.3.2 Participants feedback regarding the role of the therapist in facilitating the child’s telling of his trauma story**

All the research participants agreed with the proposed outline of the therapist’s role (Addendum 2) in facilitating the child’s telling of the trauma story. Participant # 4 maintained that the role of the therapist is described thoroughly and commented on the practical examples and guidelines that the model offers in the therapist role in exploring exploring sensations and emotions in memory work. The feedback from the participants indicated that the main role of the therapist is seen to be that of *facilitating* and not *leading* the child in telling his story. In the authors’ opinion, this is achieved by following the child’s unique process and continuously evaluating his readiness to reveal his trauma story (Geldard & Geldard, 2013:57; Levine & Klein, 2008:126; Webb, 2011:160).

### 5.3.3 Participants' feedback on assisting the child in reframing the abuse experience.

The participants were asked to comment on the importance of reframing the abuse experience for the child as part of the second phase of the therapy. Figure 5 illustrates the feedback from the participants on the importance of this aspect of the therapy.



**Figure 5: Outline of participant's feedback on the importance of reframing the abuse experience.**

Eighty percent (80%) of the participants indicated that reframing the abuse experience could be considered a very important part of therapy. The participants' motivation as to why this was considered important ranged from empowering the child to rectifying cognitive distortions of the abusive experience. Participant # 8 mentioned that reframing the abuse experience is good for the therapy process and gives the child the chance to feel more empowered and in control. The participant concluded by stating that reframing is needed to assist the child to view the abuse in a manner that the child can deal with.

Participant #10 offered no comments on this aspect, saying that her choices of therapy were EMDR, Cognitive Behavioral Therapy and Sandra Wieland's Internalization Model. However, the same participant mentioned earlier that the telling of the child's trauma story should also

include positive aspects, such as who helped them, how well they coped in the difficult situation and the strengths and wisdom shown in the experience. In the authors' opinion, these aspects form part of reframing the abuse experience for the child.

The participants were subsequently asked to evaluate and provide feedback on facilitating the re-experience of the abuse in the power position.

#### **5.3.4 Participants' feedback on re-experiencing the abuse in the power position**

Ninety percent (90%) of participants agreed that re-experiencing the abuse in the power position is a very important and valuable aspect of trauma therapy. These participants' comments corresponded with one another insofar as they allowed that the value of re-experiencing the abuse in the power position stemmed from the way in which this empowers the child by re-establishing his sense of power and control. Participant # 3 explained this as follows: *"I think it is a very important part of the therapy process and it will help the child to feel in control of his life again. Abusive situations disempower the child and by re-experiencing the abuse in the power position, the child stops being the victim and start becoming a healthy child again."*

The feedback from participants concurs with work by Van der Kolk and McFarlane (2007:19), who state that empowering experiences are necessary and valuable as part of therapeutic intervention with traumatized individuals. Participant #5 felt that she did not have enough experience with this specific aspect, and therefore did not offer any comments.

#### **5.3.5 Participants' feedback on addressing secondary losses in therapy**

Participants were asked to comment on the necessity of addressing secondary losses as part of the therapeutic process with the sexually abused child. All the participants (10) agreed on the importance of addressing secondary losses as part of the therapeutic process. Participant # 2 stated in this regard that the grieving of secondary losses often aids in the empowerment process and how to deal with future losses from the knowledge and experiences they have been exposed to. From the participants' feedback, the theme emerged that children often experience guilt owing to the various losses stemming from their abuse, and often indirectly

as a result of the disclosure of the abuse. The authors concur that this is a theme. The loss and grief children experience is a complicated and often difficult for adults to understand. It is therefore important that, when addressing various losses, the therapist takes into account not only the dynamics of sexual abuse, such as grooming, but also the child's feelings of guilt and responsibility for the losses. These should be placed in context so that the child understands that he is not responsible for the losses.

### **5.3.6 General feedback on the second phase of the therapy**

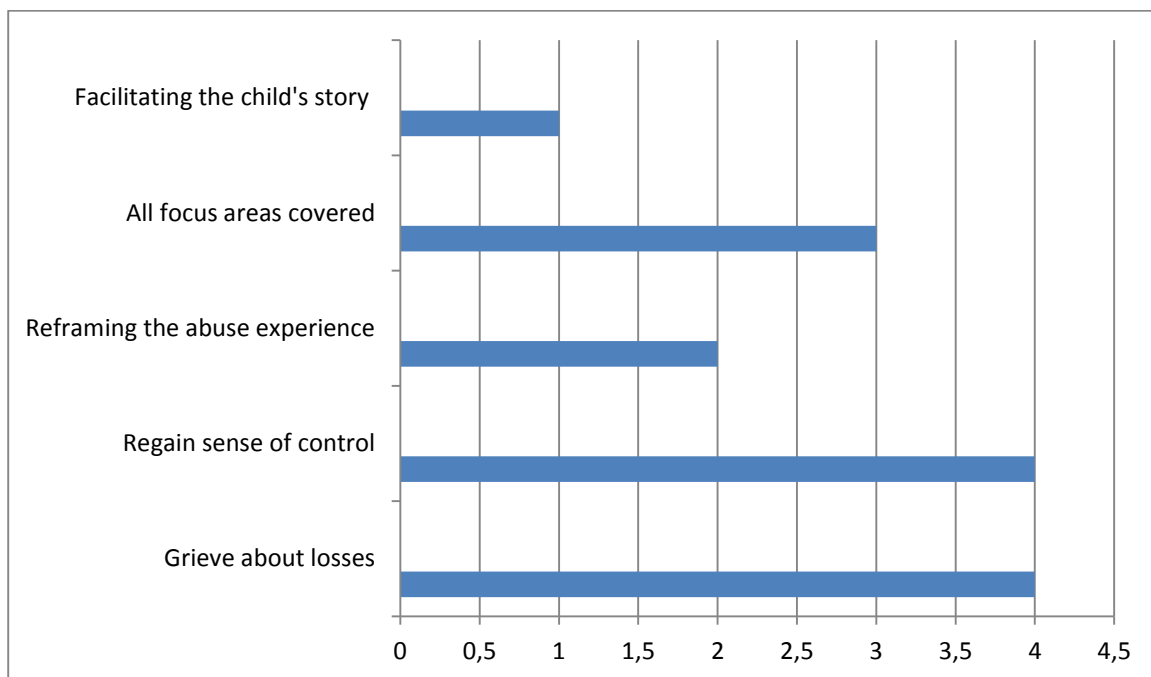
To conclude, in the participants' review of the second phase of the therapy, they were asked to comment on the strengths and weaknesses of this phase. They were also offered the opportunity of commenting on anything they felt should be added or changed in the second phase of the proposed model. None of them wanted to add or change anything in the proposed content of the second phase of therapy. Nonetheless, in the discussion on the shortcomings of this phase, the participants pointed out areas of caution and possible shortcomings. Participant #8 felt that a primary caregiver should be included to acknowledge the abuse to the child, and should apologize to the child, while Participant #4 cautioned that the therapist should take care not to have the child rationalize about what had happened, thereby avoiding communicating about the child's true feelings. Participant #10 mentioned that the release of emotions and aggression should continue throughout this phase. In line with the previous comment, Participant #5 pointed out that regular interaction of the goals and objectives of the different phases should be ensured.

The authors agree on the importance of continuous facilitation of emotional release and re-integrating the objectives set in the first phase of the therapy, during the second phase. One of the key responsibilities of the therapist in the second phase of therapy includes setting boundaries in containing the child and their emotions through continuous grounding and affect modulation as necessary, while facilitating the child's progress through all aspects included in this phase (Fitzgerald & Cohan, 2012:212; Goodyear-Brown, 2012: 303; Levine & Klein, 2007:122).

In the authors' experience, the inclusion of a non-offending parent, a care-giver or another support person in a session during the second phase of therapy can assist with the therapeutic goals of this session, especially when it comes to reframing the responsibility and guilt the

child may be experiencing. It is, however, of the utmost importance for the therapist to evaluate the parent and child's emotional readiness prior to attempting this in a therapy session (Fitzgerald & Cohan, 2012:215; Goodyear-Brown, 2012:303; Levine & Klein, 2007:97). The inclusion of a parent or caregiver in a therapy session should be based on the need of the individual child, his emotional readiness and the emotional readiness and maturity of the parent or adult who is to be included.

Participants were asked to describe the strengths of the second phase of therapy. Figure 6 was compiled from the participants' feedback to illustrate the different strengths of this phase.



**Figure 6: Strengths of the second phase of therapy as identified by research participants.**

Two aspects were selected by the participants as the greatest strengths of the second phase of the therapy, namely the extent to which this phase would empower children to regain a sense of control over their abusive experience and the opportunity offered to them to mourn their secondary losses resulting from the experience. Once the child has successfully worked through the trauma and losses associated with sexual abuse, this signals the end of the second phase of the therapy and the focus can be shifted to the immediate present.

## **5.4 PHASE 3: RECONNECTION, WORKING WITH THE HERE AND NOW AND DEVELOPMENTAL SKILLS**

The last phase of the therapy focusses on assisting children in reconnecting with significant adults and other supportive relationships, as well as equipping them with the knowledge and skills needed to optimize their socio-emotional functioning. The participants were first asked to comment on the necessity of incorporating this as part of a thorough therapeutic process.

### **5.4.1 Participants' general comments on the necessity of the final phase of therapy**

All the participants emphasized the importance of the final phase of the therapy and it would appear that there is agreement among the professionals that this phase can be considered vital to ensuring long-term positive outcomes for the child. Participants #4, #5, #7 and #8 commented that the necessity for this phase centred on the importance of equipping a child with the skills to reconnect and address possible future situations and to deal with emotions and behavioural concerns in the present.

In line with the necessity of the third phase of therapy, the participants commented on the strengths of this phase. The strengths pointed to by Participants # 4, #7 and #1 addressed behavioural patterns and the restoration of the child's inner balance. Participant #7 felt that empowering the child to deal with future situations was the greatest strength of this phase, while Participants #8 and #6 highlighted helping the child reconnect through forming supportive relationships. Fifty percent (50%) of the participants (#9, #10, #1, #7 and #4) indicated that empowering a child with skills could be seen as one of the major strengths of this phase. Thirty percent (30%) of the participants (# 2, #8 and # 3) indicated the preparation of a child for possible future therapy as one of the strengths of this phase, as this offers predictability but also normalizes the need for future intervention.

Participant #10 commented that the goals of the third phase of the therapy could be addressed very effectively by means of group work. The authors agree that including children in group work during the final phase of therapy could add to normalizing their experiences but could also enhance reconnection through the social support of the group.

#### **5.4.2 Shortcomings of the final phase of therapy as identified by the research participants**

The lack of a more detailed description of the specific features included in this phase as well as reference to specific techniques and media for addressing various aspects was pointed out as a shortcoming in the final phase of the therapy. This aspect was also raised under the general comments on the proposed model and will subsequently be discussed in point 5.5.

### **5.5 COMMENTS FROM PARTICIPANTS ON THE PROPOSED THERAPEUTIC MODEL AS A WHOLE**

Some general comments emerged from the participants' feedback across the various questions posed on the different phases of the model, which must be addressed. One point of criticism of the model was the lack of detailed descriptions of the therapeutic techniques and media that could be used in facilitating specific objectives in different phases. Participant #3 commented that: *"The model describes in detail what should be done but not how it should be done"*.

Although the model does give practical examples of how various aspects can be facilitated the point of critique highlights the need to describe specific techniques in detail. The specific technique(s) that will be used to address particular aspects will depend on the age, developmental phase, intra-personal preferences and gender of the specific child. In agreement with Gil (2006:68), the authors feel that, because of these variables, clinicians must remain flexible and equip themselves with an array of different age appropriate techniques using different modalities to achieve the same outcomes.

A question that arose from the participants concerned which alternatives are available when a child is not ready for therapy. This could be considered a shortcoming of the model, and highlights the need for inclusion of more specific alternatives in this regard.

Participant #5 commented on the importance of evaluation prior to the termination of the therapy. Terminating the therapy is considered when all the needs and subsequent areas of

the child's functioning that have been affected by sexual abuse have been addressed and provided for. This is often determined by feedback from the various role players involved in the child's life and thus through continuous evaluation and assessment (Briere, 2006:ix; Fitzgerald & Cohan, 2012:216).

## **6. LIMITATIONS OF THE STUDY**

Limits of the proposed therapeutic model was identified through the empirical study and included a) the need for more detail and reference regarding specific techniques to address the various goals of the model; as well as b) the need for alternatives when children are not ready for therapy. The limits of the proposed model was highlighted by participants concurs with the identified need for specific, detailed guidelines that covers all aspects of therapeutic intervention with sexually abused children.

One limitation is that the proposed model was not tested by using the model in individual case studies, whereby the model would have been applied in therapeutic interventions with sexually abused children. The next step in the research process, after the model was made available to peer review and advance development took place could have been to test the model in practice. This would have added more empirical value to the proposed research. However, it is recommended that this be addressed in future research on the proposed model within the new ethical requirement regarding research with children.

## **7. SUMMARY AND CONCLUSION**

The aim of this article was to outline the proposed structured play therapeutic model and the research study on the proposed model to mitigate the effects of child sexual abuse. The authors undertook a thorough literature study, which formed the foundation on which the proposed model was developed and completed. The literature study and various motivations, founded in the literature cited throughout the article made it apparent that wide consensus exists among authors and experts on the fundamental components that should form part of therapeutic interventions with children who have been sexually abused. Although individual differences and preferences regarding the specifics of when and how to address these aspects do exist, authors, experts and professionals seem to concur that the needs of the individual child should be the motivating force that directs the therapy at any given time.

The shortcomings of the proposed therapeutic model were identified in the empirical study, which centred mainly on the need for a more detailed discussion and outline on the practical “how to”, as well as the inclusion of specific techniques and media for addressing these aspects. This demonstrates practitioners’ need for practical, ‘hands on’ guidelines for implementing the model in practice.

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# SECTION C

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# SUMMARY OF FINDINGS AND RECOMMENDATIONS

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## 1. INTRODUCTION

The research was conducted to compile a structured play therapy intervention model to mitigate the effect of childhood sexual abuse. The researcher conducted a thorough literature study on sexual abuse and various factors relevant to both the phenomenon of sexual abuse and therapeutic intervention with sexually abused children. This study resulted in the structuring of a therapeutic intervention model that could be used in addressing the effect of child sexual abuse. This model could serve as a guideline for practitioners, and could assist them in working therapeutically with children who have been sexually abused. The model is comprised of phases of therapeutic intervention and gives an outline of the goals of each phase, the underlying theory and examples on how to practically implement the goals of each phase in therapy.

The research project was executed in two phases. The first phase focussed on an intensive literature study to identify various factors relevant to the phenomenon of child sexual abuse, such as defining sexual abuse, relevant legislation and the effect of abuse on the child and the broader system. This is discussed in Articles 1, 2 and 3. In the second phase of the study the researcher studied various existing therapeutic models and research on intervention with sexually abused children. The proposed therapeutic model was also developed and evaluated as discussed in Article 4. The research report includes the following:

### **SECTION A: GENERAL INTRODUCTION**

### **SECTION B: ARTICLES**

ARTICLE 1: Critical analysis of the legislation pertaining to child sexual abuse.

ARTICLE 2: Redefining sexual abuse from a legal to a psycho-social definition.

ARTICLE 3: Ecological systems perspective on the effects of child sexual abuse.

ARTICLE 4: A structured play therapy intervention model for mitigating the effects of childhood sexual abuse.

## **SECTION C: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS**

In this section, the researcher summarizes the study, draws conclusions and makes recommendations. The aim, objectives and central theoretical statement are also tested by means of the findings and conclusions.

## **SECTION D: ADDENDA**

Section D consists of various addenda, such as the proposed model and the question schedules that were used.

## **SECTION E: INTEGRATED REFERENCE LIST**

## **2. SUMMARY AND CONCLUSIONS**

The most important findings and conclusions of this research are summarized in this section and are presented by looking at both the research methodology and the various articles contained in Section B of this research report.

### **2.1 SECTION A: GENERAL INTRODUCTION**

The statistics for sexual abuse are on the increase, with the result that practitioners are faced with the phenomenon at an increasing level. The findings of the literature study indicated shockingly that South Africa has the highest prevalence rates of sexual abuse (Pereda, Guilera, Forms & Gomez-Benito, 2009: 336; Solidariteit Helpende Hand, June 2009). The high statistics for of child sexual abuse call for an in-depth understanding of the phenomenon. When studying the literature on the phenomenon of sexual abuse, it becomes clear that professionals need an understanding of not only the legislation pertaining to sexual abuse, but also the role of various factors in accurately defining sexual abuse as both a psycho-social and a legal phenomenon.

Sexual abuse is a phenomenon with a wide-spread effect, not just on statistics but also on child victims and their families. Literature clearly delineates the effect of sexual abuse on the child by offering lists of the symptoms that abused children can experience (Currie & Widom, 2010:111; Karakurt & Silver, 2014:80; Saunders, 2012:186; Yonas *et al.*, 2010:43). When studying the effects of sexual abuse on the child, professionals begin to understand that sexual abuse does not begin and end with the child. The child forms part of a broader system of

family, school and community, which are also affected by the abuse (Colarusso, 2010:5; Gil, 2006:17; Karakurt & Silver, 2014:80-81; Webb, 2011:12-13,16). The holistic effect of sexual abuse on the child highlights the need for practitioners to study and understand sexual abuse from the perspective of ecological systems.

As understanding of the effect of abuse from such a perspective develops, the need for effective therapeutic intervention that recognizes the systemic effect of abuse becomes imperative. Although research and literature in recent years have focussed on the effects of sexual abuse in childhood, appropriate therapeutic interventions have been slower to evolve (Gil, 2006:53; Saunders, 2012:186). Some evidence-based treatment approaches are available, but the challenge lies in having effective guidelines for therapists in integrating various existing interventions with child sexual abuse clients (Gaskill & Perry, 2014:191; Saunders, 2012:191) if the effect of abuse is to be addressed effectively.

Children, families and communities in South Africa are facing a crisis that is calling for therapeutic intervention to mitigate the effect of sexual abuse on children. During this research study, the researcher therefore aimed at compiling and evaluating a structured play therapy intervention model that could effectively address the effects of child sexual abuse, while taking all the relevant aspects of the phenomenon into account.

### **2.1.1 Research questions**

In the research study the researcher answered the following research questions:

- What are the various considerations that practitioners should take into account when attempting to form a holistic, well-integrated understanding of childhood sexual abuse?
- What aspects should form part of a structured play therapy intervention model for mitigating the effects of childhood sexual abuse?
- What do experts in the field of sexual abuse and play therapy feel are important in forming part of an intervention model for mitigating the effects of childhood sexual abuse?

## 2.1.2 Aim and objectives

Flowing from these research questions, the aim of the study was to develop a structured play therapy intervention model to mitigating the effect of sexual abuse. The aim of the study was reached by setting and reaching the following objectives:

NO	Formulated research question	Objectives	Correlating Article
1	What are the various considerations that practitioners should take into account when attempting to form a holistic, well integrated understanding of childhood sexual abuse?	The first objective set was to conduct a thorough literature study on various aspects pertaining to childhood sexual abuse in order to form a holistic, well-researched perspective on the phenomenon of childhood sexual abuse and available evidence-based interventions for sexually abused children.	This research question was answered and the subsequent objective was achieved in  <b>Articles 1: Critical analysis of legislation pertaining to children,</b>  <b>Article 2 : Redefining sexual abuse from a legal to a psychosocial definition; and</b>  <b>Article 3. An ecological systems perspective on the effect of childhood sexual abuse.</b>
2	What aspects should form a part of a structured play therapy intervention model for mitigating the effects of childhood sexual abuse?	The second objective was to develop a structured play therapy intervention model to mitigating the effects of childhood sexual abuse.	This research question was answered and the subsequent objective achieved firstly through the literature study that underpinned <b>Articles 1, 2 and 3</b> , which formed the theoretical foundation for the development of a prototype of the structured play therapy intervention model as outlined and discussed in <b>Article 4</b> .
3	What do experts in the field of sexual abuse and play therapy feel are important in forming a part of an intervention model for mitigating the effects of childhood sexual abuse?	The last objective of the research study was to subject the prototype of the proposed intervention model to peer review in order to determine the strengths and weaknesses of the proposed model and make the necessary adaptations to the model prior to its final dissemination.	The last research question and subsequent objective was achieved through the empirical study presented in <b>Article 4</b> .

**Table 1: Outline of Research Questions, Objectives and Correlating Articles**

### **2.1.3 Central theoretical statement**

The research was based on the theoretical statement that a structured play therapy intervention model could be developed to mitigate the effect of sexual abuse by means of an in-depth literature study and empirical study on the proposed model.

## **2.2 METHOD OF INVESTIGATION**

The method of investigation consisted of two interlinked processes, namely a literature study and an empirical study, whereby the researcher aimed to develop and evaluate a structured play therapy intervention model that could mitigate the effects of childhood sexual abuse.

### **2.2.1 Literature study**

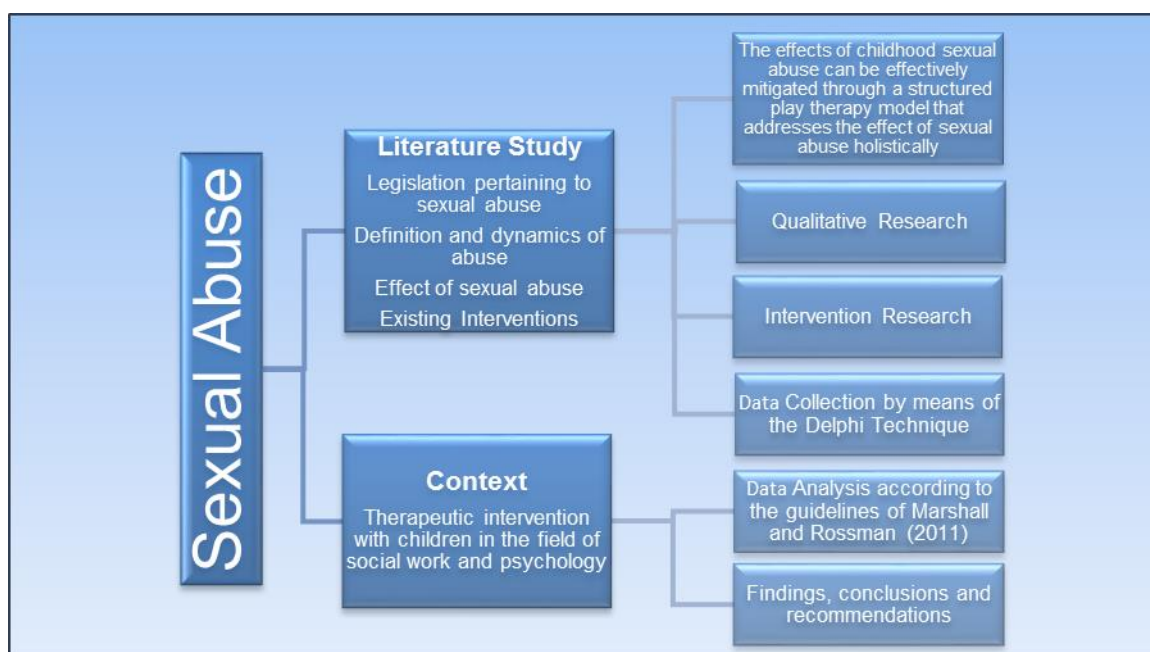
The purpose of the literature study was to help the researcher determine the state of the science and assess how the proposed study extends what is already known in the field (Melnyk & Morris-Beedy, 2012:6). The literature study assisted the researcher in critically evaluating the existing knowledge base and the disciplinary content of the literature (Bryman, 2012:101). Aspects covered as a part of the literature study included the legislation pertaining to children, a comprehensive study on the definition of sexual abuse as found in various psycho-social literature sources, an in-depth look at the effects of sexual abuse on the child, as well as various evidence-based interventions to address the effects of sexual abuse on the child.

Out of the literature study it became clear that definitions of sexual abuse are often one-sided, focussing on either the legal or the psycho-social component. Most definitions also lacked an integrated understanding of the dynamics of sexual abuse. It further became clear that the effects of sexual abuse on children are often minimized by listing various symptoms of abuse or focussing only on the direct effect of abuse on the child. The need for a holistic systems approach to understanding the effect of abuse was highlighted through the literature study. In line with practical experience, the literature study revealed that there were few therapeutic interventions available that holistically addressed the effects of sexual abuse on the child.

The researcher obtained most of the relevant literature from related professions, including social work, psychology, medicine and sociology. In order to identify appropriate sources, the following databases were used: NEXUS, ERIC, RSAT, EbscoHost, Google Books, PsycINFO.

## 2.2.2 Empirical study

The empirical study consisted out of the research design, the tools and the techniques used for data collection and the analysis of data (Punch, 2014:318).



**Figure 1: Outline of the specific research process followed**

According to answers to the research questions, qualitative research and specifically intervention research were seen as the most appropriate form of research for the specific study. Intervention research is carried out with the purpose of creating or testing innovative human service approaches to mitigating problems or improving the quality of life (De Vos & Strydom, 2011:475). In line with the aims of intervention research, the study aimed to develop and evaluate an intervention model for mitigating the effects of child sexual abuse (Fraser *et al.*, 2009:4). The following phases were followed during the research process:

- Phase 1: Problem analysis and project planning;
- Phase 2: Information gathering and syntheses;
- Phase 3: Design;
- Phase 4: Data collection and evaluation of the proposed model;

- Phase 5: Advance development and dissemination (De Vos & Strydom, 2011:476-489).

### **2.2.3 Participants**

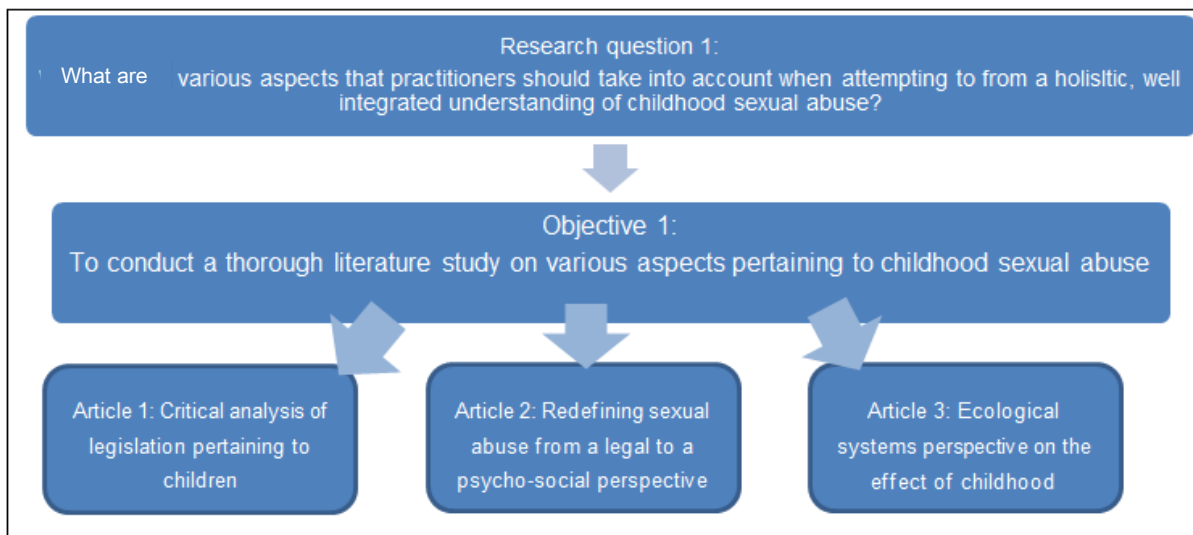
Over 30 participants were initially identified and contacted, with a brief outline of the purpose of the research study (Addendum 1). Of the initial 30 + participants identified, a total of 20 participants indicated their willingness to participate in the research study. In the second round of the data collection, these 20 participants were provided with an outline of the research model and a question schedule. Only 10 participants completed the question schedule and participated in the research study. As participation in the study was voluntary, the researchers respected the non-comments as part of the participants' choice not to participate.

The researcher made use of the Delphi Technique to collect data from a panel of experts by using a question schedule through various rounds of data collection (Hsu & Sandford, 2007:2). The question schedule was developed by using the framework of a descending ladder of abstraction (May, 2011:106). Starting with the broad concept of the intervention model in mind, the researcher constructed questions on the broad concept of each phase of the proposed model. This was followed by formulating open questions around the different dimensions and sub-dimensions of each phase (May, 2011:106).

The question schedule was evaluated by a social worker and a psychologist prior to the final distribution to the various participants. Data collected was analysed by hand and slotted into an Excel sheet for clear record keeping. The participants' responses were therefore documented in the report. Article 4 reports on the findings of the data analysis.

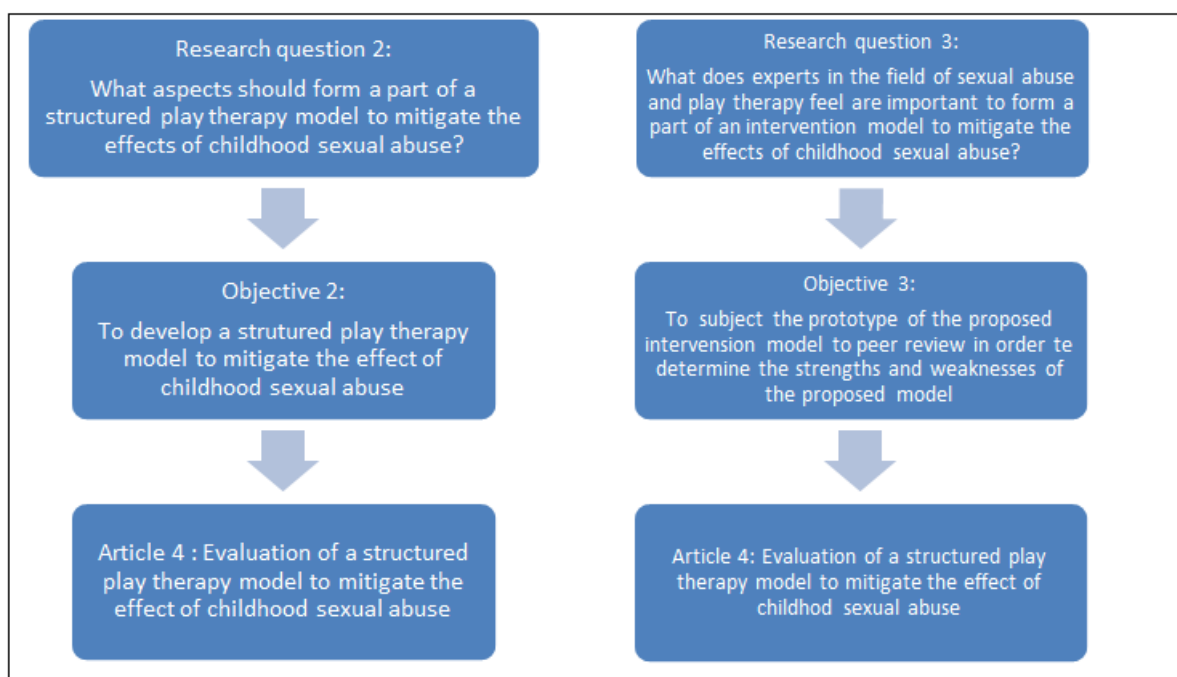
### 3. SECTION B: ARTICLES

Section B will summarize the research findings by discussing how the various research questions and objectives were addressed and answered in the various articles. The first focus of this section will be on the first research question and subsequently on objective 1 as outlined in Figure 2.



**Figure 2: Outline of the first research question, objective and subsequent articles**

The second focus of this section will be on the second and third research question and subsequently on objectives 2 and 3 as outlined in Figure 3.



**Figure 3: Outline of the second and third research questions, objectives and subsequent articles**

### **3.1 RESEARCH QUESTION 1: OBJECTIVE 1**

The following will section provides a discussion of how the first research questions was answered and subsequent objectives achieved. .

#### **3.1.1 Article 1: Critical analysis of legislation pertaining to children**

From the literature study that the researcher undertook, it became clear that legislation pertaining to sexual abuse is a central component of the phenomenon of sexual abuse that practitioners need if they are to be knowledgeable on the subject. The aim of this aspect of the study was therefore to undertake a literature analysis regarding current legislation pertaining to the sexual abuse of children. For the purposes of this study the researcher focussed on the Criminal Law (Sexual Offence and Related Matters) Amendment Act, 32 of 2007 and the Children’s Act, 35 of 2007 as amended. In order to achieve the aim of this article, the following objectives were set:

- To critically evaluate the current definitions of sexual abuse from a legal perspective, thereby providing health care professionals with a clear outline of what constitutes sexual abuse in legal terms;

- To critically evaluate the Criminal Law (Sexual Offences and Related Matters) Amendment Act, 32 of 2007 with specific reference to aspects relevant to the helping professional, thereby providing professionals in the field with a clear understanding of the practical implications of legislation when working with a child who has been sexually abused; and
- To critically evaluate the relevant articles in the Child Care Act, 38 of 2005) pertaining to the sexual abuse of children, highlighting the roles and responsibilities of the professional working in the field of sexual abuse.

From the literature study on legislation and various aspects pertaining to sexual abuse as outlined in both legislation and psycho-social literature on sexual abuse, the researcher became aware of various aspects in the Criminal Law (Sexual Offences and Related Matters) Amendment Act, (32 of 2007) of which practitioners needed to be made aware. The first aspect that was addressed in this article highlighted the definition of sexual abuse in the framework of the Criminal Law (Sexual Offences and Related Matters) Amendment Act, 32 of 2007, but also the discrepancy between the legal and psycho-social definitions of sexual abuse. Article 1, under paragraph 3.1 follows a detailed discussion on the discrepancy between non-contact sexual behaviour that is considered abusive in the Act versus psycho-social literature on sexual abuse. What is clear from this discussion in Article 1, (3.1) is that, although the Act makes reference to behaviour that constitutes non-contact sexual behaviour, these behaviours that constitute an offence are limited to a select few (Aucamp, Steyn & van Rensburg, 2012:2).

In practice, it has been experienced that there is often a link between non-contact sexual behaviour and the sexual grooming of the child. It is important, though, that health care professionals note that the Act makes no reference to any connection between non-contact sexual behaviour or offences and the sexual grooming of the child. This aspect led the researcher to take an in-depth look at grooming as described by the Act and as outlined in Article 1, par. 3.3. From the literature study the researcher formed the opinion that the Act does not take into account the full impact of grooming on the child.

Another aspect scrutinized was the issue of consent as stipulated in the Act. Section 1(2) of the Act defines the term consent as follows: “consent means voluntary or uncoerced agreement”. Article 1 (3.6) not only outlined the issue of consent as stipulated in the Act, but also highlighted the shortcomings in this regard. From the study of both the act as various

forensic literature on the issue of consent shows, it would appear that the legal parameters defining consent are limited.

Stemming from the researcher's practical experience and consultation with professionals working in the field of sexual abuse, the ambivalence and often uncertainty regarding mandatory reporting necessitated the need to critically analyse this aspect. Within the general provisions of the Act, sections 54 (1)(2), reference is made to the obligation of any person to report knowledge that a sexual offence has been committed against a child (Article 1, par. 3.7). Various shortcomings regarding mandatory reporting and the distinction between mandatory reporting where a child is involved versus a mentally disabled person was highlighted. In the researcher's opinion, children meet the same criteria, as set out in the Act to define a mentally disabled person and therefore the same provisions in terms of reporting ought to apply to children.

Although the Act represents a considerable step in the right direction in terms of protecting children against sexual abuse and enabling the judicial system to effectively prosecute sexual offenders, there are several shortcomings. These shortcomings are summarised in Article 1, paragraph 5, repeated below:

- A clearer and broader definition of non-contact sexual behaviours that form part of sexual abuse is necessary.
- Non-contact sexual behaviours must be clearly linked to grooming, and, in the event of these behaviours forming a part of the abusive experience, the presence of these acts should constitute grooming.
- The elements defining a mentally disabled person in the Act, with regard to their inability to give consent, should also apply to children in cases of sexual abuse, by taking into account the effect of grooming and the dynamics of sexual abuse.
- The issue of consent, as covered by the Act in terms of what a child under the legal age can consent to, should be broadened to include not only the exposure of a child to pornography but also the exposure of a child to sexual offences, sexual acts or self-masturbation by the perpetrator while the child is observing.
- The same obligation that rests upon any person to report suspicions of abuse of a mentally disabled person should also apply when it comes to suspicions of abuse of a

child. This implies that anyone who reports suspicions of abuse of a child in good faith must be protected by the Act against civil or criminal liability.

- Clearer guidelines in the Act about when sexual violation among children is considered a criminal offence could provide professionals with the necessary guidelines in terms of when these incidents should be reported criminally (Aucamp, Steyn & Van Rensburg, 2012:9).

Article 1 resulted in a clear understanding of both the various aspects of legislation pertaining to sexual abuse and the great responsibility with which practitioners working in the field of sexual abused are tasked. The following professional responsibilities were highlighted in Article 1, par. 5:

- It is the responsibility of health care professionals to equip themselves with extensive knowledge, pertaining not only to the relevant legislation in a case of alleged sexual abuse, but also to the dynamics of abuse.
- Health care professionals have a responsibility to educate the courts on how the presence of non-contact sexual behaviour can, in certain cases, constitute the sexual grooming of the child, as well as on the possible impact of grooming on a child.
- It is the opinion of the researcher, health care professionals working in the field of sexual abuse should be knowledgeable not only about the legal parameters defining consent but also about those factors that have an influence on a child's ability to give consent.
- The Criminal Law (Sexual Offences and Related Matters) Amendment Act, 32 of 2007, as well as the Children's Act, 38 of 2005, place a legal obligation on professionals and members of the public to report knowledge of sexual abuse, as well as a reasonable belief and/or suspicions of sexual abuse, where such a belief or suspicion is based on a constellation of various factors (Aucamp, Steyn & van Rensburg, 2012:9).

In this article, various aspects of legislation pertaining to sexual abuse of which practitioners need to be aware were identified. **In line with the first research question, this article highlighted one of the aspects that practitioners should take into account when attempting to form a holistic, well integrated understanding of childhood sexual abuse and thus contributed to partially meeting the first objective set for the research study.**

### **3.1.2 Article 2: Redefining sexual abuse from a legal to a psycho-social definition**

Sexual abuse is no longer a traumatic experienced by a select few, but the number of children affected by this phenomenon seems to be on the increase. However, health care professionals are often ill equipped at the pre-graduate level to effectively address the effects of abuse with therapeutic intervention. One of the pre-requisites for effectively addressing the effects of sexual abuse on children is a holistic understanding of the phenomenon of childhood sexual abuse.

With the literature study, it became clear that most literature focusses on either the legal or the psycho-social definition of sexual abuse and that an integrated definition seems to be lacking. To truly understand the phenomenon of sexual abuse, the first step is to formulate a more integrative definition from within the South African context. The aim of this article was therefore to redefine sexual abuse from the legal perspective to the psychosocial. In order to do this, the article:

- Summarized the legal definition of childhood sexual abuse from within the South African context;
- Critically evaluated current definitions of sexual abuse from the psychosocial perspective;
- Formulated a new, integrative definition of sexual abuse that encompasses both legal and psychosocial factors pertaining to child sexual abuse.

The in-depth literature study undertaken for Article 1 formed the foundation for this article, as it aided the researcher in not only forming a sound understanding of the legal definition of sexual abuse but also identifying discrepancies between the legal and psycho-social definitions. From this process, the researcher also identified various factors or components that should be taken into account when contemplating the redefinition of sexual abuse. The various components that redefine child sexual abuse were subsequently studied and discussed to best explain the behaviours and situations that constitute sexual abuse. The components studied and subsequently outlined in Article 2 included:

- The legal definition of sexual abuse as outlined in the Criminal Law (Sexual Offence Amendment Act), 32 of 2007 (Article 2, paragraph 4);
- The various parameters that define behaviour as sexually abusive (Article 2, paragraph 5) ;

- The categories and dynamics in the Child Sexual Abuse Accommodation Syndrome (CSAAS) (Article 2, paragraph 6);
- The experience of the victim in this situation through studying the Traumagenic dynamics, as described by Finkelhor and Brown (1985:530-541) (Article 2, paragraph 6).

Following on from the study of the various components that constitute child sexual abuse, the researcher concluded by redefining sexual abuse as follows:

- Exposure of a child to sexually inappropriate stimuli that can include but are not limited to sexual penetration, sexual violation and compelling a child to witness sexual acts (Criminal Law Sexual Offence Amendment Act, 32 of 2007);
- Where the behaviour falls within the parameters defining sexually abusive behaviour that includes lack of mutual consent, inequality and a sexualized motive, and
- Correlation with the characteristics of secrecy, helplessness, entrapment and eventual accommodation of the abuse;
- Where the child's experience of the abuse is shaped by traumagenic dynamics of traumatic sexualization, betrayal, powerlessness and stigmatisation, resulting in symptoms of abuse-related trauma. The absence of trauma and symptoms of abuse-related trauma does not, however, mean that sexual abuse did not take place (Aucamp, Steyn & van Rensburg, 2013:132-133).

To conclude the findings of Article 2, the following aspects are highlighted:

- a) An integrated psycho-social definition is necessary when considering the phenomenon of child sexual abuse;
- b) A holistic integrated definition of sexual abuse should encompass the legal definition of abuse, behaviors that can be considered abusive and also the fundamental dynamics of sexual abuse, characteristics of the abusive situation and the individualized effect of the abusive experience on the child;
- c) The inclusion of all the aforementioned aspects could lay the foundation for a comprehensive understanding of sexual abuse.

**Article 2 aided the researcher in identifying various crucial components, not only in redefining the phenomenon of sexual abuse but also in forming a holistic understanding of sexual abuse, which partially contributed to meeting the first objective of the research study.** This article further contributed to the fields of social work and psychology by providing practitioners with a holistic, comprehensive definition of sexual abuse that lays the foundation for truly understanding the phenomenon of sexual abuse.

### **3.1.3 Article 3: An ecological systems perspective on the effect of childhood sexual abuse**

The aim of this article was to provide an ecological perspective on the effects of child sexual abuse on the child. In order to achieve this aim, the following objectives were set:

- To describe the multi-faceted effect of sexual abuse on the child; and
- To outline the various factors that play a role in determining the child's individual traumatic experience.

Through the literature study undertaken, it became clear that symptoms associated with sexual abuse are extensive and well documented. The focus on symptomology, however, poses various dangers. Practitioners run the risk of losing sight of the child's unique experience or else interventions aim only to reduce the symptoms so that they lose focus on the underlying dynamics causing these symptoms. Further, symptoms are used to determine whether abuse did take place. In Article 3, focus on the symptoms of abuse is therefore avoided and a more holistic, integrated approach is taken to study the effects of abuse from an ecological systems perspective.

From the research study on the effects of sexual abuse on the child, it became clear that sexual abuse is multi-faceted. In Article 3, paragraph 4, the multi-faceted effect and the need for a multi-level approach to understanding this are outlined. This led the researcher to take an in-depth look at the systems theory, specifically Bronfenbrenner's ecological systems approach. Through the literature study, various factors that play a role in either mitigating or exasperating the effect of sexual abuse on the child were identified. These factors were organised within the various levels of an ecological systems approach (Article 3, par. 4.1- 4.3).

From the information obtained through the study on the effect of sexual abuse on the child, the following conclusions were drawn:

- It is imperative that practitioners have knowledge on the various factors (including risk and protective factors) that play a role in negotiating trauma;
- The need for individual assessment or evaluation of each child as a prerequisite for therapeutic intervention was highlighted;
- A holistic understanding of all the factors that have contributed to the child's current problem situation and experience is necessary in order to implement appropriate intervention;
- A holistic, ecological systems understanding is necessary when attempting to fully understand the effect of sexual abuse on the child.

Article 3 assisted the researcher in identifying the various factors that play a role in understanding the child's unique experience of abuse and the various role players within the ecological systems perspective that should be considered when attempting to understand the phenomenon of child sexual abuse. This article further contributed to the fields of social work and psychology by creating an awareness on the part of professionals of the multi-faceted effect of sexual abuse which could possibly aid them in more effective evaluation and intervention planning in individual cases. This knowledge base could result in understanding and identifying areas and levels of functioning that have been affected by the abuse. This article further lays the foundation for advocating for the needs of sexually abused children at various levels of society.

#### **3.1.4 Summary and conclusion on first research question and first objective:**

The first research question of the study centred on the various aspects that practitioners should take into account when attempting to form a holistic, well integrated understanding of childhood sexual abuse. This research question gave rise to the first objective set for the research study, which was to conduct a thorough literature study on various considerations pertaining to childhood sexual abuse in order to form a holistic, well researched perspective on the phenomenon of childhood sexual abuse and the available evidence-based interventions for sexually abused children. Articles 1, 2 and 3 were based on the literature study. The following components were identified as crucial in aiding professionals in forming a holistic understanding of the phenomenon of sexual abuse:

- Understanding of legislation, shortcomings and aspects embedded in the legislation about which professionals need to be knowledgeable when engaging in the field of sexual abuse (Article 1);
- A holistic, integrated definition of sexual abuse that incorporates legal definition, along with dynamics such as grooming, accommodation of sexual abuse and traumagenic dynamics (Article 2);
- Understanding of the effect of sexual abuse on the child, not limited to symptoms but including an ecological systems perspective identifying various factors that can either mitigate or exacerbate the effects of abuse on the child (Article 3)

Through these three articles, various aspects pertaining to childhood sexual abuse that could assist practitioners in forming a holistic perspective on the phenomenon of sexual abuse were identified and discussed. **The first objective of the research was therefore achieved through identifying and concluding the in-depth study of the various aspects pertaining to childhood sexual abuse.**

### **3.2 RESEARCH QUESTION 2: Objective 2**

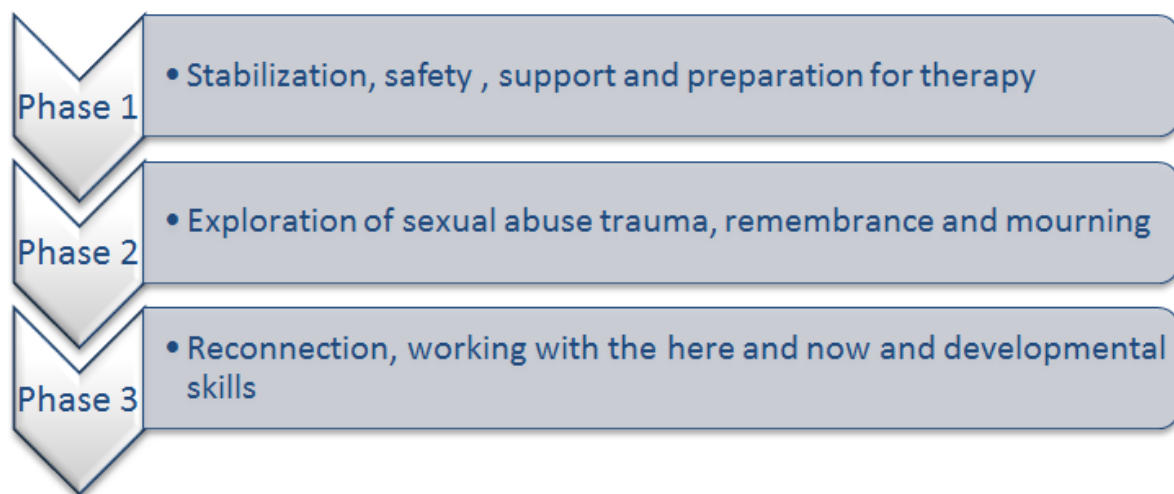
**Article 4: A structured play therapy intervention model to mitigate the effects of childhood sexual abuse (Outline of the therapeutic model)**

The second research question centred on the features that should form part of a structured play therapy intervention model for mitigating the effects of childhood sexual abuse. In line with the second research question, the second objective of the research study was subsequently to develop a structured play therapy intervention model to mitigate the effects of childhood sexual abuse. In line with the second objective of the research study, one of the objectives of the fourth article was to outline the intervention model for mitigation of the effects of child sexual abuse

The literature study undertaken indicated that, although many treatment methodologies for abused children are described by various authors, many of these specify a particular treatment strategy or else emphasize only certain dimensions of play. The literature study further gave rise to the belief that the foundation for a therapeutic model for mitigating the effects of

childhood sexual abuse must incorporate not only the underlying theory of childhood sexual abuse, but also an appreciation of what the experience of sexual abuse means to the victim.

Stemming from the in-depth literature study, the researcher developed a prototype of the proposed intervention model. The proposed model consisted of three interlinked but interdependent phases and is discussed in detail in Article 4, paragraph 4. The phases of the proposed model as outlined in Article 4 are reproduced in Figure 4:



**Figure 4: Outline of the phases of the proposed model.**

Through the discussion of the proposed therapeutic model for mitigating the effect of sexual abuse, as well as highlighting the theoretical foundation for the various aspects included in the proposed model, the second objective of the research study was met. This was done by developing a structured play therapy intervention model for mitigating the effects of childhood sexual abuse and providing a detailed outline of the proposed intervention model.

### **3.3 RESEARCH QUESTION 3: OBJECTIVE 3**

#### **Article 4: A structured play therapy intervention model to mitigating the effects of childhood sexual abuse (Empirical study on the therapeutic model)**

The final research question focused on what experts in the field of sexual abuse and play therapy felt was important in forming part of an intervention model for mitigating the effects of childhood sexual abuse. The final objective of the research study was subsequently to subject the prototype of the proposed intervention model to peer review to determine the strengths

and weaknesses of the proposed model. In line with the aforementioned research question and the final objective, the aims of Article 4 were to outline the research study on the proposed structured play therapy intervention model for mitigating the effects of child sexual abuse. To reach the aim of this article, the following objectives were set:

- To give an outline of the research methodology underlying the study;
- To discuss the problem analysis and project plan;
- To discuss the research findings on the proposed model.

After the early development and design of the proposed therapeutic intervention model, it was made available for evaluation by the participants by means of the Delphi Technique. In the initial process of contacting possible research participants, an invitation was sent to 30 therapists who met the inclusion criteria. Twenty (20) therapists indicated their willingness to participate in the research. Data was collected by means of a question schedule. The participants received an outline of the proposed therapeutic model (Addendum 2) as well as a question schedule (Addendum 3) to aid them in the critical evaluation of the proposed model. Open questions were formulated relating to each phase of the proposed model to extensively evaluate all the core components of the different phases. Only 10 participants sent their evaluations of the model. The fact that only 10 reacted was seen as part of the ethical considerations that participants were under no obligation to take part in the research and could withdraw at any stage.

All 10 of the participants agreed that the therapeutic goals of the proposed model were relevant and addressed the needs of the child who has been sexually abused. Additional objectives that emerged from the participants' feedback included to strengthen the child's personal boundaries; to create a relationship of trust and safety between the child and therapist; and to identify areas of dysfunction or need for the child that are related to the sexual abuse (Article 4, paragraph 5.1).

The relevance and importance of the first phase of therapy was reviewed by the participants and is discussed in paragraph 5. 2 of Article 4. All the participants agreed on the importance of the first phase of the therapy, which focuses on stabilization, safety and preparation for therapy. The various strengths of this phase were highlighted. Regarding the second phase of the therapy, none of the participants felt that they wanted to add to or change anything in

the proposed content of this phase. The participants agreed on the possible shortcomings of this phase and it are outlined and discussed in paragraph 5.2.7 of Article 4, and include the involvement of a primary caregiver in acknowledging the abuse, an apology to the child, avoiding rationalization of the abuse, and continuous emotional release and interaction of all the goals and objectives throughout the various phases of therapy.

The second phase of the therapy is discussed in paragraph 5.3 of Article 4. The various aspects of this phase were evaluated by the participants. They highlighted the following aspects as the greatest strengths of the second phase of therapy: (a) the extent to which children are empowered to regain a sense of control over their abusive experience and; (b) the mourning of secondary losses resulting from the abusive experience (Article 4, 5.3.6). The final phase of therapy was evaluated and the participants' comments on this phase are outlined in paragraph 5.4 of Article 4. Based on the participants' evaluation of the final phase, the data indicated that there was agreement that this phase is important to ensure long-term positive outcomes. The strengths of this phase are outlined in paragraph 5.4.

**With the evaluation by experts in the field of sexual abuse and play therapy of the proposed therapeutic model for mitigating the effect of sexual abuse, the third objective of the research study was met.**

The research was conducted according to a qualitative paradigm, which means that the research findings cannot be generalised. Therefore, following on from the research findings, the hypotheses were set. From the literature study, the need for guidance and training of professionals working with sexually abused children was indicated:

- If the proposed model was used to train professionals in the field, it could provide them with an understanding of the phenomenon of sexual abuse as well as with guidance for therapeutic intervention.
- If professionals working in the field of sexual abuse are trained, the training should include the following to equip them with solid understanding of nature and depth of child sexual abuse:
  - a sound understanding of all the legislation pertaining to sexual abuse;
  - knowledge of all the aspects underlying the phenomenon of sexual abuse;

- a sound understanding of the effects of sexual abuse on the child and various factors that might mitigate or exacerbate the effects of the abuse and broader systems; as well as a sound theoretical foundation for the various therapeutic goals and objectives for sexually abused children, which could equip them to address the effects of abuse both holistically and effectively.
- If social workers and psychologists entering the field of therapeutic intervention with sexually abused children worked under the supervision of or in consultation with more experienced and well-trained individuals to ensure not only that legal guidelines were adhered to but also that they developed a sound understanding of all the factors pertaining to sexual abuse, this could lead to more effective intervention with sexually abused children and their families.

#### **4. TESTING THE CENTRAL THEORETICAL ARGUMENT**

The research was based on the following theoretical argument that a structured play therapy intervention model to mitigate the effects of sexual abuse could be developed by means of an in-depth literature study and empirical study on the proposed model. The central theoretical statement was proven based on the qualitative findings and subsequent conclusions of the various sections of the research study.

#### **5. RECOMMENDATIONS**

From the research study, it is clear that the phenomenon of sexual abuse is a reality in South Africa and that practitioners and families are faced with it on an increasing basis. The need for effective intervention is indisputable. Stemming from the findings and conclusions of the research study, the following general and specific recommendations are made:

##### **General recommendations**

- Parents and primary caregivers form a crucial support system for the child who has been sexually abused. However, when the family is viewed as a system, a problem for one member brings problems for all. Evidence further strongly suggests that non-offending mothers and fathers experience significant distress and are faced with various crises following the sexual abuse of their child. Owing to the predominant transactional patterns associated with families, various research indicates that the reaction of parents, caregivers or significant others has a considerable effect on the child and the extent to which he will

be able to cope with the effects of sexual abuse. It is therefore recommended that a support program for parents and/or caregivers be developed that will not only equip parents with the necessary knowledge and skills for supporting their child, but will also ultimately provide them with the necessary support to deal with their own emotions, stress and crises stemming from the sexual abuse of their child.

- A question that arose from the feedback from some of the participants concerning the proposed therapeutic model was that of the alternatives available when a child is not ready for therapy. As this is a valid question, which did not fall within the scope of the specific research study, it is recommended that a research study be undertaken to identify various factors that may affect a child's readiness for therapy and subsequent alternatives to formal therapeutic intervention that may assist children in this process.
- When studying the effect of sexual abuse from an ecological systems perspective, one becomes aware of the far-reaching effect of abuse, not just on the child and his immediate family but also on the broader exo- and macrosystem that includes teachers, prosecutors and medical practitioners. The extent to which these role players are able to support parents has an influence on parents' own ability to cope with the reality and subsequent effect of sexual abuse of their child. Research further indicates that professionals working in fields dealing with traumatic subject matter demonstrate high levels of secondary trauma and burnout. If practitioners want to address the effect of sexual abuse from an ecological systems perspective, support for the role players within the exo- and macro system, needs investigation.

### **Specific recommendations**

- The next phase of the research should focus on implementing the proposed therapeutic model in an empirical setting with a sexually abused child or children, as this would add more empirical value to the research study, and thus the therapeutic model.
- That a quantitative study involving more research participants over a wider geographical area be undertaken to add to the empirical value of the research findings on the therapeutic model.

Helen Keller once said: "Alone we can do so little, together we can do so much". Within the phenomenon of sexual abuse and a passion for minimizing the effects of sexual abuse, these words could not be more accurate.

## 6. CONTRIBUTIONS OF THIS RESEARCH

This research has made contributions to the disciplines of both social work and psychology and especially to professionals working in these fields who specialize in therapeutic intervention with sexually abused children. The various articles that comprised this study contributed to the field of social work and psychology in the following ways:

a) Practitioners are offered a sound understanding of the legislation pertaining to children which could aid them not only in ethically but also in legally sound practice. It further highlights the role and responsibilities of professionals to children who have been sexually abused and to advocating for the rights of sexually abused children when legislation falls short;

b) The study formulated a well-researched, theoretically sound and comprehensive definition of sexual abuse that will enable practitioners to really understand the phenomenon of sexual abuse from both the legal and the psycho-social perspectives. This definition can be used in practice to explain the phenomenon of sexual abuse and bring home a true understanding thereof for parents, professionals and those in the legal arena; and

c) Through the ecological systems perspective on the effects of sexual abuse of the child, a systems approach and understanding of sexual abuse is established that can be used to advocate for the needs of sexually abused children at various levels.

d) Lastly, the proposed model provides professionals with much-needed guidelines on therapeutic intervention with sexually abused children.

This study brings together four crucial components and foundational pillars, namely, legislation, comprehensive definition, the understanding of multi-faceted effects and practical guidelines for the therapy needed for effective intervention, as well as advocating for the needs and rights of sexually abused children at all levels of society.

Table 2 gives an outline of the published articles through which the contribution of this study has been made:

Article	Name of article	Scientific journal
1	Critical analysis of legislation pertaining to children	<i>Child Abuse Research: A South African Journal</i> (CARSA), 13(1) 2012
2	Redefining sexual abuse from a legal to a psycho-social perspective	<i>South African Journal of Criminology (Acta Criminologica)</i> , 26(2) 2013
3	An ecological systems perspective on the effect of childhood sexual abuse	<i>Child Abuse Research: A South African Journal.</i> (CARSA), 15(1) 2014

**Table 2: Outline of the various articles published as part of the dissemination of the research study**

The final article containing the proposed therapeutic model as well as the empirical study regarding the model (Article 4) will be prepared for dissemination in CARSA (Child Abuse Research: A South African Journal).

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# **SECTION D: ADDENDA**

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**ADDENDUM 1**

**INVITATION TO RESEARCH PARTICIPANTS TO  
PARTAKE IN THE RESEARCH STUDY**

Dear research participant,

**RE: MOTIVATION UNDERLYING THE PROPOSED RESEARCH AND  
THERAPEUTIC INTERVENTION MODEL.**

We would like to thank you for considering participating in the research of the undersigned social worker as part of her PHD studies in Social Work, at the North West University.

**1. THE TITLE OF THE SUGGESTED RESEARCH ARE AS  
FOLLOWS:**

*A structured play therapy intervention model to mitigate the effects of childhood sexual abuse.*

**1.1 THE MOTIVATION FOR THIS PROPOSED RESEARCH STEMS  
FROM THE FOLLOWING PROBLEM STATEMENT:**

Sexual abuse is a phenomenon that health care practitioners are faced with on an increasing basis. It is indisputable that sexual abuse has a multi-facet effect on the child and his functioning (Colarusso, 2010: 3; McFarlane & Yehuda, 2007:157; Van der Kolk & MacFarlane, 2007:15-16). Literature thoroughly discusses the effects of sexual abuse on children ranging from initial effects such as feelings of guilt, fear, helplessness and loss of trust, to long term effects which range from depression, denial, being overly responsible to dissociation (Heithritter & Vought, 2001:25;51).

Although the theoretical topic of sexual abuse is briefly discussed pre-gradually, there seems to be a vast gap in specialised skills and knowledge in private practice regarding effective structured play therapy programmes for children who have been sexually abused. While the need for therapy increases, few interventions address the effects of sexual abuse and the need(s) of the abused child in totality. In order for therapeutic interventions to be effective, we need an integrated approach that addresses all aspects of the child's functioning –integrated and interdependent whole.

## **2. RESEARCH QUESTIONS**

From the literature study the following research questions emerged.

- What are the various aspects that practitioners should take into account when attempting to form a holistic, well integrated understanding of childhood sexual abuse?;
- What aspects should form a part of a structured play therapy intervention model to mitigate the effects of childhood sexual abuse?; and
- What do experts in the field of sexual abuse and play therapy feel are important to form a part of an intervention model to mitigate the effects of childhood sexual abuse?

## **3. WHAT ARE THE AIMS OF THE PROPOSED RESEARCH STUDY**

The aim of the study is to develop a structured play therapy intervention model to mitigate the effect of sexual abuse. In order to reach this aim the following objectives are set:

### **Objective 1**

To conduct a thorough literature study on various aspects pertaining to childhood sexual abuse in order to form a holistic, well research perspective of the phenomenon of childhood sexual abuse and available evidence based interventions for sexually abused children.

### **Objective 2**

To develop a structured play therapy model to mitigate the effect of childhood sexual abuse

### **Objective 3**

To subject the prototype of the proposed intervention model to peer review in order to determine the strengths and weaknesses of the proposed model and make the necessary adaptations to the model prior to final dissemination of the model.

### **3.1 METHOD OF INVESTIGATION**

The method of investigation will consist of two processes namely a literature study and an empirical study. The researcher will make use of intervention research in order to:

- (a) develop a detailed description of the proposed therapeutic intervention model;
- (b) evaluate the effectiveness of the program (Fraser, Richman, Galinsky & Day, 2009:4).

The following phases will be followed during the research process:

- Phase 1: Problem analysis and project planning;
- Phase 2: Information gathering and syntheses;
- Phase 3: Design;
- Phase 4: Data collection and evaluation of the proposed model;
- Phase 5: Advance development and dissemination (De Vos en Strydom, 2011:476-489).

### **4. YOUR ROLE IN THE RESEARCH PROCESS:**

The proposed therapeutic intervention model was developed stemming from a thorough literature study undertaken by the researcher. Due to ethical concerns of subjecting children to the model through a pilot test, the model will be distributed to experts in the field of sexual abuse and therapy with traumatized children to critically evaluate the model. If you agree to participate in the proposed research your contributions will form part of the evaluation and advance development phase of the research process – thus the critical evaluation of the proposed therapeutic mode.

If you wish to participate in the research study an outline of the proposed therapeutic model together with a question schedule to assist you in critically evaluating the model will be made available to you.

Participation in this research study is voluntary and you are allowed to withdraw from the research study at any time.

If you have any further enquiries please feel free to contact the researcher.

Kind regards

Louise Aucamp

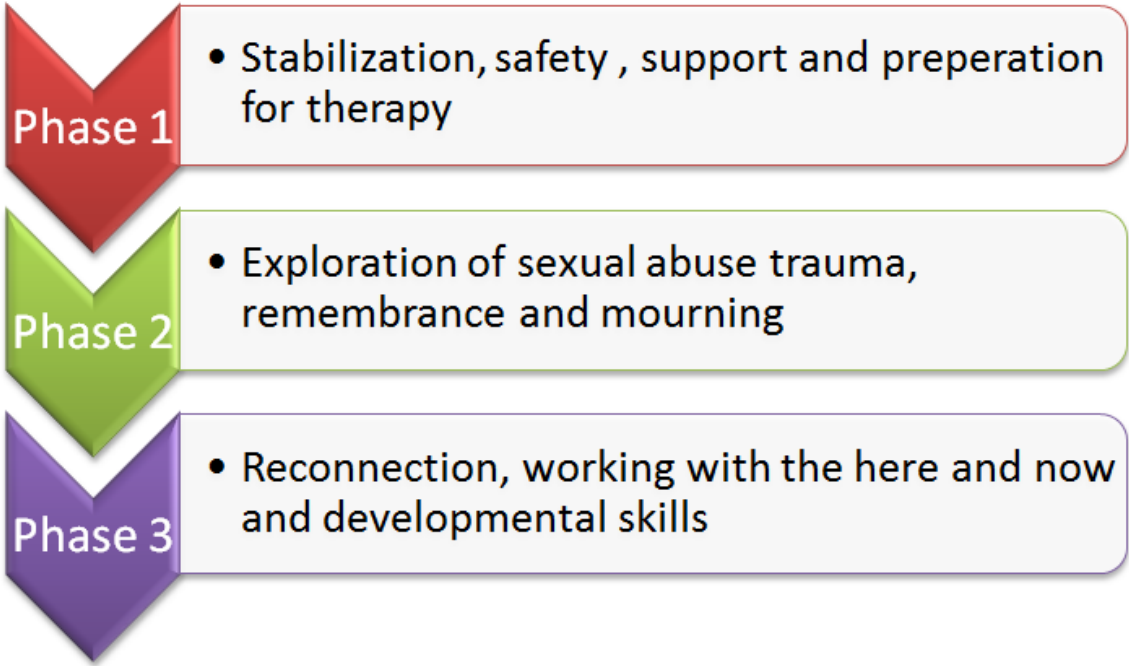
**ADDENDUM 2**

**OUTLINE OF THE PROPOSED THERAPEUTIC MODEL**

**STRUCTURED PLAY THERAPY INTERVENTION MODEL TO MITIGATE THE EFFECTS OF CHILDHOOD SEXUAL ABUSE**

**1. INTRODUCTION TO THE THERAPEUTIC MODEL**

The proposed therapeutic model consists of 3 phases:



**Figure 1: Outline of the 3 proposed phases of the therapeutic model**

The three phases of the model are interlinked and follows consecutively on one another. The amount of time / sessions spend on each phase is determined individually according to the unique process of each individual child.

It should be noted that depending on the individual needs of each child and their unique trauma experience, developmental phase, and support system – not all children will necessarily need all three phases of therapy at a specific time.


In some cases it might be that a child, at a specific time and in a specific developmental phase might only require phase 1 therapeutic input. While another might need phase 1 – 3 therapeutic input. It may also be that a child in a specific developmental stage might require only phase 1 therapeutic input, yet at a later developmental stage have a need for phase 2 therapeutic input. The following of the therapeutic model as a phased process should therefore be an individualized process according to the specific needs of each child.

## **2. CORE THERAPEUTIC GOALS OF THE MODEL**

The core therapeutic goals of the model can be summarized as follows:

- Helping the child learn how to regulate emotions;
- Promote acceptance of painful feelings;
- Promote direct expression of feelings in healthy supportive relationships
- Desensitize traumatic memories;
- Correct faulty belief systems;
- Enhancing integrative functioning by helping children process abuses experience through various modes of experience;
- Help the child to reduce symptomatic behaviour e. g withdrawing, acting out, sexualized behaviour
- Changing learned behaviour patterns.

### 3. OUTLINE OF THE DIFFERENT PHASES OF THE PROPOSED THERAPEUTIC MODEL




- Stabilization, safety , support and preperation for therapy


#### PURPOSE OF THIS PHASE

To support and help the child to gain a sense of control over their emotions through grounding and affect modulation, and provide them with sense of security (in both circumstances and relationships) prior to the exploration of abuse specifics, so that they will be better equipped to deal with and tolerate distressing affect when abuse exploration begins.

The first phase of therapy includes the following:



- Creating a safe and predictable environment
- Motivation for therapy and providing information
- Teaching grounding and affect modulation techniques to the child and caregivers
- Formation of healthy supportive relationships

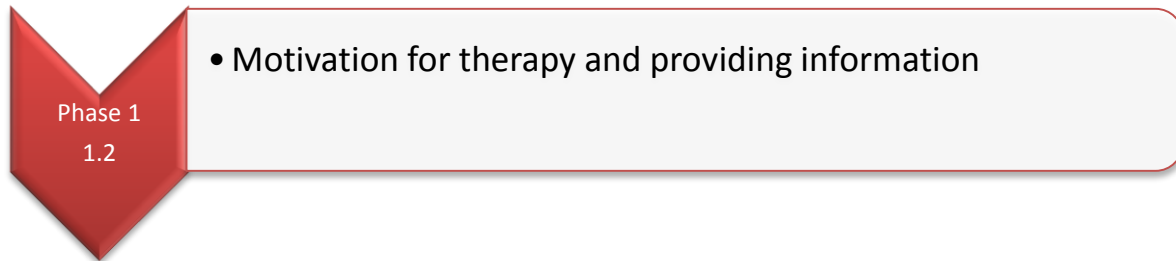


- Creating a safe and predictable environment

#### Creating a safe and predictable environment includes the following:

- Ensuring the child's safety from further abuse and protecting the child from perpetrating adults through enforcing boundaries and safety limits ;
- Maintaining or re-enforcing predictable daily structures in child's life through set routine, rules and boundaries and predictable adult behaviours;
- Minimizing further losses in the child's life;

- Providing a child with predictability in terms of therapy – knows the reason why he is there, when he will be coming, what he can expect of therapy and of the therapist

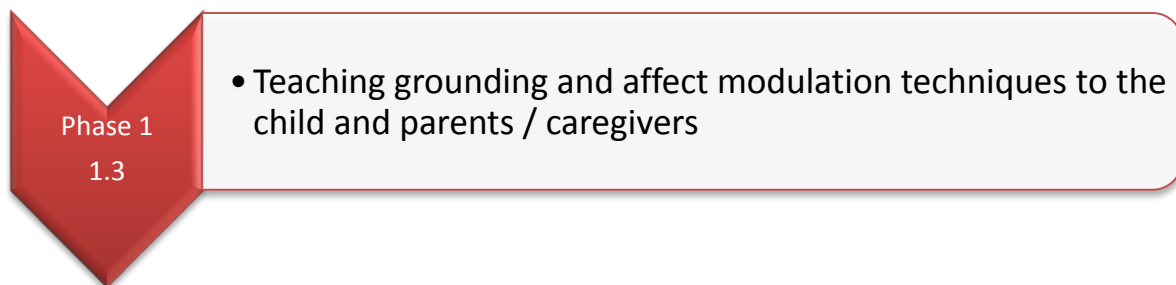


Phase 1  
1.2

- Motivation for therapy and providing information

Motivation for therapy and providing information includes the following:

- It is Important to acknowledge the abuse although intensive exploration of abuse at this stage is contraindicated;
- If the presence and influence of abuse is not acknowledged early in therapy the child's denial may be exacerbated;
- Motivate the child for the need for therapy and provide predictability by providing child with appropriate information and explanations on therapy;
- Motivate the parents/ caregivers for the need for therapy and their role within the therapeutic process. Also providing parents / caregivers with predictability by providing them with information on the therapeutic process ect.



Phase 1  
1.3

- Teaching grounding and affect modulation techniques to the child and parents / caregivers

Teaching grounding and affect modulation techniques to child and parents includes the following:

- Grounding techniques includes techniques and strategies to help the child focus on current reality in order to reinforce a sense of safety and that he is not in the trauma situation.

*Practical techniques in grounding a child includes the following:*

- *The use of sensory stimuli in the grounding process;*
- *Use of bodily sensations related to empowerment and strengths;*
- *Orientating the child in the here and now;*
- *Making use of an object of safety;*
- *Repeating a word, sound or phrase or muscular activity;*
- *Teaching parents/caregivers to assist a child by facilitating practical techniques;and*
- *Teaching affect modulation and constructive emotional expression.*

*Practical techniques in affect modulation or emotional expression are:*

- *Breathing*
- *Rocking: constructive rocking movement calms the limbic system*
- *Progressive relaxation techniques*
- *Helping the child identify and label his feelings*
- *Helping child to express feelings through constructive activities and eventually to express feelings verbally*
- *Focus is on healthy expression of emotions in general rather than trauma related emotions*
- *Modelling: modelling constructive expression of emotions to the child*
- *Mirroring: reflecting to the child his behaviour and emotions that is observed, helping him to label emotions and cause there of*

If a child can be supported and helped to gain a sense of control over their emotions through grounding and affect modulation, prior to the exploration of abuse specifics, they will be better equipped to deal with and tolerate distressing affect when abuse exploration begins.

Phase 1  
1.4

- Formation of healthy supportive relationships

The formation of healthy supportive relationships are necessary in order to:

- Enhance the child's experience and perception of safety;
- Healthy supportive relationships are needed for behavioural change. As supportive relationship is the basic motivation for change;
- Supportive relationships help or teach the child to self-regulate;
- Supportive relationships help the child to internalize new messages about himself, about adults and about the world. It therefore helps to replace the negative messages which the child internalized due to the trauma; and
- Formation of healthy supportive relationships is achieved through involving parent/ caregivers in all four aspects of phase 1 and by equipping parents with knowledge and skill with regards to all the previously discussed aspects as well as basic good parenting skills.

Phase 2

- Exploration of sexual abuse trauma, remembrance and mourning

**PURPOSE OF THIS PHASE:**

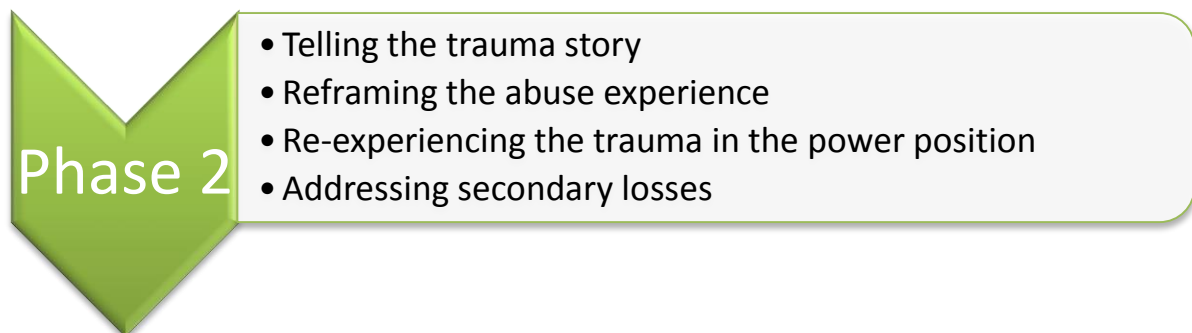
To integrate trauma memories into autobiographic memory so that eventually these memories will cease to trigger the implicit memory system and the child will be able to remember without re-experiencing the full extent of the original psychological arousal or emotions.

Although memory work is critical in helping traumatized children recover, therapist must proceed deliberately and cautiously. Memory work addresses disturbing events and the associated emotions in order to help the child integrate them with other life experiences. Once these painful memories have been transformed they no longer produce feelings of terror and helplessness.

Continuously throughout this phase therapists will assist children in dealing with owning their emotions; expressing them constructively and making use of grounding and affect modulation when emotions are overwhelming.

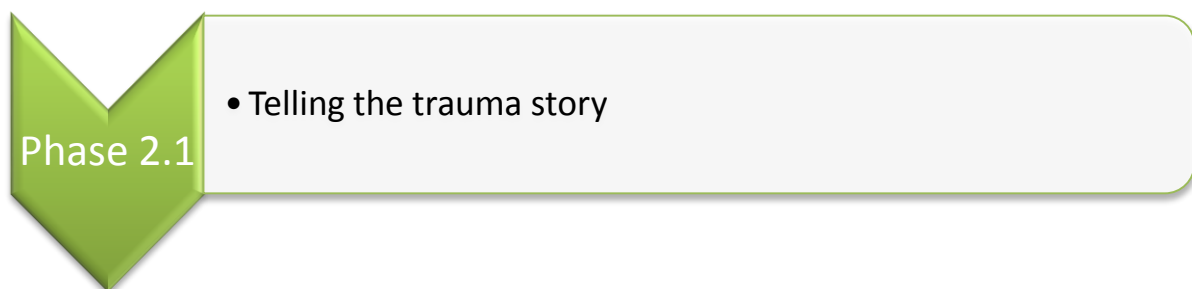
The focus of this phase is therapeutic intervention, at the appropriate time, that is neither so non-demanding as to be useless nor so evocative or powerful that the client is re-traumatized. We miss the therapeutic window if we avoid exploration of the abuse or when exploration is too intense or too fast paced to allow for adequate processing of the trauma.

The second phase of therapy includes the following:

A graphic for Phase 2 consisting of a green downward-pointing arrow on the left containing the text 'Phase 2'. To the right of the arrow is a light gray rounded rectangular box containing a bulleted list of four items: 'Telling the trauma story', 'Reframing the abuse experience', 'Re-experiencing the trauma in the power position', and 'Addressing secondary losses'.

Phase 2

- Telling the trauma story
- Reframing the abuse experience
- Re-experiencing the trauma in the power position
- Addressing secondary losses

A graphic for Phase 2.1 consisting of a green downward-pointing arrow on the left containing the text 'Phase 2.1'. To the right of the arrow is a light gray rounded rectangular box containing a bulleted list of one item: 'Telling the trauma story'.

Phase 2.1

- Telling the trauma story

Telling the trauma story involves the following:

In this phase the primary goal is to gradually expose the child to, and help him face and make sense of the abuse experience and associated emotions at a pace that is safe, manageable and not overwhelming.

The therapist should begin by giving the messages that she works with children with whom bad things have happened, that she is not afraid of the material and is willing to listen, that it will not change the way she thinks of the child, that she is able to handle what happened and able to contain the child. This messages re-affirm the messages that was given during the first phase of therapy when the motivation for therapy was addressed.

In telling the trauma story memory work is more effective when the child uses several sensory modalities to process the memories. Telling the trauma story involves helping children to tell their trauma story through use of dolls, puppets, sand tray, role play, art work, other forms of playing out the trauma.

a) *The therapists role in telling the trauma story:*

- Observing and describing the child's play;
- Asking the child to describe / explain her play;
- Helping the child to focus/voice/play out sensory details / emotions / thoughts and factual events;
- Commenting on emotions/feelings and emotions – assisting the child in experiencing personal feelings (instead of avoiding);
- Setting boundaries in containing the child and their emotions through continuous grounding and affect modulation as necessary while facilitating the child's telling of the trauma story.

b) *Exploring sensations and emotions in memory work:*

- First just observe and allow the child to experience – do not interrupt or interpret too quickly, first allow the child and the brain to process the feeling/sensation/emotion and then explore;
  - What do you notice in your body /where in your body do you feel that ...?
  - What are you noticing about your (body part you notice is moving/or tense) ...?
  - Does this feeling/emotions/bodily sensation have a size/shape/colour ...?
  - When you feel .....what is happening in the rest of your body?
- Various medium can also be used to facilitate the exploration of sensations and emotions in memory work by asking the child to mold the emotions with clay – choosing specific clay colours and or mixing colours to indicate the various emotions experienced.
- Body diagram can be used to pin point body sensations using various colours and or shapes to indicate the sensation experience in different areas;
- Drawings can also be used to draw various emotions experienced through feeling faces and or symbolic drawing of the feelings experienced.



## Phase 2.2

- Reframing the abuse experience

### Reframing the abuse experience for the child involves the following:

- For the child to start shifting internalizations of being bad and or responsible and or any other negative internalizations resulting from the abuse they need to become aware of the role of others in the abuse (responsibility and blame);
- To correct these cognitive errors therapist may need to inform the child of others responsibilities / parents or offenders. The metaphor of a dustbin is used in explaining this to the child;
- Providing information (bodily responses and grooming) that is age and abuse appropriate to the child;
- Normalizing thoughts and feelings;
- Reality check (difference in size between offender and child /impact of threat and fear /child's lack of knowledge/ responsibility of adults and the offender)



## Phase 2.3

- Re-experience of trauma in power position

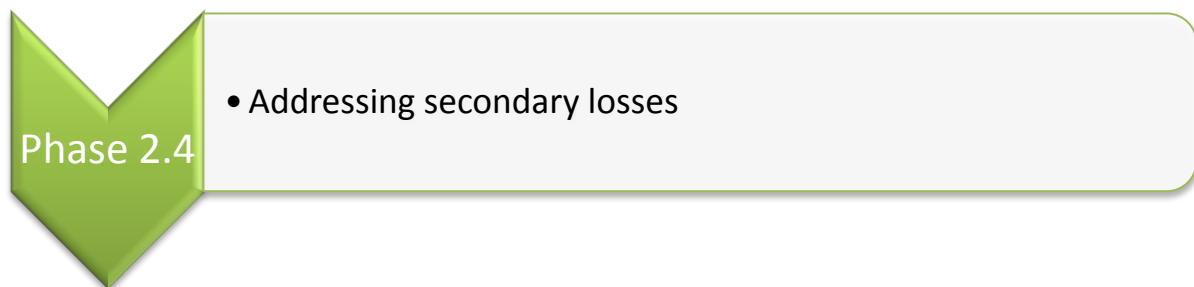
### Re-experience of the trauma in the power position involves the following:

- In order to recover from trauma the child needs to do what they could not do in the trauma situation – they need to discharge the energy that was mobilized in the trauma (failed attempt to defend themselves and which left them disempowered and thus on alert);
- Re-experience in the power position is about allowing the child to emerge as the victor or hero;

- In order to restore the child's sense of control – positive endings in traumatic play is important so that the child can feel that he has mastered the trauma;

*Suggestions for initiating / facilitating the power position:*

- If you could change what happened in any way, how would you like to change it?
- If you could do anything in this situation to the perpetrator, what would you like to do to him
- If you could have anyone with you to help you, who would you like to have with you and what must they do?
- What do you have or know now that you didn't know then, that you can bring into the situation?



Addressing secondary losses involves the following:

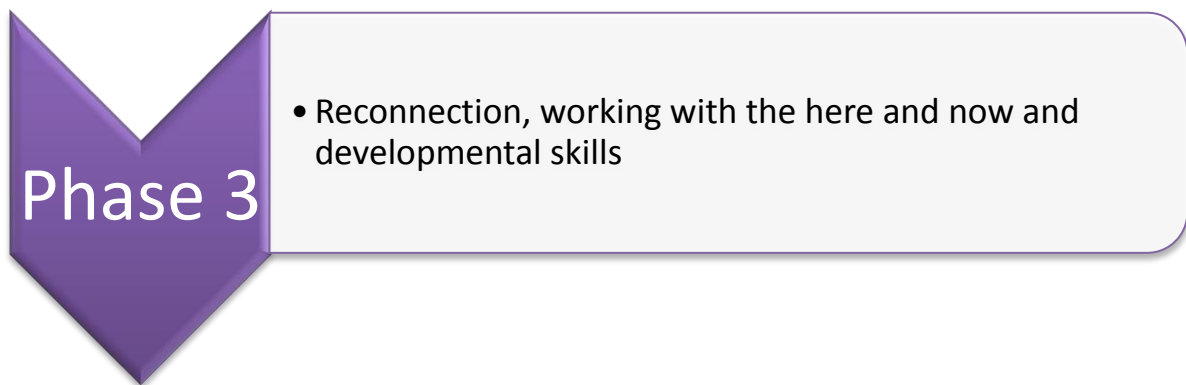
Often in the abuse experience and also after the abuse has been disclosed the child may experience various secondary losses that needs to be addressed as part of the therapeutic process. A wide variety of secondary losses can be experienced by the child which can include, amongst others: loss of relationships with significant others, loss of relationship with the alleged offender; changes in circumstances and way of life ect. In addressing secondary losses the child will be offered the opportunity to acknowledge and grieve these losses and an attempt will be made to provide the child with closure.

*To facilitate the grieving of secondary losses the following aspects can be looked at:*

- What has changed since the abuse and what has remained the same?
- What have they lost or what do they miss about their live (before or during the abuse)?
- People, they feel angry at ...
- People, places and activities that they miss ...

*This can be done through the use of various media such as:*

- Sand tray of then and now;
- To make a collage of one of these aspects;
- Writing letters to various significant others;
- Drawings; and
- Rituals of saying goodbye.



**PURPOSE OF THIS PHASE:**

To address any learned behavior patterns and to equip the child for the future and overall healthy socio-emotional functioning. In this phase healthy supportive relationships will again be reinforced. The third phase of therapy consists of the following:

## Phase 3

- Addressing learned behaviour patterns and / or behavior the child is struggling with
- Reinforcing supporting relationships and addressing future situations and follow-up therapy

## Phase 3.1

- Addressing any learned behavior patterns or behaviour that the child is struggling with

Addressing learned behaviour patterns and/or behaviour that the child is struggling with includes the following:

- Addressing sexualized or acting out behaviour the child may still struggle with;
- Working on restoring the child's self-image, body image and gender role identity;
- Restoring balance in ego-state functioning; and
- Reinforcing personal boundaries and safety.



## Phase 3.2

- Reinforcing supporting relationships, and addressing future situations and follow-up therapy

Reinforcing supporting relationships and addressing future situations includes the following:

- Equipping the child with skills in problem solving and communication to address future situations that might be difficult;
- Reinforcing techniques in grounding, affect modulation and constructive expression of emotions;
- Explaining in a child friendly manner the concept of forgiveness and forgiveness as an ongoing process;
- Discussing the possible need for follow-up therapy in future (different developmental phase, different or new questions regarding abuse experience and thus different needs in therapy); and
- Reinforcing supportive relationships as support for the child in future difficult situations and possible need for follow-up therapy

## **ADDENDUM 3**

### **SEMI-STRUCTURED QUESTION SCHEDULE**

## **FEEDBACK ON THE PROPOSED INTERVENTION MODEL**

### **Therapeutic goals of the model**

1. In your opinion to what extent do the therapeutic goals of this model address the therapeutic needs of the child who has been sexually abused?
2. Are there any therapeutic goals which you feel are not addressing the therapeutic needs of the child who has been sexually abused ?
3. Are there any therapeutic goals which in your opinion should be added to the goals of the intervention model ? If yes, please state what these therapeutic goal(s) should be and why.

### **First phase of therapy**

4. In your study of the proposed model, what is your opinion on the necessity of the introductory or first phase that focuses on stabilization, safety and preparation for therapy ?
5. In your opinion what is the importance, if any of creating a safe and predictable environment for the child as part as of the therapeutic process?
6. Should a child be motivated for therapy by explaining the necessity of therapy in a child friendly / developmentally sensitive manner?
7. In your opinion should the abuse be acknowledged by the therapist at the start of therapy ?
  - If yes please motivate your answer.
  - If no please motivate your answer.
8. Please give your opinion on teaching a child techniques and skills in grounding, affect modulation and constructive expression of emotions prior to exploring the child's sexual abuse trauma.
9. In your opinion what is the importance, if any of beginning to establish healthy supportive relationships in the child's life, prior to exploring the child's sexual abuse trauma ?
10. What are the short comings in the proposed first phase of therapy ?
11. What are the strengths in the proposed first phase of therapy ?

12. Anything else that you think should be added or changed in this phase ? If yes please discuss and motivate your answer.

### **Second phase of therapy**

13. Within a therapeutic model that attempts to mitigate the effect of childhood sexual abuse, is it important to help the child tell his trauma story ?
  - If yes, please motivate in your opinion why this is important.
  - If no, please motivate in your opinion why this is not important.
14. What is your opinion on the proposed role of the therapist in facilitating the child's "telling" of his or her trauma story?
15. Is there anything that in your opinion should be added to the therapist role in facilitating the child's "telling" of their trauma story. If yes please indicate what you think should be included.
16. What is your opinion on the reframing of the abuse experience for the child ?
17. What is your opinion on re-experiencing the abuse in the power position ?
18. What is your opinion on addressing secondary losses as part of the second phase of therapy ?
19. What are the short comings in the proposed second phase of therapy ?
20. What are the strengths in the proposed second phase of therapy ?
21. Anything else that you think should be added or changed in this phase ? If yes please discuss and motivate your answer.

### **Third phase of therapy**

22. In your study of the proposed model, what is your opinion on the necessity of the third phase of therapy that focuses on reconnection, working with the here and now and developmental skills ?
23. What are the short comings in the proposed third phase of therapy ?
24. What are the strengths in the proposed third phase of therapy ?
25. Anything else that you think should be added or changed in this phase ? If yes please discuss and motivate your answer.
26. Any other comments or suggestions pertaining to the proposed model of intervention?

**ADDENDUM 4**

**CONFIRMATION OF LANGUAGE EDITING**

**ADDENDUM 5**  
**PLEDGE OF HONOUR**

31 March 2015

**To whom it may concern,**

I hereby declare that I have read and understood the material explaining plagiarism as provided by the University of the North West and that I understand the procedures of accurate citation and bibliographical practise.

I confirm that this theses is the result of my own personal research and is solely my own work.

I affirm that any formulation, idea, reasoning, research or analysis borrowed from a third party is correctly and accurately indicated as such, clearly and transparently, and in such a way that the original source is recognisable, in respect of citation techniques and the authors rights.

I declare that I have not plagiarised nor committed any other kind of fraud.



Louise Petra Aucamp

Student number: 21000832

# **SECTION E:**

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