

GUIDELINES FOR SUPPORT TO MOTHERS OF SEXUALLY ABUSED CHILDREN IN NORTH-WEST PROVINCE

by

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October 2015

DECLARATION

I, **Gaboipolelwe Margaret Masilo**, declare that "**Guidelines for Support to Mothers of Sexually Abused Children in North-West Province**" is my original work and that all the sources I have used or cited have been indicated and acknowledged by means of complete references.

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: *15th October 2015*

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ABSTRACT

Introduction

Sexual abuse against children and infant is increasing at a shocking rate in South Africa. Report of South African Police Service for 2008/2009 indicates that South Africa has the highest baby and infant rape in the world, with more than 67,000 rape cases annually in the country. Children are the victims of 41% of all rape cases and attempted rape reported in the country. Often mothers are blamed for not taking care or supporting their sexually abused children (SAC) post disclosure and yet there is no documentation of their experiences or their support to these mothers within North West Province. The purpose of this study was to explore and described the experiences of mothers of SAC with the aim of developing guidelines for support to these mothers in North West Province.

Methods

Concurrent convergence triangulation mixed method design comprising of three phases was adopted for this study. Stage one comprised qualitative and stage two consisted of quantitative. Stage one explored and described the experiences of mothers of SAC while stage two determined the correlations between demographic data, coping strategies, levels of post-traumatic stress disorder (PTSD), depression and social support. Phase two comprised literature review and conceptual framework while phase three is guidelines development. The population consisted non abusive

mothers of SAC and participants aged 19 years to 70 years whose children aged 0 to 16 years were interviewed. A purposive sampling technique was used to select mothers of SAC. In depth unstructured interview was conducted on 17 participants until data saturation was reached in stage one TESCH's method was used to analyse data. The sample size for stage two was 180 participants determined through the use of Raosoft sample size calculator. Four instruments namely: Brief Cope Inventory, Post Traumatic Stress Disorder, Beck Depression Inventory and Social Support Grid were used to collect data regarding coping, PTSD, depression level and social support level respectively. Data was analysed using statistical package for social sciences (SPSS) version 21. Chi-Square and frequency distribution were employed to analyse the demographic characteristics, examine the association among depression, PTSD levels, coping strategies and social support received of participants'.

Results

The findings showed that mothers expressed various types of trauma. They also blamed themselves for not taking care of their children, and demonstrated a wide range of psychological difficulties and lack of support from stakeholders. The age of participants ranged between 19 to 70 years, with the majority of respondents in the 30-40 years bracket at 35%. The results also showed extreme PTSD 47.8%, little support 38.8%, not coping 76.1% and little depression 36.1%. The relationship between variables indicated the following: PTSD and social support P- value 0.363, depression and social support P- value 0.5410, coping skill and PTSD P-value 0.576, coping and depression P-value 0.648. There was no statistical significance among the variables because the P-values are more than the significance level of 0.05.

Conclusions

Guidelines for support to mothers of SAC are discussed based on the six systems of the ecological model of the impact of *Sexual Assault on Women's Mental Health* and in relation to the three themes that emerged during data analysis as well as the related statements. Recommendations are made for nursing education practice, research and for the policy makers.

Keywords: child sexual abuse, experience, disclosure, support, guidelines

TABLE OF CONTENTS

DECLARATION	ii
ACKNOWLEDGEMENTS.....	iii
ABSTRACT	v
TABLE OF CONTENTS.....	viii
LIST OF TABLES.....	xiv
LIST OF FIGURES.....	xv
LIST OF ACRONYMS.....	xvi
CHAPTER 1.....	1
<i>OVERVIEW OF THE STUDY</i>	<i>1</i>
1.1 Introduction.....	1
1.2 Background	1
1.3 Problem Statement	6
1.4 Purpose of the Study.....	8
1.5 Significance of the Study.....	9
1.6 Definitions of Key Concepts.....	9
1.6.1 Child	9
1.6.2 Child Sexual Abuse	9
1.6.3 Guidelines	10
1.6.4 Mother of a Sexually Abused Child	10
1.6.5 Rape	10
1.6.6 Secondary Victim.....	10
1.6.7 Secondary Victimization.....	11
1.6.8 Support.....	11
1.6.9 Experience	11
1.7 Research Strategy	12
1.8 Ethical Considerations.....	12
1.8.1 Principle of Beneficence	14
1.8.1.1 Right to Fair Selection and Treatment.....	14
1.8.1.2 Right to Privacy.....	15
1.8.2 Confidential Procedures	15

1.9 Thesis Structure	15
1.10 Summary	16
CHAPTER 2.....	17
<i>LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK.....</i>	<i>17</i>
2.2 Prevalence of Child Sexual Abuse	17
2.3 Factors Contributing to Child Sexual Abuse in South Africa	20
2.4 Experiences of Mothers of Sexually Abused Children	24
2.4.1 Mothers' Experiences About Self After CSA Disclosure	24
2.4.2 Mothers' Experiences of Seeking and Receiving Formal Support After Disclosure of CSA	25
2.4.3 Mothers' Experiences with the Perpetrator	28
2.5 Impact of Child Sexual Abuse on Mothers of SAC	28
2.5.1 Impact of Child Sexual Abuse Disclosure on the Emotional and Psychological Status of Mothers of SAC	29
2.5.2 Impact of Child Sexual Abuse Disclosure on the Financial Status of Mothers of SAC	30
2.5.3 Impact of Child Sexual Abuse on the Social Status of Mothers of SAC	30
2.6 Effect of Parental Response on the Coping Skills of Victims of CSA.....	30
2.7 Coping Mechanisms	34
2.9 The Researcher's View of the Literature	36
2.10 Recommendations for Parental Guidelines for Support in the South African Context	37
2.11 Theoretical Framework of the Study	37
2.11.1 Overview of the frame work.....	37
2.11.2.1 Individual System	38
2.11.2.2 Assault Related Factors.....	41
2.11.2.3 Microsystem Factors	41
2.11.2.4 Meso/Exosystem Factors.....	42
2.11.2.5 Macrosystem Factors.....	43
2.11.2.6 ChronosystemFactors	44
<i>2.12 Reasons for using ecological model of the impact of sexual assault on women's mental health. 44</i>	
2.13 Summary	45
CHAPTER 3.....	46
<i>RESEARCH DESIGN AND METHOD.....</i>	<i>46</i>
3.1 Introduction.....	46
3.2 Research Strategy	46
3.3 Research Design	47
3.3.1 Stage 1—Qualitative Research Design.....	48
3.3.2 Exploratory Research Design.....	49
3.3.3 Descriptive Research Design	50
3.3.4 Contextual Research Design	50

3.4 Research Method	51
3.4.1 Study Setting.....	51
3.4.2 Study Population	52
3.4.3 Sampling.....	52
3.4.3.1 Inclusion Criteria.....	53
3.4.3.1 Exclusion Criteria.....	54
3.4.4 Sample Size.....	54
3.4.5 Data Collection.....	54
3.4.5.1 In-Depth Interviews.....	54
3.4.5.2 Field Notes	57
3.4.6 Data Analysis	59
3.4.7 Literature Control and Conceptualization.....	60
3.4.8 Measures to Ensure Trustworthiness	61
3.4.8.1 Credibility	61
3.4.8.2 Dependability	64
3.4.8.3 Confirmability	64
3.4.8.4 Transferability	65
3.5 Stage 2—Quantitative Design	65
3.5.1 Study Setting.....	65
3.5.2 Target Population.....	65
3.5.3 Sampling Technique.....	65
3.5.4 Sample Size.....	66
3.6 Data Collection.....	67
3.7 Validity and Reliability.....	70
3.8 Data Analysis and Interpretation.....	71
3.9 Summary.....	73
CHAPTER 4.....	74
<i>FINDINGS OF THE QUALITATIVE STAGE.....</i>	<i>74</i>
4.1 Introduction.....	74
4.2 Discussion and Literature Control.....	74
4.2.1 Theme 1: Reaction of the Participants to Disclosure of Child Sexual Abuse.....	76
4.2.1.1 Category 1.1: Emotional and Psychological Reactions	76
4.2.1.1.1 Sub-Category 1.1.1: Guilt Feelings and Self-Blame After Discovering CSA.....	76
4.2.1.1.2 Sub-Category 1.1.2: Experience of Emotional and Psychological Pain Post-Disclosure	81
4.2.1.1.3 Sub-Category 1.1.3: Depression as a Result from Disclosure of CSA.....	82
4.2.1.1.4 Sub-Category 1.1.3: Suicidal Ideation.....	83
4.2.1.2 Category 1.2: Socio-Economic Reactions	85
4.2.1.2.1 Sub-Category 1.2.1: Social Reactions 1.2.1.1 Self-Isolation to Protect the Child	85

4.2.1.2.2 Sub-Category 1.2.2: Financial Constraints	86
4.2.1.3 Category 1.3: Spiritual Reactions.....	88
4.2.1.3.1 Sub-Category 1.3.1: Coping Through Religious Beliefs	88
4.2.1.3.2 Sub-Category 1.3.2: Coping Through Believing in Supernatural Powers	90
4.2.2 Theme 2: Effects of Sexual Abuse on a Child as Viewed by Mothers.....	92
4.2.2.1 Category 2.1: Physical and Psychological Trauma Observation.....	93
4.2.2.1.2 Sub-Category 2.1.2: Child Experiences of Psychological Trauma.....	94
4.2.2.2 Category 2.2: Need to Take Revenge on Perpetrator	96
4.2.2.2.1 Sub-Category 2.2.1: Revenge on Perpetrator.....	96
4.2.3 Theme 3: Experiences Regarding Support Participants Received, Both Formally and Informally.....	98
4.2.3.1 Category 3.1: Experiences Related to Medical Support.....	98
4.2.3.1.1 Sub-Category 3.1.1: Experiences Regarding Interaction with the Multidisciplinary Team that Attended to Their Children.....	98
4.2.3.2 Category 3.2: Experiences Related to Legal Support.....	101
4.2.3.2.1 Sub-Category 3.2.1: Views About Support Received from Police and the Judiciary.....	101
4.2.3.3 Category 3.3: Experiences Related to Societal Support.....	103
4.2.3.3.1 Sub-Category 3.3.1: Views About Support Received from the Family.....	103
4.2.3.3.2 Sub-Category 3.3.2: Neighbours' Willingness to Support	106
4.2.3.3.3 Sub-Category 3.3.3: Community Members' Willingness to Support.....	106
4.2.3.3.4 Sub-Category 3.3.4: The Need to Form Support Groups	107
4.3 Summary.....	109
CHAPTER 5.....	110
<i>FINDINGS OF THE QUANTITATIVE STAGE</i>	<i>110</i>
5.1 Introduction.....	110
5.2 Overview of the Demographic Factors.....	110
5.3 Prevalence of Depression and PTSD of Mothers of SAC.....	112
5.3.1 Level of Depression Among Mothers of SAC.....	112
5.3.2 Level of PTSD Among Mothers of SAC	113
5.3.3 The Level of Coping of Mothers of SAC	113
5.4 Relationship Between PTSD and Demographic Factors	114
5.5 Relationship Between Depressive Disorder and Demographic Factors.....	116
5.6 Correlation Between Social Support, Levels of PTSD and Depressive Disorder.....	118
5.7 Correlation Between Coping Skills, Levels of PTSD and Depressive Disorder	119
5.8 Summary.....	120
CHAPTER 6.....	122
<i>INTERPRETATION AND APPLICATION OF THE CONCEPTUAL FRAMEWORK TO THE FINDINGS</i>	<i>122</i>
6.1 Introduction.....	122
6.2 Interpretation and Discussion of the Findings of the Study.....	123

6.2.1 Level of Depression and PTSD, and Exploration and Description of the Experiences of Mothers of SAC	123
6.2.2 Correlation Analysis.....	124
6.2.2.1 Correlation among Coping Skills, Levels of PTSD and Depressive Disorder	124
6.2.2.2 Correlation Among Social Support, Levels of PTSD and Depressive Disorder	125
6.3 The Relationship Among Socio-Demographic Factors, Depression and PTSD	126
6.4 Application of the Conceptual Framework to the Results of this Study	127
6.4.1 Description of the Process of the Application of the Findings to the Conceptual Framework.....	127
6.4.1.1 Individual-Level Factor.....	128
6.4.1.1.1 Socio-Demographic Factors	129
6.4.1.1.2 Personality Characteristics.....	130
6.4.1.1.3 Pre-Existing Mental Health Conditions	130
6.4.1.1.4 Genetic and Biological Factors	130
6.4.1.1.5 Coping Responses	130
6.4.1.2 Assault Related Factors	131
6.4.1.3 Microsystem Factors.....	132
6.4.1.4 Meso/ExosystemFactors	134
6.4.1.5 Macrosystem Factors.....	135
6.4.1.6 Chronological Factors	136
6.5 Summary.....	136
CHAPTER 8.....	150
<i>LIMITATIONS, JUSTIFICATION, RECOMMENDATIONS AND CONCLUSION OF THE STUDY</i>	<i>150</i>
8.1Introduction	150
8.2 Summary of the Study	150
8.2.1 Purpose of the Study	151
8.2.2 Objectives of the Study.....	151
8.2.3 Research Design.....	152
8.2.4Summary of the Research Findings	153
8.3Justification of the Study.....	153
8.6Recommendations	156
8.6.1 Research	156
8.6.2 Clinical Practice.....	156
8.6.3 Education	158
8.6.4 Policy Makers	159
8.7Summary	159
ANNEXURE A.....	169
<i>Ethical Clearance</i>	<i>169</i>
ANNEXURE B.....	170

<i>Request for Permission to Conduct the Study</i>	170
ANNEXURE C	172
<i>Permission to Conduct Research</i>	172
ANNEXURE D	173
<i>Letter to the Manager of Mafikeng Provincial Hospital Thuthuzela Care Centre</i>	173
ANNEXURE E	175
<i>Informed Consent Form</i>	175
ANNEXURE F	178
<i>Screening Tool for Participant Recruitment</i>	178
ANNEXURE G	179
<i>Survey Questionnaire</i>	179
ANNEXURE H	187
<i>Interview Transcript</i>	187
ANNEXURE I	191
<i>Confirmation by Language Editor and Typesetter</i>	191

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LIST OF TABLES

Table 4.1: Profile of mothers of sexually abused children	75
Table 4.2: Themes, categories and sub-categories that emerged from the qualitative data analysis.....	77
Table 5.1: The demographic data of mothers of SAC	111
Table 5.2: Level of depression among mothers of SAC.....	112
Table 5.3: Level of PTSD among mothers of SAC.....	113
Table 5.4: The level of coping of mothers of SAC.....	114
Table 5.5: The mothers' age in relation to level of PTSD	114
Table 5.6: The mothers' marital status in relation to level of PTSD.....	115
Table 5.7: The mothers' employment status in relation to level of PTSD	116
Table 5.8: The mothers' age in relation to level of depression.....	116
Table 5.9: The mothers' marital status in relation to level of depression	117
Table 5.10: The mothers' employment status in relation to the depression level	118
Table 5.11: The mothers' social support in relation to PTSD	118
Table 5.12: The mothers' depression level in relation to social support level	119
Table 5.13: The mothers' coping skills in relation to PTSD	120
Table 5.14: The mothers' coping skills in relation to level of depression	120

LIST OF FIGURES

Figure 2.1: Ecological model of the impact of sexual assault on women's mental health	39
Figure 3.2: Stage one of the research process: flow diagram.....	48
Figure 3.3: North-West Province map (http://www.places.co.za/mapsnorth.west.map.html)	52
Figure 3.4: Stage two of the research process: flow diagram.....	66
Figure 6.1: Ecological model of sexual assault as applied to this study.....	133

LIST OF ACRONYMS

CA	Child Abuse
CSA	Child Sexual Abuse
CSAD	Child Sexual Abuse Disclosure
DENOSA	Democratic Nursing Organization of South Africa
DoH	Department of Health
EMV	Ecological Model Violence
KZN	KwaZulu-Natal
MPH	Mafikeng Provincial Hospital
NWP	North-West Province
PTSD	Post-Traumatic Distress Disorder
RAINN	Rape Abuse and Incest National Network
RSA	Republic of South Africa
SAC	Sexually Abused Child(ren)
SADC	South African Development Communities
SAPS	South African Police Service
TTCC	Thuthuzela Care Centre
USA	United States of America
WHO	World Health Organization

CHAPTER 1

OVERVIEW OF THE STUDY

1.1 Introduction

This study was aimed at developing guidelines for support to mothers of sexually abused children (SAC) by exploring and describing the experiences of these mothers. This chapter provides the background and rationale, problem statement, objectives, purpose of the study and research design and methods applied. Ethical considerations and measures of trustworthiness are also addressed in this chapter.

1.2 Background

Child Sexual Abuse (CSA) is a public health concern that affects children worldwide and places great pressure and demand on care givers of the SAC. According to Finkelhor (1997:409), child sexual abuse is a global health problem, and for years it has compounded in a number of countries. Myric and Green (2013:198) reported that mothers of SAC are faced with a challenge of supporting their children during their traumatic stage, while they themselves suffer a secondary trauma after disclosure about their children's sexual abuse. In a similar vein, Kelly (1990:25) and Pretorius, Chauke and Morgan(2011:1) acknowledged that mothers of SAC experience a significant high level of psychological distress and concluded that sexual abuse of a child is a major short and long-term stressor for the parents.

Lipton (1997:123), Hébert, Daigneault, Collin-Vézina and Cyr (2007:806) concurred with Kelly (1990:25) that CSA has serious long-term physical, psychological and emotional consequences on mothers of SAC, family and community as a whole. The same authors further underscored that the family experience violence and interrelation abuse. It is therefore imperative that this problem be addressed through research to explore and describe the experiences of mothers whose children are sexually abused in the North-West Province (NWP).

Hill (2001:386) supported Hébert et al. (2007:806) and Kelly (1990:25) that CSA is a crisis with disruptive long-term effects on the mother of the SAC's life and the mother may develop suicidal tendencies, self-blame, low self-esteem and even psychological distress. The mothers of SAC blame themselves for not playing a more protective role (Pretorius et al., 2011:14). This suggests that mothers of SAC need support post-CSA disclosure

The United States Department of Justice National Victimization Survey (2009:1) indicated that Rape Abuse and Incest National Network (RAINN) organization reported that in 2007 there were 248,300 survivors of rape and sexual assault in the United States of America (USA) and 15% of sexual abuse and rape cases are under the age of 12 years, and another 29% were aged 12. The same survey stipulated that in 1995 child protection services agencies identified 126,000 SAC - of these, 75% were girls and nearly 30% of these SAC were between the ages 4 and 7 years. Surprisingly, 93% of these children knew their perpetrators, for instance 34.2% of perpetrators were family members, 58.7% were acquaintances and only 7% were

strangers (The United States Department of Justice National Victimization Survey 2009:1).

A study conducted by Speizer, Goodwin, Whittle, Glyde and Rogers (2008:458) on the prevalence of CSA before 15 years in three South American countries, namely, El Salvador, Honduras and Guatemala, revealed the CSA prevalence to be 6.4% in El Salvador, 7.8% in Honduras and 4.7% in Guatemala. According to International Statistics, in the World Bank (2011:1), sexual assault data available internationally indicated that 14,000 of the 331,815 reported crimes committed against women in Russia, were of a sexual nature. The World Bank (2011:1) further stated that 23.3% of women in Canada were raped and 20% of girls in Europe revealed that they had experienced at least one incidence of sexual abuse in their lifetime. These sexual assault statistics reveal that women and child rape is a global health problem that brings about negative outcomes.

The World Bank (2011:16) reported that the incidence of rape in 12 African countries increased from 182 in 2001 to 270 in 2002. Breiding, Reza, Gulaid, Blanton, Mercy, Dahlberg and Bamrah (2011:203) found that approximately 5% of women in Swaziland have experienced coerced sex, sexual touching and incest before the age of 18 years, and they also mentioned that about 43% of girls had experienced multiple incidences of sexual abuse during childhood.

Child Network Gravity of Girl Child Sexual Abuse cited in the World Health Organization (WHO) (2005:63) conveyed that in Zimbabwe at least 6,270 girls younger than 18 years of age reported rape annually and that the age that is mostly

affected is between 6 to 10 years. According to the WHO (2011:50), the study conducted in Zimbabwe found that CSA is increasing and that one study established that CSA accounts for between 40% and 60% of all reported cases and that many are believed to go unreported. According to the WHO (2011:65), in 2009 the Family Support Trust, a Zimbabwean Non-Governmental Organization (NGO), reported having seen about 70,000 cases of rape during the last decade and of these rape cases 60% are children under the age of 18 years.

Sexual violence against children and infants is increasing at a shocking rate in South Africa (Meier, 2002:1). Likewise, the South African Police Service (SAPS) Report for (2008/2009) indicated that South Africa has the highest incidence of baby and child rape in the world, with more than 67,000 rape cases annually in the country. The report further signalled that over 15% of 41% reported sexual assault cases were of children under the age of 11years, another 26% were of children between 12-17years.

The World Bank (2005:16) pointed out that in South Africa, sex crime happens every twenty seconds. According to the Integrated Provincial Strategy to prevent and Combat Sexual Offences (2008), reports of sexual assault were high in the North-West Province (NWP) 137.5/100,000 in 2001/2002 and 130/100,000 in 2006/2007, and it further emphasized that the NWP reports an average of about 5,039 incidences of rape cases annually. These results indicate how serious the problem is throughout South Africa. The researcher is of the opinion that there is secondary trauma that is experienced by mothers of SAC after disclosure. According to the SAPS Crime Offences Report (2011:25), South Africa is hard hit by sexual offences. The report

further indicated that the highest incidence (1780) of all sexual offences was recorded in the Western Cape, followed by the Free State and the Northern Cape - while Limpopo Province is ranked at the bottom. The report highlighted that the NWP is amongst the provinces that experienced an increase of sexual offences as it increases by 6.6% (SAPS 2011:28).

Sexual offences of women of under 18years and older between 2006/2007 and 2010/2011 increased from 34,816 to 36,093, while that of children younger than 18years increased from 25,428 to 28,128 which is an increase of 2.6%(SAPS 2011:12).These figures underscore the seriousness of the child sexual offences in the country. The report further indicated that according to SAPS Annual Report 2008/2009(2009:13), 39.5% of sexual offences were committed against children in the age group of 15years to 17years and that 60.5% sexual offences were common against children below 15years of age in 2008/2009.The report also drew attention to the fact that 29.4% of these sexual assault offences involved children aged 0-10years (SAPS, 2011:11).

The records at Mafikeng Thuthuzela Care Centre (TTCC) in the NWP indicated that 138, 155 and 207 children were examined for sexual assault in 2009, 2010 and 2011, respectively. These sexual assaulted children were referred from different institutions in the province. The numbers demonstrate escalation of sexual assaults on children in the NWP. The researcher is of the view that for every CSA there is a mother who is negatively affected, emotionally and psychologically, by her child's sexual abuse disclosure and, as such, may benefit from the development of guidelines for support

that would be preceded by exploring and describing the experiences of mothers to SAC. This issue necessitated research on the experiences of mothers of SAC so that effective guidelines for support can be developed based on the findings.

The TTCC is located at a Hospital in NWP where this study was conducted and has been launched five years ago (November 2006) and yet it is admitting many child sexual abuse cases monthly and even annually. This state of affairs has necessitated the researcher to develop interest in conducting a study on the experiences of mothers of SAC so that guidelines for support to these mothers could be developed to improve their care at health services centres.

1.3 Problem Statement

The literature confirms that attention is often given only to the SAC and yet for every sexually traumatized child there is a mother that is negatively affected or traumatized by child sexual abuse disclosure (Elliot & Carnes, 2001: 320). The effects of children's sexual abuse disclosure make the mothers to present with psychological, emotional, spiritual and socio-economic problems as well as poor coping skills (Plummer, 2006:105). According to Tshabalala-Msimang (Department of Health, 2003:11), the national management guidelines for sexual assault pronounced that in cases of CSA, patients' provision of care should be extended to the caretaker/parent, but apparently this is not happening. Hill (2001:386) highlighted that services to support the mothers of SAC are not integrated in the Primary Health Care (PHC) package. This suggests that professionals need guidelines to support mothers of SAC during the time when they take their children for treatment. Mothers of SAC are often in a state

of shock after becoming aware that their children were sexually abused, and they go through the stages of grief and pain (Smith ^(b), Bryant-Davis, Tillman & Marks, 2010:264).

The researcher observed that it is never acknowledged that these mothers need a support from the family, community and even health professionals - instead they are being blamed for not playing a parental role. After the child is sexually abused the mother is confronted by accountabilities such as having to travel to various health facilities on several occasions accompanying her child, family disorganization - especially if the child was sexually abused by a family member, being blamed for not taking care of her child. Some mothers may be unemployed and yet they are expected to take the child to locations where they can obtain legal and social support. Despite the challenges these mothers are going through and the support they give to their children in the process of CSA, nobody acknowledges the pain and secondary trauma they experience. The researcher also observed that mothers wait long queues before they could get assistance in health facilities. These experiences exacerbate the burden of an already traumatized unsupported mother of SAC post-CSA disclosure

In these multiple stress situations that they experience with trauma they hardly receive any support from both formal and informal systems. This clinical and observational experience provided the impetus for the proposed research on the experiences of mothers whose children were sexually abused in the NWP. To date, in South Africa there is negligible established research that has explored and described

the experiences of mothers whose children were sexually abuse with the aim of developing guidelines to support them. Thus, this study was aimed at answering the following questions:

- ✿ What are your experiences following your child's sexual abuse disclosure?
- ✿ What is the relationship between levels of depression, PTSD, coping strategies and social support among mothers of SAC?
- ✿ What kind of support do you expect to receive?

1.4 Purpose of the Study

The primary purpose of this study was to develop guidelines for support to mothers of sexually abused children in northwest province.

In order to achieve this purpose, the objectives of the study were to:

- ✿ Explore and describe the experiences of mothers of SAC in NWP.
- ✿ Examine the relationship among socio-demographic factors, depression, social support, coping skills and PTSD.
- ✿ Explore the correlation between:
 - ◆ Levels of PTSD and social support;
 - ◆ Levels of PTSD and coping skills; and
 - ◆ Levels of depression and coping skills.

- ✿ Describe the theoretical framework within which the guidelines for support are to be developed.
- ✿ Develop guidelines for support to mothers of SAC in NWP

1.5 Significance of the Study

The research findings of this study would assist policy developers to ensure implementation of guidelines for mothers of SAC following CSA disclosure. The research findings for this study could also assist health care providers to inform curriculum developers on health care training for professionals and policy makers to create a climate that would support mothers of SAC.

1.6 Definitions of Key Concepts

1.6.1 Child

According to the Children's Act No. 38 of 2005, a child means any person under the age of 18 years. In this study, a child is a person, either a male or female of any race under the age of 0 to 16 years, who was sexually abused within a 12 months prior the commencement of data collection.

1.6.2 Child Sexual Abuse

According to the Republic of South Africa (RSA, 2007:7), child sexual abuse is an unlawful and intentional act of sexual penetration without consent of the complainant. Sexual abuse is an activity with a child before the age of legal consent that is for gratification of an adult. In this study, it is a forced sexual intercourse with a child who is 16 years old and below without the consent of one of the parties.

1.6.3 Guidelines

Guidelines are general rules, principles, or piece of advice (Concise oxford English 1986; 632). In this study, guidelines are principles or standards that are used to support mothers of SAC in the NWP.

1.6.4 Mother of a Sexually Abused Child

A mother is a woman in relation to the child or children whom she has given birth. (Concise Oxford English Dictionary (1998:928). In this study, it means any non-offending woman, stepmother, caregiver, foster parent, adoptive parent, grandparent and biological mother who is taking care of the SAC 0 to 16 years.

1.6.5 Rape



In criminal law (sexual offences and related matters), rape is when any person who unlawfully and intentionally commits an act of sexual penetration with a complainant without the consent of the complainant (RSA, 2007:6). In this study, rape is the forceful sexual penetration committed by a man with intention of having sexual act for gratification with a child of 0 to 16 years.

1.6.6 Secondary Victim

This refers to a friend or a family member of a survivor who has been sexually assaulted or a person who receives a compensable injury as a direct result of witnessing the act of violence that resulted in the compensable injury or harm to the primary victim of that act (Campbell & Raja, 1999:265). In this study, a secondary victim is the non-offending mother, caregiver or foster parent of a SAC who is the

primary victim of sexual abuse.

1.6.7 Secondary Victimization

According to Campbell and Raja (1999:265), secondary victimization refers to behaviours and attitudes of social service providers that are “victim blaming” and insensitive, and which traumatize victims of violence who are being served by those agencies. In this study, it is the professionals blaming or being insensitive to mothers of SAC when they bring their children for examination after abuse.

1.6.8 Support

It is an activity of providing for or maintaining by supplying with money or necessities, emotional support. It is the act of sustaining life by food or providing a means of subsistence or the activity of contributing to the fulfilment of a need or furtherance of an effort or purpose (Concise Oxford English Dictionary 1998:1440). In this study, support means giving emotional, psychological, spiritual, financial and physical care to mothers of SAC following sexual abuse disclosure by family members, clinicians and the legal system.

1.6.9 Experience

A practical contact with and observation of facts or events.(Concise Oxford English Dictionary (1998:501) In this study, experience refers to what is happening in the lives of non-offending mothers of SAC, after the disclosure of sexual abuse of the child, that is happening in her, and the changes within her that is psychologically, physically and socially.

1.7 Research Strategy

The study is divided into three phases, phase one consists of two stages, namely, qualitative and quantitative approaches. In stage one the experiences of non-offending mothers of SAC are explored and described and the conceptual framework within which the guidelines are described is developed. In stage two, the relationship between coping skills, depression, social support and PTSD are examined in mothers of SAC following disclosure. The stress responses of mothers of SAC are measured using four different instruments, namely; Beck Depression Inventory (BDI), PTSD Checklist (PCL), Social Support Grid and Brief COPE Scale. Phase two is a literature control or conceptualization of the findings. A literature review is used to control the empirical findings from which concluding statements and inferences were made. Phase three focuses on the conceptual framework description and guidelines development. The guidelines were developed from the literature review and the findings of the analysis of the experiences of mothers of SAC following disclosure and the findings of the conceptual framework.

1.8 Ethical Considerations

Due to the sensitivity of the research all ethical measures were adhered to. Ethical clearance was obtained from North-West University (NWU, Annexure A). A permission to conduct the study was requested and obtained from the NWP Department of Health (DoH), hereinafter abbreviated as NWP DoH, to access the participants (Annexures B and C) as well as the Mafikeng Hospital Chief Executive Officer and the Chief Nursing Service Manager in which the TTCC is situated (Annexure D). Informed consent was obtained from participants (Annexure E).

The written consent was issued in English, but the researcher translated it to Setswana as it is the language used mostly in the province. A screening tool for participants' recruitment (Annexure F) and a survey questionnaire (Annexure G) was administered. The participants were informed that they were free to withdraw or decline from the participation any time (Polit & Beck, 2010:127). The participants were made aware that their withdrawal from participation would not prevent them from receiving any service. The names of the participants were protected, and confidentiality and privacy were maintained (Burns & Grove, 2009:202; Polit & Beck, 2010:127). The names of participants were not recorded during the interviews. Each participant who agreed to participate was informed about the objectives, purpose and the significance of the study (DENOSA Position Standard, 1998:323) as stated in Brink et al. (2012:48).

The participants were informed that the information for the study was only for research purposes and that it shall not be used against them in any way. The interview questionnaire was shown to them and the qualitative broad questions were mentioned to them to check if they have interest in becoming participants (Polit & Beck, 2010:127). Participants were informed about the field notes that were jotted down during the interviews and they were also asked permission to use a voice recorder to record the interview proceedings. Participants were allocated alphabet codes to avoid using their names and to ensure anonymity and confidentiality (Polit & Beck, 2010:547).

1.8.1 Principle of Beneficence

In this study, the researcher protected the participants from emotional harm by not coercing them to participate in the study or asking questions that had no objective focus. The researcher ensured that she was sensitive to the participants' needs by not harming the participants, such as, by not exposing participants to any deep-seated fears and anxieties (Polit & Beck, 2010:122). During recruitment of the participants the researcher ensured that participants were not coerced by explaining that they were not obliged to participate and that their participation was completely voluntarily. The principle of beneficence was also met by explaining to the participants that the information will not be disclosed in public against them. To avoid emotional harm, the questions were asked in such a way that they did not create insecurity to the participants.

To prevent harm to the participants were informed that they were free to withdraw from the study at any stage when they experience any emotional discomfort. During the interviews the participants were closely observed for repeated, emotional, non-verbal cues and whether the conversation should continue or not. This principle was observed by adhering to the following rules: right to fair selection and treatment and right to privacy:

1.8.1.1 Right to Fair Selection and Treatment

This principle includes the participants' right to fair selection and treatment. The selection of the population understudy was fair because they were selected for reasons directly related to the problem being studied. The researcher respected any

agreement made with the participants (Brink, et al., 2006:40).

1.8.1.2 Right to Privacy

The researcher respected the right to privacy of individuals by interviewing them in a private room and by not divulging any information concerning the interview, except to the supervisor as agreed (Brink et al., 2006:40).

1.8.2 Confidential Procedures

The researcher made the participants aware that although their names were recorded in writing when obtaining the consent form and those alphabetical codes would be used during interviews and their names would not appear on the interview schedule and that raw information would remain nameless. In this study, the researcher ensured confidentiality and anonymity by keeping all the interview materials, such as voice recorders and transcripts under lock and key.

1.9 Thesis Structure

Chapter 1:	Overview of the Study
Chapter 2:	Literature Review and Conceptual Framework
Chapter 3:	Research Design and Method
Chapter 4:	Findings of the Qualitative Stage
Chapter 5:	Findings of the Quantitative Stage
Chapter 6:	Interpretation and Application of the Conceptual Framework to the Findings
Chapter 7:	Guidelines for Support to Mothers of Sexually Abused Children
Chapter 8:	Limitations, Justification, Recommendations and Conclusion of the Study

1.10 Summary

This chapter outlined the overview of this study which encompasses the introduction, background, problem statement, questions, purpose, objectives and significance of the study, definitions of operational concepts research design, literature control ethical considerations and thesis structure.

CHAPTER 2

LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

2.1 Introduction

This chapter discusses the literature review undertaken on guidelines to support to mothers of SAC in the NWP. According to Benton and Cormack (2000:87), a literature review provides the researcher with knowledge of the field being researched and contextualizes the research problem being considered. Reasons for a literature review are to ensure that the researcher does not merely duplicate previous studies and what the most widely accepted empirical findings are in the field of study. The following issues, namely, the prevalence of CSA, factors contributing to CSA, impact of sexual abuse on mothers of SAC, experiences of mothers of SAC, effects of parental responses on the coping skills of victims of CSA, coping mechanisms and support programmes for mothers are discussed in this chapter. Finally, the identified research gaps are discussed in terms of an outlook for parental support guidelines in the South African context.

2.2 Prevalence of Child Sexual Abuse

Child sexual abuse is worldwide and is associated with variety of short and long term problems in both females and males. According to Stolenborgh, van Ijzendoorn, Euser and Bakermans- Kranenburg (2011:79) the prevalence of CSA rates varies from 0.1% to 71% world-wide. This demonstrates the seriousness and prevalence of CSA

and the necessity of support the mothers need while their children are being taken care of post disclosure. In the same vein Pereda, Guilera, Forns, and Gomez-Benito (2009:328) stated that CSA has been considered one of the most serious public health problems facing the society, especially children. They reported that data from published research asserted that CSA is a historical problem that occurs in all levels of cultures and societies.

Pereda et al. (2009:328) mentioned that CSA is a complex universal problem that results from interaction of individuals, family, community social, cultural factors and is not an isolated sporadic reality. Lalor and McElvaney (2010:93) reported that in the USA, 32.3% of females and 14.2% of males experienced at least one episode of childhood sexual abuse such as kissing or touching in a sexual ways. They further reported that about 20.4% females experience contact sexual abuse before the age of 17 years while 5.6% experienced penetrative abuse before the same age. Frederick (2010:1) reported that in Asia CSA is experienced by children of all age groups, of both sexes, children in conflict with law, those on the street and separated from families as well as those with mental and physical problems and poverty stricken children.



In Swaziland, about 33.3% children experienced some form of sexual violence as well as coerced sex before the age of 18 years (Lalor & McElvaney, 2010:93; 2004:441). In Tanzania, about 27.9% experienced unwanted fondling, 11.2% coerced sexual intercourse and 5.6% oral sex. Jewkes and Abrahams (2002:1238), cited in Lalor and McElvaney (2010:94), highlighted that about 1.6% of children are persuaded to have

sex before the age of 15 years. The statistics above indicates that Africa is also experiencing a serious problem of CSA.

According to a study conducted by the SAPS, the *International Police Agency* (Interpol, 2006:11) indicated that South Africa leads the world in rape cases. It further reported that in 2006 there were 55,000 rape cases reported in South Africa and out of these rape cases about 1,300 were women and children. The same report stated that more than 67,000 cases of child and baby rape occur annually in South Africa. It further states that some cases of rape are unreported. According to a follow-up report, in 2007 there was an increase of 36.1% in sexual offences against children, which represented 7,276 cases committed against children. Those mostly affected (39.5%) are 15-17 year olds (South African Police Service Report 2008/2009: 13-14). The same report further indicated that 27,417 (60%) of the sexual cases involved children of age 15 years, 29.4% of these sexual offences involved children aged 0-10 years. According to the WHO (2004:28), child sexual abuse is increasingly recognized as a global public health problem, and South Africa is one of the countries where the highest rate of child sexual abuse cases is reported by police officers yearly. The child sexual abuse cases reported to police services in the year 2000 in South Africa were 21,427, affecting children in the ages range 0-17 years.

Out of these sexual abuse cases, 4,797 were reported in KwaZulu-Natal (KZN) Province while 4,316 were reported in Gauteng Province. The escalation of 10,242 child sexual abuse cases in KZN was further reported in the following year (LoBaido, 2001:3). These child sexual abuse statistics are a serious concern and the researcher

associates it to the trauma the children and mothers are experiencing. Despite these statistics, there is little support for mothers after they become aware that their children were sexually abused. The records at TTCC in the NWP indicate that 138, 155 and, 207 children were examined for sexual assault in 2009, 2010 and 2011, respectively. These SAC were referred from different institutions in the province. The numbers demonstrate escalation of sexual assaults on children in the NWP. The above literature review results indicate that CSA is a global health problem and this can be attributed to the fact that, among others, children cannot fully comprehend and they also do not all have a verbal capacity.

2.3 Factors Contributing to Child Sexual Abuse in South Africa

A large body of evidence suggests that influences of child rape include key aspects of the social context in which it occurs, e.g., cultural norms around gender roles, parent-child relationships, nature of the welfare system, and the nature and extent of social protection and responsiveness of the criminal justice system (Jewkes, Penn-Kekana & Rose-Junius, 2005:1810). Risk factors for CSA include high levels of poverty, power inequality between men and women, generally negative attitudes towards women, and lack of sufficient policies and programmes to prevent and/or manage child maltreatment (WHO, 2002). Smith (b) et al. (2010:260) reported that many factors contribute to the high rates of sexual assault in South Africa, including hostile attitudes toward females in society, the expectation that girls will perform traditional roles, and the two cultural values that (a) girls do not own their bodies and (b) children should not question adults. The role of social orientation and cultural norms around gender roles are seen as some of the contributory factors of CSA in South

Africa.

Alcohol and substance abuse are also recognized as factors for CSA. Richter and Dawes (2008:86) and Jewkes et al. (2005:1815) also supported that alcohol abuse often plays a role in the rape of women of all ages, since alcohol removes layers of inhibition, making it more likely for an act of rape to occur. Mathoma, Maripe-Perera, Khumalo, Mbayi and Seloilwe, (2006:68) argue that although alcohol can contribute to CSA, mental health problem in Southern Africa is another factor contributing to CSA and is exacerbated by growing poverty coupled with inadequate legislation that protects children against sexual abuse.

Richter and Dawes (2008:86) reported that poor socio-economic conditions also contribute to CSA. The high levels of unemployment in South Africa result in family stresses which can lead to punitive behaviour towards children (Richter & Dawes, 2008:86). In addition, due to the lack of job opportunities in their vicinity, many parents leave their children alone or with relatives to find work, thereby rendering their children vulnerable to all sorts of abuse, including sexual abuse (Madu & Peltzer, 2000:264). Smith ^(b) et al. (2010:258) agreed with Madu and Peltzer (2000:264) in that orphaned or neglected children whose parents leave them at home to travel long distances to work are also at an increased risk of CSA. A woman may also be hesitant to report that her husband is raping children in the home, due to the fact that the husband is the only source of income in the family (Meier, 2002:533). So the mother would risk the life of her child, for the source of income. Overcrowding in poor families is also a risk factor for CSA because it precludes separation of sexually active

adults and children, which may give rise to circumstances where sexual abuse can occur (Townsend & Dawes, 2004:71).

The issue of gender imbalance is particularly true for South Africa which is traditionally a male dominated and patriarchal society where women hold limited power and authority (Robertson, 1998:139). Research in South Africa indicates that gender power inequalities and the norm of male sexual entitlement contribute to the high rate of rape (Lewis, 1997:40). Rape is used to express male control over women and is important in the social construct of South African male dominance over females, which is viewed as a way to gain status and respect in male peer groups (Jewkes & Abrahams, 2002:1238). It is evident that the limited power and authority of South African women put them at a disadvantage of being forced into sex. Based on this, this patriarchal society needs to be educated about the trauma and the negative impact on children and that it is against the law.

According to Meier (2002:533), many girls and women believe that knowing the boy or having a boyfriend does not allow them to refuse sex, even if it is forceful and approximately 50% of young males believe that a female's refusal of sex meant that she was consenting. Furthermore, almost one third of them did not believe that sexual violence applies if they were forcing someone they knew to have sex with. Lalor (2008:95) reported that in South Africa there is a myth that a man with HIV can be cured by having sex with a virgin - this is considered a risk factor for rape, however, the degree to which a male's rape is based on the myth is unknown and there is speculation that the increase in CSA is linked to the spread of HIV where

younger children are targeted by sexual perpetrators since they are thought to be less likely to have HIV. The fear of HIV seems to be increasing the rape of the virgins based on the belief that they do not have HIV (Jewkes & Abrahams, 2002:1240). SAC may, therefore, be at an increased risk of HIV infection due to the relationship between CSA and other high-risk behaviours (Lalor, 2008:95). In South Africa the myth that an HIV/AIDS positive man can be cured by having sex with a virgin leads men to rape children with the hope of being cleansed.

Rape as a demonstration of a culture of violence from apartheid, alcohol, drug use, and societal tolerance for rape are also contributing factors (Jewkes & Abrahams, 2002:1238). The apartheid system and its demise have also had an effect on the high number of rapes in schools, where political unrest and violence occurred during apartheid, which has contributed to an increase to gang rape activity in South Africa over the years (Meier, 2002:532). The author further stated that gangs have been reported to disrupt school lessons, bully teachers and rape students. Additionally, some schools lack sanitation facilities and many lack electricity - classmates and teachers have been reported to rape many girls in school bathrooms (Meier, 2002:532). The literature show that the unrests that occurred in South African schools as a result of the apartheid system led to a culture leading to CSA.

In addition to the above factors, the Centre for the Study of Violence and Reconciliation (CSVR) reported that other factors leading to rape are the perpetrator's sense of entitlement to instant gratification and inability to delay gratification in releasing sexual energies (Hamber & Lewis, 1997:40). Therapists at CSVR indicated

that young perpetrators cite boredom or the yearning to have sex as their reasons for rape and it has been suggested that some adult perpetrators use rape as a means to escape the tedium of unemployment and poverty (Hamber & Lewis, 1997:40). The social factors, myths and stereotypes that are viewed as contributory factors to CSA need to receive serious attention.

2.4 Experiences of Mothers of Sexually Abused Children

2.4.1 Mothers' Experiences About Self After CSA Disclosure

Mothers of SAC experience shock, trauma and emotional pain when trying to care for and support a child who has been deliberately hurt by a perpetrator (Herman, 1997:33). In line Fong and Walsh-Bowers (1998:32) supported Herman, (1997:33) who also reported that mothers of SAC experience trauma, shock, denial and they do not think straight or have the ability to determine right from wrong. The authors added that mothers who participated in their study believed their daughters though they felt guilty, helpless, and experienced depression, nightmares and insomnia. The mothers of SAC blamed themselves for sexual abuse that was committed by perpetrators.

Fong and Walsh-Bowers, (1998:34): Hébert, Lavoie, and Parent (2002:360), reported that if the CSA was from incest, the mother may experience a feeling of helplessness, betrayal and depression. Financial dependence on the perpetrator may also be a source of severe anguish. They further indicated that mothers experience high rates of psychological distress after the CSA has been disclosed, and stated that mothers played a central role in facilitating recovery of their children, however, there has been

little focus on the mothers' needs and profiles. Parents and family members of SAC may experience feelings of guilt, sadness, and worthlessness (Smith ^(b) et al., 2010: 264). This notion is in line with Plummer's (2006:105) study which reported that emotional and behavioural responses of mothers after CSA disclosure included confusion, anger, depression, self-blame, disbelief, denial and rumination. Mothers reported feelings of helplessness, vulnerability, betrayal, outrage, shock, disbelief, depression, fear, lethargy, anxiety and uncertainty about how to channel their anger (Hamber & Lewis, 1997:20). Distress experienced by mothers following disclosure of CSA is related to their personal histories of CSA, social support they receive and coping strategies they employ with their children's disclosures (Hiebert-Murphy, 1998:423). Studies conducted by Hiebert-Murphy (1998:423) and Plummer (2006:113) concluded that non-offending mothers with a history of CSA experienced significantly more general psychological distress. The mothers of SAC experienced unexplainable distress, anxiety and PTSD symptoms post disclosure and this was made worse by lack of support from professionals and family members.

2.4.2 Mothers' Experiences of Seeking and Receiving Formal Support After Disclosure of CSA

According to Elliot and Carnes (2001:327), studies on non-offending caregivers showed that the experiences and responses of mothers of SAC vary with regard to discovering and dealing with their children's victimization. Furthermore, non-offending caregivers' reactions to their children's disclosure of CSA and subsequent emotional and protective responses were significant factors in CSA recovery (Elliot & Carnes, 2001:327). The mother's experiences of the negative responses received when

disclosing sexual abuse, caused distress blaming both mothers and victims for the assault.

Hébert et al. (2002:360) indicated that mothers of SAC experienced frustration when dealing with professionals such as social workers, members of the legal system, police officers and nurses who blame them for their children's sexual abuse. It is frustrating for non-offending mothers to deal with unfamiliar medical, legal, and social services procedures and it becomes worse if the professionals have little regard and marginalize the mothers (Hébert et al., 2007:809). Mothers feel unsupported, hopeless and have lost faith because of the ineffectiveness of criminal justice system (Hamber & Lewis 1997:27). They further indicate that the feeling of being unsupported intensifies if they receive no psychological and social support and it is made worse if their first interface with the police is contentious and fails to meet their needs (Hamber & Lewis 1997:27). It is evident that mothers were frustrated by being assisted by unsupportive and professionals of different faces.

Mothers have experienced dissatisfaction with the interventions they have received from agencies after the disclosure of their children's sexual abuse (Elliot & Carnes, 2001:327). They added that some received negative treatment from professionals in the form of name calling, dismissal of concerns, and retaliatory actions toward them (Joyce 2007:1). Mothers of SAC have reported the following: unfair treatment; feeling judged and blamed; receiving unsolicited instructions on mothering; emotional and financial burdens; struggling to cope with uncertainty; accusations that they promote false allegations of CSA; and difficulty seeing the "system" as a positive resource for

the future. Some mothers reported that they regretted contacting professionals for assistance. Such unfair treatment by professional has made some parents to prefer to cope with the situation without professional assistance (Plummer & Eastin, 2007:778-785). The above discussion indicates that the professionals judged and treated mothers as outcasts instead of providing much needed emotional support. It is evident that strategies to empower professionals with skills to enhance mental health of mothers of SAC are needed.

In South Africa, poor services by police and other professionals seemed to intensify the mothers' emotions, particularly outrage, isolation, vulnerability and helplessness (Hamber & Lewis, 1997:20, 21). The government and legal systems often fail to respond to sexual assault and only a small amount of rape cases are tried in court (Jewkes & Abrahams, 2002:1240).

Judges and magistrates tend to offer light sentences to perpetrators (Jewkes & Abrahams, 2002:1240). These notions are supported by Hamber and Lewis (1997:26) that the police members dealing with CSA do not regard it as crime and, as a result, they use inappropriate intervention techniques that seek to reconcile the perpetrators with the mothers of SAC. Jewkes and Abrahams (2002:1240) further stated that whether or not the courts and police decide to respond it is generally ineffective due inconsistent policies. It is apparent that the legal system fails to regard CSA as a serious crime and it also attempts to reconcile the mothers of SAC with perpetrators. The response displayed by the legal system to CSA cases makes mothers to suffer more depression, deviant behaviour and PTSD. This kind of behaviour needs

immediate attention.

Due to negative and accusatory characterizations of non-offending parents post-CSA disclosure, their therapeutic needs have largely been ignored (Stauffer & Deblinger, 1996:66). Hébert et al. (2007:805) recommended that mothers need financial, physical, social and spiritual support and that few studies have explored potential factors related to psychological distress in mothers. Therefore, these mothers need a full support by all systems.

2.4.3 Mothers' Experiences with the Perpetrator

Cyr, Wright, Toupin, Oxman-Martinez, McDuff, and Thériault (2007:47) noted that a perpetrator's identity is an abuse-related variable that independently correlates with the mother's distress score reaching a clinical level. The disclosure of an intra-familial perpetrator increases the likelihood for the mother to experience a high clinical-level of psychological distress (Hébert et al., 2007:807). Some mothers believed that their child's sexual abuse would taint, damage, or stigmatize the child and also had anxiety and fear that their child may not be able to establish future relationships, marry, or bear children (Hamber & Lewis, 1997: 33). Mothers experience variety of psychological distress following CSA disclosure.

2.5 Impact of Child Sexual Abuse on Mothers of SAC

Child sexual abuse modifies the non-offending parents' life, including losses or changes in income and relationships with family and friends, dependence on government programmes, employment disruption and changes of residence (Massa & Lundy, 1998:385). Kouyoumdjian, Perry and Hansen (2009:41) indicated that CSA

impacts negatively on mothers of SAC and results in a myriad of adverse short- and long-term consequences such as difficulties in mental health, behavioural functioning and interpersonal relationships. Lewin and Bergin (2001:364) acknowledged that parents frequently experience significant distress following CSA disclosure, with many experiencing a variety of psychological symptoms.



2.5.1 Impact of Child Sexual Abuse Disclosure on the Emotional and Psychological Status of Mothers of SAC

Newberger, Waternaux and Newberger (1993:98) emphasized that mothers suffer severe and intensive emotional distress following disclosure of their CSA. Elliot and Carnes (2001:320) supported Newberger et al. (1993:98) that families experience numerous stress-inducing changes following a child's disclosure of sexual abuse. Equally, Newberger et al. (1993:92) reported that mothers of SAC suffer significantly from their children's disclosure and therefore they should be acknowledged as secondary victims and given appropriate psychiatric care. Lewin and Bergin (2001:372) concurs with Newberger et al., (1993:92) that parents frequently experience significant distress following CSA disclosure, with many showing a variety of psychological symptoms, the most commonly observed in non-offending parents of SAC being PTSD (Lipton, 1997:123). Empirical studies have confirmed the relationship between CSA and parental depression; fathers experience significantly higher levels of depression than mothers (Elliot & Carnes, 2001:320). Mothers of SAC are to receive appropriate psychological support to prevent psychological disorders such as: depression, maladaptive behaviour and PTSD.

2.5.2 Impact of Child Sexual Abuse Disclosure on the Financial Status of Mothers of SAC

Parents without family support and/or economic stability experience higher levels of stress (Massat & Lundy 1998:379). Other studies reported that parents might lose their jobs as some may be unable to deal with their daily job activities (Plummer & Eastin, 2007:781). In cases whereby the perpetrator is the source of income and is sent to jail, the mother will lose the financial dependence to manage the household.

2.5.3 Impact of Child Sexual Abuse on the Social Status of Mothers of SAC

In a South African study by Hamber and Lewis (1997: 33), two mothers reported that they tried to encourage their children to keep the rape a secret, for fear of stigmatization and victimization from the community. Other mothers expressed that they wanted to move away from their community because of the current and future stigma that community members would attach to their SAC. Sometimes if both parents do not agree on moving, it may lead to family disorganization and divorce (Celano et al., 1996:1). The stigma that the community attaches to mothers post CSA disclosure make them blame themselves, withdraw, or even relocate for something that is not their fault.

2.6 Effect of Parental Response on the Coping Skills of Victims of CSA

Responses of non-offending parents have a significant impact on the post-disclosure adjustment of child victims. Negative parental responses aggravate behavioural disturbances in child victims and supportive responses positively influence adjustment in child victims (Stauffer & Deblinger, 1996:65). Non-offending parents'

emotional reactions following the abuse are a significant predictor of the overall level of distress of victims of CSA (Hèbert et al., 2007:807). Distress of caretakers has an influence on the symptomatology of the SAC; the higher the distress, the higher the symptomatology (Lipton, 1997:124). Distressed mothers of SAC are unable to give an appropriate support to their SAC which is a need for their recovery.

Research has shown that the recovery of SAC is associated with how the parent reacts and responds to the child's disclosure of CSA (Kouyoumdjian et al., 2009:41). Existing CSA research suggests that parental support following abuse is influential in predicting the victim's adjustment outcomes (Kim, Trickett & Putman, and 2010:611). The above mentioned studies have also suggested that parental support may be a better predictor of the child's psychological adjustment than abuse-related factors. Parental support is important as it influences a mother's coping skills.

Parental support after disclosure of CSA greatly influences the child's adjustment outcomes, this support is particularly important for the child's resilience (Kim et al., 2010:611). The level of support survivors receive from parents predicts later effects of childhood sexual abuse on outcomes such as distress and psychological adjustment (Kim, Noll, Putnum & Trickett, 2007:339).

Both theoretical and empirical literature suggest that children's emotional and behavioural adjustment following abuse is associated with the reactions and support they receive from parental figures (Elliot & Carnes, 2001:321). Non-offending parents' reactions and support following their children's victimization have been found to be influential in explaining the variability of the child victims' adaptations (Kim et al.,

2007:339). It is important to offer the child full support post disclosure.

Parental, particularly maternal belief, support and protection are associated with a variety of abuse-specific and non-abuse specific factors. Four factors that have received the most empirical examination include: (1) mother's relation with the perpetrator, (2) mother's own history of childhood abuse, (3) victim's age, and (4) victim's gender (Elliot & Carnes, 2001:317). The evidence from the literature has shown mainly inconsistent or no relationship among the four factors and maternal response post-CSA disclosure. Mothers were more likely to provide more emotional support to younger children who had experienced CSA (Smith (a), Sawyer, Jones, Cross, McCart, & Ralston, 2010:789). Pintello and Zuravin (2001:348) found that male sexual abuse victims were more than twice as likely to be believed and protected by their mothers as were female victims. The mothers' relationship with the perpetrator determined her level of stress.

Caretakers with higher education tended to be less supportive toward their children due to a sense of greater humiliation for those with higher community status; there was also less support for older children who are less likely to be believed and more likely to be held responsible for abuse than younger children (Lipton, 1997:123). Mothers were less likely to blame the child or doubt the disclosure, if the perpetrator was a family member (Smith (a) et al., 2010:790). Mothers were not blaming the children for the ordeal.

The mother is an important factor in mediating the child's trauma related to the sexual abuse and maternal support positively correlates with better prognosis for the

SAC (Smith (a) et al., 2010:785). Mothers influence the coping behaviours of their SAC in a meaningful way (Esparza, 1993:99). Sexually abused girls who believed that their mothers supported them responded more adaptively to the stress of CSA. Sexually abused children who live in a psychologically dysfunctional family environment had worse outcomes than SAC who lived in an emotionally supportive family environment (Esparza, 1993:87).

The mother's reactions can be damaging or supportive to the child. Depending on how a mother understands the rape, internalization of rape myths, and stigmatization of the SAC may affect her reaction to the child (Hamber & Lewis, 1997:25). These authors found that lack of maternal support could lead to the child using maladaptive coping strategies such as avoidance and self-blame, emotional difficulties, behavioural problems, and negative attitudes toward the mother. A mother's negative reactions and maladaptive views can affect her SAC's outcomes, self-esteem and the quality of the mother-child relationship (Hamber & Lewis, 1997:33). Emotionally supported mothers of SAC responded better to CSA disclosure.

Observational research has shown that mothers of SAC showed less maternal attachment behaviours of acceptance, sensitivity, cooperation and accessibility, which have been suggested to be dimensions that influence the quality of attachment (Kim et al., 2010:611). Mothers of SAC girls were also shown to give less positive structure and use penalizing strategies more often than the mothers of comparison girls (Kim et al., 2010: 611).

A caregiver's response may be supportive toward the child in some ways (providing

physical and safety needs), but unsupportive in other ways (with holding emotional support) (Elliot & Carnes, 2001:315). Parents experience adverse emotional responses to CSA that can also impede their ability to provide consistent emotional support to the SAC (Elliot & Carnes, 2001:318).

In a study on attachment, depression behaviour and anxiety among non-offending mothers of SAC, Lewin and Bergin (2001:365) acknowledged that the psychological status of the mother affects her ability to be responsive and sensitive to her child and that this will affect the recovery of the SAC from the abuse.

Lewin and Bergin (2001:372) further stated that a supportive relationship and maternal warmth are predictors of the child's psychological adjustment. Mothers of SAC presented with low attachment behaviour, anxiety and depression, which differed significantly from a comparison group in a small study (Lewin & Bergin, 2001:372).

2.7 Coping Mechanisms

According to Tedlie, Folkman and Maskowitz and Acree (2003:746), coping mechanisms of mothers of SAC have been identified as potentially salient variables and further indicated that negative life events can undermine the mother of SAC's self-concept, and even sense of self control. The undermining of both self-concept and control lead to stress in these mothers of SAC and ultimately result in adverse outcomes. Loss of power is associated with heightened level of distress (Hébert et al., 2007:806).

Corcoran (1998: 839) identified maternal support as a crucial factor relating to outcomes of CSA. Most of the studies reported negative events like rumination that can interfere with the mother's ability to take appropriate action on behalf of the SAC and problem-focused is a positive coping mechanism that has been negatively correlated with rumination (Tedlie et al., 2003:746). Rumination is associated with behavioural problems such as substance abuse (Plummer, 2006:105,106).

2.8 Support Programmes for Mothers

There are a variety of group therapy approaches for SAC and their non-offending parents, including the following: structured cognitive behavioural groups, client-directed self-help groups, insight-oriented self-help groups, individual therapy interventions and art therapy (Elliott & Carnes, 2001:324; Celano et al., 1996:3). Studies suggest that cognitive-behavioural treatment that combines parent and child interventions may lead to better adjustment in both the child and the parent (Elliott & Carnes, 2001:325). Trauma-focused cognitive behavioural therapy has been found to be efficacious (Tavkar, 2010:19) - the benefits include reductions in depression, shame, abuse-related attributions and behaviour problems; increased social competencies, knowledge of body safety skills, and cognitive reframing to address self-blame, feelings of powerlessness and hopelessness and sexualized behaviours.

Celano et al, (1996:3) conducted a study to evaluate and compare the efficacy of two short-term individual therapeutic interventions for sexually abused girls and their non-offending female caretakers - and PTSD symptoms and overall psychosocial functioning improved for both children and caretakers post intervention. Smith (a) et

al. (2010:785) conducted a study on mothers' reports of maternal support following CSA using the Maternal Self-Report Questionnaire (MSRQ). The study was designed to develop a reliable and valid mother report measure for assessing maternal support following a child's disclosure of sexual abuse. Smith ^(a) et al., (2010:785) also reported that there was a need to develop a tool to assess what sort of support mothers would need to help the mothers' better support their children. However, there is dearth of literature on guidelines or programmes to support the mother of CSA in South Africa.

- ❖ Therefore, it was crucial to conduct a mixed methods study to explore and describe the experiences of mothers of SAC that would eventually lead to the development of guidelines for mothers of SAC in the NWP.

2.9 The Researcher's View of the Literature

The existing literature focuses only on assessing whether mothers support their abused children after disclosure and yet the mothers are experiencing secondary trauma while they are supporting the child who is a primary victim. Sexual abuse survivors may therefore benefit from intervention programmes and guidelines for support focusing on enhancing parental functioning after CSA disclosure. Despite the acknowledgement of the important role that mothers play in the coping and/or adjustment of child victims of sexual abuse, it is only recently that there have been research efforts to understand their psychosocial challenges (Kim et al., 2010:611). The studies that do exist are mainly from developed countries and are not easily generalizable to other populations.

- ❖ To date, in South Africa, very little research has been conducted to explore the experiences, specifically describing the prevalence of psychological responses

such as PTSD, depression, coping mechanism, social support and distress of non-offending mothers of sexually abused children.

2.10 Recommendations for Parental Guidelines for Support in the South African Context

Parental support is a key factor in developing intervention programmes for SAC and should include social, legal, psychological and financial support after disclosure of CSA (Stauffer & Deblinger, 1996:66). Support systems for mothers of SAC are very limited (Hébert et al., 2007:809). Non-offending mothers in South Africa have very few institutional and social support resources available to them (Hamber & Lewis, 1997:41). To date, there is no evidence of institutional psychosocial support guidelines available to non-offending caregivers of SAC in South Africa. Although the literature is silent about the existence of guidelines for support currently in South Africa for non-offending caregivers, results from parental support intervention programmes discussed above can be used and adapted to the local context.

- ❖ It is against this background that a literature search on the topic is imperative so that gaps on the topic could be identified and addressed. The results obtained will assist the researcher to develop guidelines that will inform the provincial department of health, curriculum and policy developers, clinicians and policy makers how to support mothers of SAC following disclosure.

2.11 Theoretical Framework of the Study

2.11.1 Overview of the frame work

The theoretical framework for this study derived from the *Ecological Model of the Impact of Sexual Assault on Women's Mental Health* (Campbell, Dworkin& Cabral, and 2009:227). Bronfenbrenner first developed the ecological model in 1979 to explain

how different ecosystems affect an individual (Campbell et al., 1999:267; Neville & Heppner, 1999:42). Bronfenbrenner's original model (1979, 1986, and 1995) explained how sexual assault affects women's well-being and recovery process. Campbell et al. (2009:30) developed a model based on the two models - their model's premise being that sexual assault survivors' mental health is shaped by their interaction with their ecosystem, not only sexual assault. The researcher also adopted Campbell's (2009:267) *Ecological Model* as a theoretical framework to guide this study.

2.11.2 Description of the Model

The ecological model recognizes the interwoven relationship that exists between the different systems of the human being. Within Campbell's Ecological Model (Campbell et al., 2009:227) there are six interacting subsystems within larger systems conceptualized in a series of expanding circles (Figure 2.1). According to Campbell et al. (1999:269), the factors that influence the recovery process of survivor of trauma post-assault are the following levels of interacting systems: individual, assault, microsystem, meso/exosystem, microsystem and chronosystem (Campbell et al., 2009:268).

2.11.2.1 Individual System

Individual system is where the personal factors implicate on the person and these are somewhat intrapersonal. At the individual level there are five socio-demographic variables that can influence recovery of an individual, namely, personal factors, pre-existing mental health conditions, genetic and biological factors and coping responses (Campbell et al., 1999:270).

◆ Socio-Demographic Variables

Campbell's model indicates that several studies have found that older survivors experience increased depression and general trauma while younger age has been found to predict PTSD and depression. They further indicated that older survivors have been found to experience fewer PTSD symptoms and have not found any effect of stress on age (Campbell et al., 2009:231). These authors indicated that several studies found that income level, marital and employment status in post-rape distress did not have any association between income level, marital and employment status with post-assault distress. The study also did not find any relationship of education and post-sexual assault.

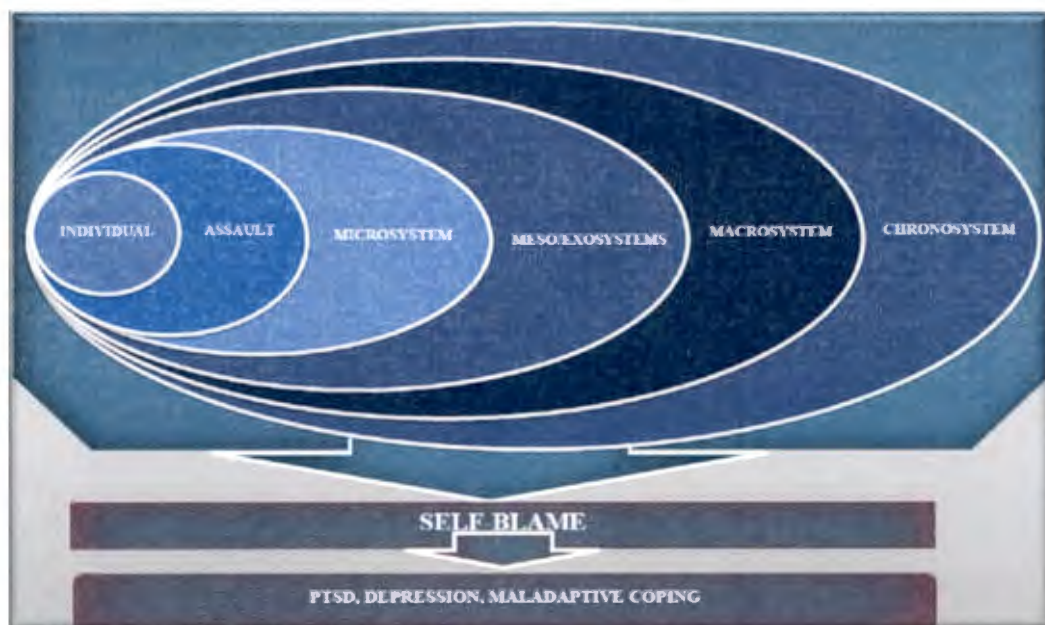


Figure 2.1: Ecological model of the impact of sexual assault on women's mental health

◆ Personality Factors

Campbell et al. (2009:228) found that self-criticism, impulsiveness anxiety, hostility and depression predict PTSD in post-sexual assault victims.

♦ **Pre-Existing Mental Health Conditions**

According to Campbell et al. (2009:230), various studies have identified that pre-existing mental health conditions are related to post-assault mental health sequelae such as PTSD and depression. They further indicated that people who attempted suicide pre-assault experienced significantly more post-assault depression and anxiety than those who did not have pre-existing conditions.

♦ **Genetic and Biological Factors**

Campbell et al. (2009:231) reported that to date no studies have examined genetic factors as predictors of post-rape stress, but in traumatic stress the body reacts by altering cortisol responses thus contributing to PTSD.

♦ **Coping Responses**

According to Campbell et al. (2009:231), victims coping responses affect post-assault psychological health. Survivors use various approaches of coping such as emotional or cognitive activity, avoidant or the consistent coping (Campbell et al., 2009:231). Coping strategies of the woman that use different coping strategies - such as avoidant maladaptive coping could lead to depression and PTSD. In this study the individual is the mother of a SAC, whose recovery is improved or increased by socio-demographic variables such as marital status, for those who are married and also who have partners they are supported by them and for those who are unemployed are supported by families.

2.11.2.2 Assault Related Factors

According to Campbell et al. (2009:232), at this level the recovery of the woman post-sexual assault may be influenced by who the perpetrator is (stranger or non-stranger), and the injury sustained by the victim. They further indicated that stranger rapes tended to be more violent and invasive than that of non-stranger rape and that sexual assault by a partner is found to be a significant predictor of PTSD. The type of assault and the perpetrator is related to post-assault depression, PTSD and the type of coping (Campbell et al., 2009:233).

In this study assault is the disclosure of the CSA abuse because it causes psychological trauma to the mother. The type of sexual abuse sustained by the child could determine the recovery received by the mother. If post-disclosure, the mother is not supported by an informal or formal system and she may blame herself for the abuse and may ultimately develop depressive and PTSD symptoms as well as maladaptive coping.

2.11.2.3 Microsystem Factors

According to Campbell et al. (2009:233), at this level the recovery of the victim may be influenced positively or negatively by social support received from microsystems such as friends, family, peers and intimate partners. Availability of positive support is related to better adjustment, recovery post-assault and less psychological distress. Negative reaction from family, friends and peer is found to increase a victim's self-blame, anxiety, depression and PTSD. Increased levels of depressive symptoms need support from both informal and formal support providers. In this study, the

microsystem is the interaction of the mother of SAC with the family, friends and intimate partners that facilitate sexual assault recovery. The availability of the microsystem is related to better adjustment and less psychological distress. Social support following CSA disclosure increases psychological well-being. Intervention by friends and intimate partners and social support facilitates the healing process of the mother of SAC following disclosure. The availability of support from family members, friends, parents, and intimate partners reduce the psychological distress the mother is experiencing. Negative social reactions from family members, friends and peers increase anxiety, depression, PTSD and self-blame.



2.11.2.4 Meso/Exosystem Factors

According to Campbell et al. (2009:234), at this level the factors that may increase recovery post-assault are police pursuing prosecution through the criminal justice system, medical system, mental health system and the advocacy community. If the victim does not receive needed support services from criminal justice and police, mental health providers and the advocacy community then she starts to blame herself. If the feelings of self-blame persist, the victim's psychological being becomes negatively affected and the negative interaction post-assault intensifies the secondary trauma that affects the victim's stress. The authors further reported that stress correlates with depression, PTSD, maladaptive coping and self-blame. Self-blame predisposes the mother to PTSD, depression and maladaptive coping (Campbell et al., 2009:231). The mental health providers are found to be helpful in improving recovery of women post-assault. Community health centres were found to be helpful to be used to address the negative experiences of post-sexual assault

victims who experience problems in attaining legal and medical systems (Campbell et al., 2009:235). The sexual assault victims seek help from rape crisis centres or shelters. Individual counselling and self-help reported PTSD to be reducing PTSD, distress level and increases social support, self-efficacy and self-control (Campbell et al., 2009:234).

In this study, meso/exosystem involves the legal, medical, mental health systems and the advocacy community that interact with the mother of SAC post-disclosure. The mother views the police as the system which is not prosecuting criminals through justice, the medical team who is asking her blaming questions and the community members who are helping her to negotiate with the legal system. In turn, if the mother of SAC view the questions asked by the legal and medical team as appropriate and real, then she starts blaming herself just because she is being blamed. Self-blame increases anxiety, depression, PTSD and maladaptive coping (Campbell et al., 2009:234).

2.11.2.5 Macrosystem Factors

At the level of macrosystem, Campbell et al. (2009:235) highlighted that the post-sexual assault recovery of the woman may be affected by cultural-specific beliefs, e.g., the culture that condones male violence against women. These factors are more likely to make women blame themselves because they believed they were raped while they were high. They take the responsibility from the perpetrator of blaming themselves for the rape. In this study, mothers blamed themselves, because they felt they should not have accommodated their family members who perpetrated the child sexually and the sexual cultural orientation made them to accept the blame from others. The

self-blame made the mother of SAC to suffer depression, PTSD and maladaptive coping.

2.11.2.6 Chronosystem Factors

In this system, Campbell et al. (2009:236) stated that the factors that may improve or increase recovery are the history of prior victimization of post-assault survivors. This level supports the notion that victims of repeated sexual assault have more self-blame, societal blame and higher levels of trauma (Campbell et al., 2009:235). Victimization is more strongly associated with the negative psychological outcomes such as PTSD ideation, depression and age (Campbell et al., 2009:237).

In this study, mothers of SAC whose other siblings were once abused sexually and whose court cases were prolonged were more depressed than those whose court cases did not take long and whose children had no prior history of CSA. The mothers of SAC blamed themselves for the action of the perpetrator that they failed to protect their children, the blame made them to suffer depression, PTSD and maladaptive coping.

2.12 Reasons for using ecological model of the impact of sexual assault on women's mental health.

The Literature revealed that these mothers experienced secondary trauma and consequently suffer from PTSD and depressive (Willingham, 2007:71; Fong & Walsh-Bowers, 1998:34). Therefore their recovery process is a concern when diagnosed with PTSD and depression. Ecological model of the impact of sexual assault on women's mental health developed by Campbell et al. (2009) assessed the risk factors that

could impede or promote the recovery process. The risk factors discussed by Campbel et al. (2009) are individual system, assault related factors, microsystems, exosystem, mesosystem, macrosystem and chronosystem. This model was found appropriate to guide the development of the guidelines because it addresses the changing ecological environment in which an individual resides and the relationship at the larger social contexts that an individual finds her in. The model also provides a supportive framework for understanding individuals exposed to psychological trauma. It is against this background that the researcher used this model to develop guidelines for support to mothers of sexually abused children.

2.13 Summary

This chapter focused on two sections, the literature review and theoretical model that guided this study. The literature review revealed that the mother of SAC suffers traumatic stress post-CSA disclosure and that maternal support is imperative. In this regard, it is important that the guidelines for support to mothers of SAC be developed with the hope of giving quality care to mothers as secondary victims. The second section describes the model that guided this study. The model examined the psychological impact of adult sexual assault from an ecological theoretical perspective to understand how factors at multiple levels of the social ecology contribute to post-assault sequelae (Campbell et al., 2009:225).

CHAPTER 3

RESEARCH DESIGN AND METHOD

3.1 Introduction

This chapter describes the research design strategy and methods used in this study. The two-stage designs described in this chapter are qualitative and quantitative. Each stage of these two stages consists of: study design, research setting, target population, sample size, sampling procedure, instrumentation, data collection and analysis, trustworthiness/validity and reliability.

3.2 Research Strategy

The study was divided into three phases, phase one consisting two stages. Stage one is qualitative and stage two is quantitative. In stage one, the experiences of mothers of SAC were explored and described. In stage two, coping skills, social support, depression and Post Traumatic Stress Disorder (PTSD) of mothers of SAC were examined following disclosure of their children's sexual abuse. A brief description of the research strategy is illustrated in Figure 3.1.

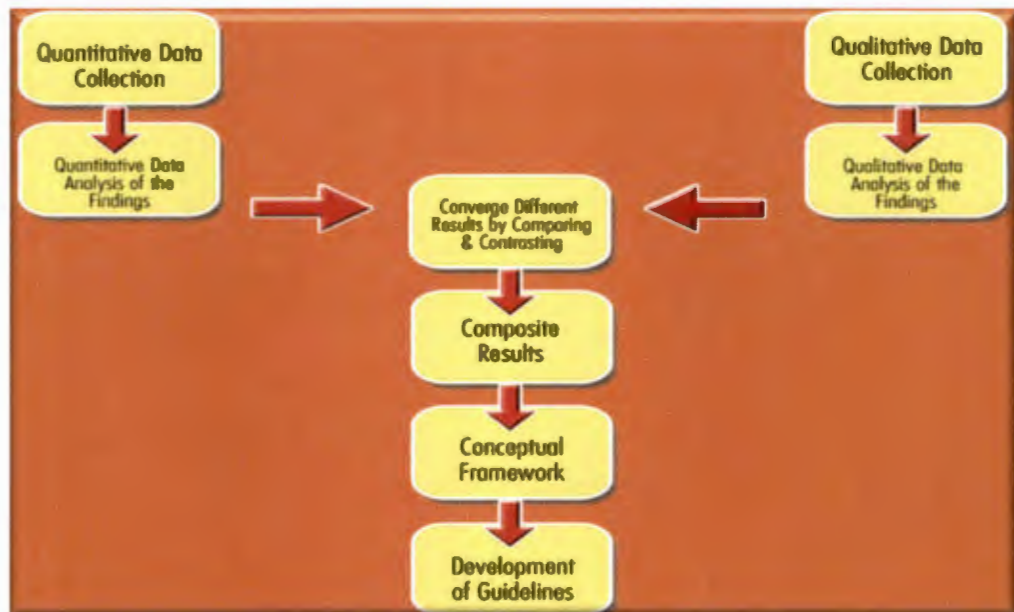


Figure 3.1: Concurrent convergence triangulation mixed methods design: flow diagram

Phase two consists of literature review and conceptual framework. Phase three focused on guidelines development, conclusion, limitations and recommendations.

3.3 Research Design

The concurrent triangulation mixed method was employed by using both qualitative and quantitative design at the same time period within the same study of the research process (Creswell, 2009:67).

Creswell and Plano-Clark (2007:213) reported that in a triangulation mixed method the researcher collects both qualitative and quantitative data concurrently and then compares the two databases to determine if there is any convergence, differences and combination. In this design, there are two relatively independent stages, one with qualitative and the other with quantitative. The purpose of the concurrent mixed methods design is to obtain similar or different, but complimentary data on the same topic (Creswell& Plano-Clark, 2007:66; Creswell, 2009:213). In this study, the two datasets of results were merged into an overall interpretation so that a complete picture could be obtained from both datasets (Creswell & Plano-Clark, 2007:66).

3.3.1 Stage 1—Qualitative Research Design

This stage involved qualitative, descriptive, exploratory and contextual design. A summary of stage one is illustrated in Figure 3.2.

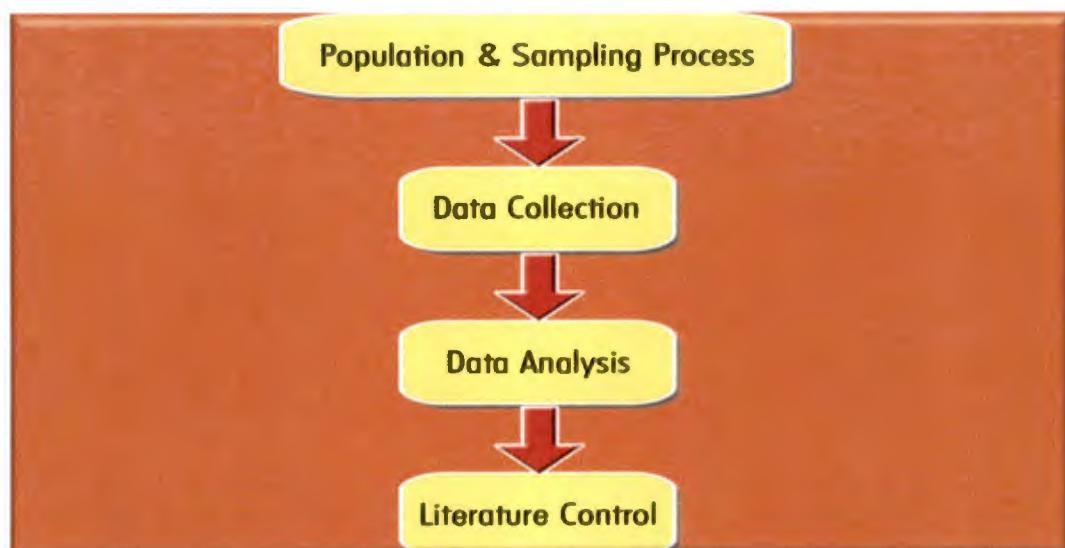


Figure 3.2: Stage one of the research process: flow diagram

Polit and Beck (2010:259) described a qualitative research design as that which emerges as a researcher makes on going decisions that reflects what is already known. This approach was appropriate for exploring and describing the experiences of mothers of SAC so that the findings could be used effectively to develop guidelines to support mothers of SAC.

The researcher utilized a qualitative approach to explore the experiences and the meaning the participants attached to their feelings and perceptions about the CSA disclosure. The design was used to develop an in depth understanding of the experiences of mothers of SAC in the NWP and also to explore the experiences and the meanings the participants attached to their everyday environment.

The researcher built rapport with the participants while they expressed themselves in their own language to create a relationship of trust to enable the researcher to enter the participants' social constructions to get a dense description (Sarantakos, 2005:45).

3.3.2 Exploratory Research Design

A qualitative research strategy is based on the premise that knowledge about human beings is not possible without exploration of their experiences (Burns & Grove, 2009:23). Exploratory research in its totality is committed to investigate a problem which provides insights into the researcher and search every detail of the way in which this problem is manifested (Burns & Grove, 2009:359; Polit & Beck, 2010:22). The researcher used exploratory research to explore the experiences, because she did not know the participants' reactions, about their CSA disclosure. The researcher explored the dimensions of the phenomenon and the manner in which it manifested

(Brink et al., 2012:22), e.g., support provided to the participants, how they were treated by stakeholders and other factors related to the problem under investigation such as their beliefs and culture as assigned to their experiences (Polit & Beck, 2010:22). The findings of this exploration helped the researcher to develop guidelines to support mothers of SAC.

3.3.3 Descriptive Research Design

The researcher requested participants to describe their views, cultural beliefs and values that they experienced as well as relate to some events in their environment (Burns & Grove, 2009:46). In this study, various observation methods intensified the descriptions of culture/behaviour, language and beliefs. Participants provided rich and detailed data that assisted the researcher to construct some themes. The researcher only searched accurate information about the experiences of mothers of SAC, as well as the support they received. The researcher described attitude and behaviours of mothers of SAC to complete a picture of their experiences and social support after the disclosure of CSA. Brink et al. (2012:102) argued that descriptive design is appropriate where the researcher intends to answer the research question such as "What are your experiences following your child's sexual abuse disclosure?"

3.3.4 Contextual Research Design

In a contextual design the phenomenon of interest is studied in terms of its immediate context. Holloway and Wheeler (2013:35) described a context as the environment in which the study is conducted; it also includes the participants' culture and location which affect the behaviour. This study is contextual in nature as it is

executed in the context of mothers of SAC. Lincoln (1985:189) acknowledged that the phenomenon must be studied in its natural setting because individuals take their meaning from themselves within their context. The researcher conducted the study in TTCC and the homes of participants; therefore, it was of contextual in nature as it was conducted in a certain setting within a certain context.

3.4 Research Method

3.4.1 Study Setting

The study was conducted in Thuthuzela Care Centre (TTCC) which is attached at a hospital, and in the homes of the participants in Bojanala, Kenneth Kaunda, Doctor Segomotsi Ruth Mompoti and Ngaka Modiri Molema districts in the NWP. The TTCC was chosen because it is a one-stop facility that has been introduced as a critical part of South Africa's anti-rape strategy, aiming to reduce secondary victimization, improve conviction rates and reduce the cycle time for finalization of case (National Prosecuting Authority, South Africa). Some participants' residential areas were used as settings for interviews. Figure 3 shows a map of the NWP, its bordering provinces (Limpopo, Gauteng, Free State and Northern Cape) as well as its border with Botswana. The study site, TTCC, is located within the Mafikeng Hospital.



Figure 3.3:North-West Province map (<http://www.places.co.za/mapsnorth.west.map.html>)

3.4.2 Study Population

The population of the study comprised mothers whose children had experienced sexual abuse, and their names found in the sexual assault register in TTCC in the NWP. These children were referred for sexual assault examination and evaluation by child protection services, physicians, district surgeons, crisis centres, districts, community hospitals, police officers and emergency departments in the NWP.

3.4.3 Sampling

A non-probability, purposive sampling technique was used to select mothers of SAC. According to De Vos et al., (2006:202), purposive sampling refers to, the process of selecting participants who are rich in information needed by the researcher. Non-probability sampling increases the likelihood of obtaining divergent data (Burns &

Grove, 2009:716; De Vos et al., 2006:202). The researcher consciously selected participants according to her judgment because she was looking at the suitability of the problem with the hope that the mothers of SAC would provide the best answers to the questions. The participants were chosen on the basis that they were the mothers of SAC who were found in the sexual assault examination register at TTCC at a hospital in the NWP.

3.4.3.1 Inclusion Criteria

The following inclusion criteria were used to recruit participants to the study:

- ✿ The mother was a primary caretaker of any sexually abused child aged between 0-16 years;
- ✿ The mother of the SAC who was not accused of physical and sexual abuse;
- ✿ The sexual abuse must have occurred within one year;
- ✿ The sexual abuse included oral, vaginal or anal penetration or unclothed touching of a child from an adult perpetrator, including incest;
- ✿ Mothers who volunteered to participate in the study;
- ✿ The SAC was either a male or a female; and
- ✿ The CSA must have occurred in NWP.

3.4.3.1 Exclusion Criteria

The following exclusion criteria were used to rule out participation in the study:

- ✿ Mother was accused of physical or sexual abuse.
- ✿ Mother of SAC who was not mentally sound.

3.4.4 Sample Size

The sample size was governed by data saturation. Data saturation was reached after 17 participants were interviewed. According to Brink et al. (2006:173), data saturation occurs when additional participants provide no new information and when those that emerge become repetitive.

3.4.5 Data Collection

The researcher used unstructured in-depth interviews, voice or tape recorder and field notes to collect data. Burns and Grove (2009:544) stated that data collection in a qualitative design is a series of interrelated activities with the purpose to gather information to ensure that the research question is answered

3.4.5.1 In-Depth Interviews

An in-depth interview, a technique that allows discussion between the researcher and the participant was used (Brink et al., 2012:152). The selected participants were informed about the phenomenon under investigation, so that they can provide relevant information (Sarantakos, 2005:280). The in-depth interview was appropriate for this study because the researcher did not have knowledge about the phenomenon under study (Brink et al., 2012:151). The researcher used the in-depth

interview to determine the participants' experiences, opinions and their reactions towards the disclosure of their children's sexual abuse and to understand the participants' point of view. The aim was to understand the participants' responses to questions in the wider context of the interview (De Vos et al., 2006:293). The researcher built rapport before interview was conducted so that the participants could be free to describe their experiences and opinions. The researcher used the following questions:

- ✿ **What are your experiences following your child's CSA disclosure?**
- ✿ **What kind of support did you expect to receive?**

These questions assisted the researcher to gather information about the experiences of mothers of SAC following disclosure. The researcher continued with follow-up questions, depending on the participant's response and probed to increase the probability of deriving more detailed information. Probes also increased rapport because they made the participants to realize that the researcher had an interest in their problem (Burns & Grove, 2009: 716).

The participants were further asked to describe the support they received and needed. The interview was conducted in Setswana as most participants could understand it. The interview took 45 to 60 minutes to complete. The interview focused on the experiences of the mothers of SAC and the social support needed by participants. During the interview the researcher used skills such as probing and clarifying (Henning, van Rensburg & Smith, 2004:79). Probing was used to obtain more information so that the participants could elicit useful information (Burns &

Grove, 2009:716). Probing also gave the researcher a dense description of the experiences of mothers of SAC following disclosure.

Individual in-depth interview provided information about participant's attitude, their values and what they think could be done to support them. Interview assisted the researcher to find out from the participants those issues that could not be observed, because feelings, thoughts and intentions cannot be observed. The advantage of this method of data collection is that it produces more information on the participant's culture, attitude and beliefs (De Vos et al., 2006).



♦ **Tape Recording**

During the interview the researcher used the voice recorder with the participants' permission. Recording devices provide evidence of what the participant said to the researcher, increases validity of the information, provides evidence of the researcher being in the field and data may be listened to without any loss of information (De Vos et al., 2006:298; Burns & Grove, 2009: 716). The recorded interview is long-lasting and does not change and it helps the researcher to concentrate on interview proceedings (Burns & Grove, 2009: 716).

♦ **Intuition**

The researcher immersed herself into the phenomenon under investigation for several times until she totally understood it. The researcher then compared and constructed the information before determining the final themes (Brink et al., 2012:114). The researcher described the themes as they emerged. Intuition guided

the researcher in the clinical field by listening to what the participants were saying and how they were saying it.

♦ **Bracketing**

According to Tufford and Newman (2012:80), bracketing mitigates the deleterious effects of preconceived ideas that may affect the research process. The researcher used bracketing to increase the research rigour and to help shed light on current confusions and consistency in the research field. Bracketing also facilitates the researcher to reach deeper levels of reflection across all stages of qualitative research. In this study, the researcher put aside her values, beliefs and opinions that she might have about the experiences of mothers of SAC post-disclosure. Bracketing was done to enhance objectivity and to discover new ideas about the topic from the participants' point of view.

3.4.5.2 Field Notes

De Vos et al. (2006) stated that field notes are a written account of what a researcher hears, sees, thinks and experiences about the course of interviewing while Polit and Beck (2010:355) maintained that field notes are taken by the researcher to document the unstructured observations made in the field, and interpretation of those observations. Field notes include both empirical observations and interpretation, a researcher's emotions, preconceptions, expectations and prejudices so that a final product can be developed from them (De Vos et al., 2006:299). The researcher documented field notes in the order they occurred in the field. The researcher documented what she saw, experienced, heard and thought about the interview. Field

notes are categorized as follows: reflective notes, descriptive, personal and methodological (Beck & Polit, 2010:355). During the interview the researcher reflected some of the statements mentioned by the participants to ensure the understanding thereof (Henning et al., 2004:75).

♦ **Observational Notes**

Observational notes are descriptions of events, conversations and the context within which they occurred (Polit & Beck, 2010:354). The researcher observed some verbal and non-verbal cues as well as some activities that took place at the research site. The description notes assisted the researcher to obtain a “thick” description (Polit & Beck, 2010:354). In this study, the researcher established some critical indications of their relationships such as mothers being forced or coerced by family members not to report the perpetrator to the police officers, especially in the case of incest. Some mothers of SAC denied being cohabitating while the researcher could observe that it is happening.

♦ **Methodological Notes**

Methodological notes are reminders about the subsequent observations made by the researcher (Polit & Beck, 2010:354). The researcher while in the field (study site), took notes of everything that she encountered during the interview.

♦ **Theoretical Notes**

According to Polit and Beck (2010:354), theoretical notes are interpretive efforts attached to the meaning of what the researcher observed. In this study, the

researcher saw, heard and sensed some behaviours and attitudes to which she attached meaning. The researcher interpreted her observations and also attached the meaning to her interpretations.

♦ **Personal Notes**

These are reflective notes; they reflect the researcher's experiences in the field. Polit and Beck (2010:354) stated that personal notes are comments about the researcher's feelings during the process of interview. The researcher kept a record of all her feelings such as emotions and reactions that she felt during the data collection process.

3.4.6 Data Analysis

Analysis was done according to the Tesch's eight steps of open-coding as cited by Creswell (2009:186):

1. The researcher read the entire transcript carefully to get a sense of the whole and jotted down some ideas that came to her mind.
2. The researcher selected one interview and read it to try to grasp the meaning in the information. The researcher wrote the thoughts in the margin.
3. After going through the transcripts, the researcher arranged similar topics in groups by forming columns labelled major topics, unique topics and leftovers.
4. The themes or topics were abbreviated as codes, which were written next to the appropriate column of the transcripts. The researcher then observed the

organization to check if any new categories have emerged.

5. The researcher found the most descriptive wording for themes or topics then categorized them. Lines were drawn between categories to show the relationships.
6. The researcher made the final decision on the abbreviations for each category and then sorted them alphabetically.
7. The material belonging to each category was assembled and a preliminary analysis was performed.
8. The researcher recoded existing material, where deemed necessary, and finally interpreted the data to be included in a written report (De Vos, 1998:343).

3.4.7 Literature Control and Conceptualization

A literature control on experiences of non-offending mothers of SAC was done to ground the research findings. According to Brink et al. (2012:68), the literature control is used as the basis for comparing and contrasting findings of a qualitative study. Henning et al (2004:28) and Smith (a) et al. (2010:788) stated that a literature control is used to show the relevance of the findings in relation to the existing body of literature. The same authors further alluded that it is necessary to conceptualize the study to argue the findings. The professionals, journals, books, periodicals, and other people's research articles were consulted to ground the study findings. This was helpful in providing research ideas, experiences or perceptions of what is already known about guidelines for support to mothers of SAC.

3.4.8 Measures to Ensure Trustworthiness

The goal of rigour in qualitative research as described by Lincoln and Creswell (cited in De Vos, 2006:346) is to accurately represent study participants' experiences. Trustworthiness was utilized to reflect the assumptions of the qualitative paradigm (Lincoln, 1985:282; Guba, 1979:290). Four aspects of the model were used. To ensure and maintain trustworthiness in this research, the criteria of credibility, dependability, confirmability and transferability were used (Guba, 1979:290), as discussed in the subsections that follow.

3.4.8.1 Credibility

According to De Vos et al., (2006:346) truth value is the alternative to internal validity that demonstrates the research was conducted with the aim of ensuring that participants were identified and described. The researcher established confidence in the truth of the findings for the participants and the context in which the study was undertaken (Lincoln, 1985:283). This established how the researcher obtained the experiences of mothers of SAC. The researcher then verified the findings by interviewing participants who were familiar with the phenomenon under investigation. Credibility was ensured by accurately identifying participants whose children had experienced sexual abuse. This was achieved as follow:

♦ **Prolonged Engagement**

The researcher had long engagement in the field with the participants to gain their trust (Brink et al., 2012:118). The researcher employed prolonged engagement because she spent enough time with the participants building rapport and trust in

order to uncover the experiences so that the culture and beliefs of the participants could be learned to dispel any misinformation. Prolonged engagement assisted the researcher to apply persistent observation so that characteristics and elements that were relevant to the problem could be identified (Brink et al., 2012:173). The researcher kept notes to describe and interpret the behaviour and experiences within the study site (Polit & Beck, 2010:497). The researcher immersed herself within the data collection process by attentively listening to participants, narrating their stories and also listened to the voice recorder several times until she had internalized the content of the tape recorder. During the data analysis process, the researcher read through the raw data several times in order to determine the experiences of the participants.

♦ **Peer Debriefing**

Peer debriefing facilitates the researcher's consideration of methodological activities and provide feedback concerning the accuracy and completeness of the research data collection and data analysis procedures (De Vos et al., 2006:66). The researcher and the independent co-coder analysed data independently to identify themes categories and sub-categories. They then discussed their findings and ultimately reached consensus to identify and confirm the themes that emerged from the data analysis.

♦ **Member Checking**

Member checking is done when data categories, interpretations and conclusions are verified with participants with whom the data were originally obtained (Polit & Beck, 2010:499). Member checking is necessary to ensure credibility of an account (Brink et

al., 2012:173). Furthermore, Lincoln (1985:285) posited that this is the crucial technique for establishing credibility. Member checking with peers to ensure accuracy of information given and recorded and assessing the intentionality of the participants was done (Brink et al., 2012:173). The researcher gave participants feedback on the emerging study findings to ensure that what the researcher had captured is the correct information provided by the participants (Brink et al., 2012:173). The tape recorder was played back to participants to ensure that the correct information was obtained and transcribed. Follow-up questions and probes were used by the researcher during interviews to ensure understanding of experiences of mothers and verify development of the themes.

♦ **Triangulation**

Triangulation refers to the use of multiple data sources and using different methods in the same study for validation of findings (Flick, 2014:180; Brink et al., 2012:173). Triangulation was advantageous as it helped the researcher to explain the attitudes and behaviours of mothers of SAC who were under investigation and also to verify that participants had supplied the relevant needed details. Flick (2014:214) indicated that triangulation is systematically used to extend and complete possibilities of knowledge production. The researcher used many methods during data collection to overcome deficiencies such as: collection of both empirical and theoretical data through in-depth interviews, probing, tape recording and field notes to determine the experiences of participants following their children's sexual abuse disclosure and a literature control to explore different sources based on the experiences of mother of SAC so that meaning could be attached to those experiences.

3.4.8.2 Dependability

Polit and Beck (2010:491) referred to dependability as stability of data over some time and condition. This criterion was achieved through data coding and categorizing in the analysis. The process of data collection, analysis and interpretation was monitored and audited by experts (peer) to ensure that the study was acceptable and dependable (Brink et al., 2012:119). Field notes were kept and the research methodology was fully described (Brink et al., 2006:118). To ensure consistency the researcher used the same questions to explore experiences of participants and the researcher also kept personal notes to promote an audit trail (Polit & Beck, 2010: 492). The researchers used a code-recode procedure during the data analysis and a co-coder was also consulted to code the data independently (Brink et al., 2012:185). The co-coder and the researcher met to compare and contrast the information and ultimately reached consensus on the emerged themes (Brink et al., 2012:185).

3.4.8.3 Confirmability

The researcher was supervised by an expert in the field of qualitative research. Confirmability was used to ensure that findings, recommendations and conclusions were supported by the data such as the use of direct quotations (presented in italics) of participants' responses. Purposive sampling was used to maximize the range of specific information obtained from the particular context and to confirm that the sample selected upheld the characteristics of the phenomenon under study (Brink et al., 2012:174). The study was consistent across the whole research process and was guided by the research questions and objectives (Brink et al., 2012:118; De Vos et al., 2006:345).

3.4.8.4 Transferability

Transferability is concerned with the precondition that the findings must reflect the participants' voices and refers to the extent to which findings from the data can be transferred to other settings (Polit & Beck, 2010:493). The researcher provided sufficient descriptive data in the research findings that could be evaluated for applicability to other settings or contexts. The researcher explained the research questions, purpose of the study and the objectives to ensure that the richness of the research results could be shared with other professionals who provide care to mothers of SAC and might want to improve on it. Direct quotations from the participants were utilized to ensure thick description of data. The themes, categories and sub-categories were described fully.

3.5 Stage 2—Quantitative Design

The quantitative stage also focused on research design and methods for this study which comprised the population, sampling methods, sample size, data collection and analysis and validity and reliability. A summary of this stage is illustrated in Figure 3.4.

3.5.1 Study Setting

The research setting was the same as described for stage one of this study.

3.5.2 Target Population

The population of the study was the same as in stage one of this study.

3.5.3 Sampling Technique

Purposive probability sampling was used to select the participants purposively based

on the judgment of the researcher regarding the characteristics of interest found in the participants (Brink et al., 2012:141;Dores and Tongo 2007:147).

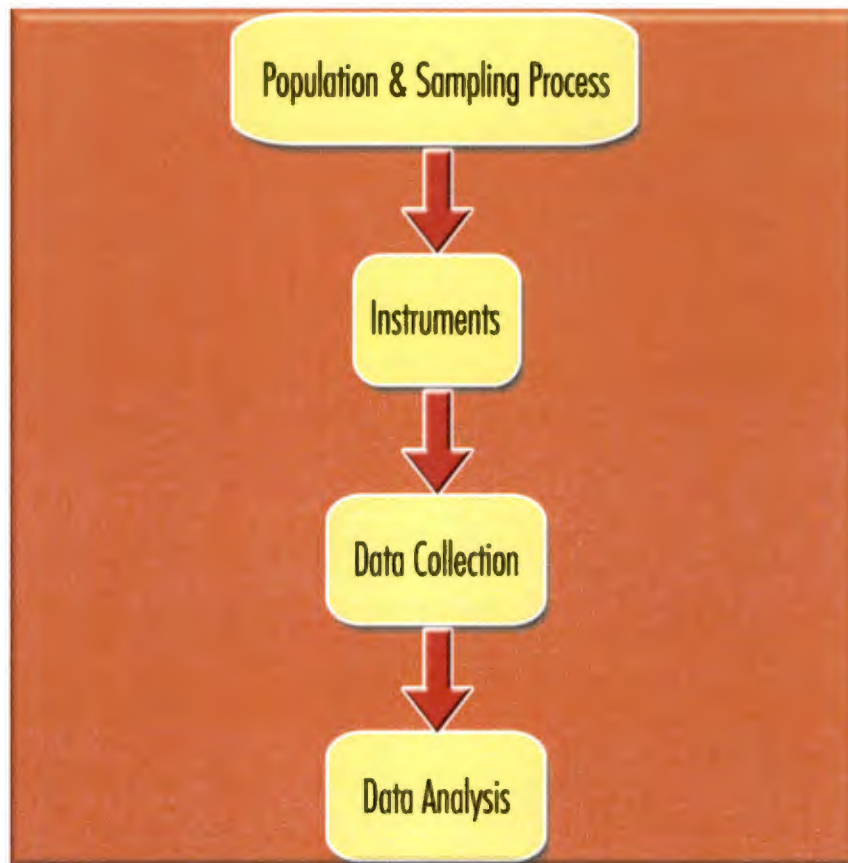


Figure 3.4: Stage two of the research process: flow diagram

3.5.4 Sample Size

The maximum population of SAC under the age of 18 years at TTCC for the year 2011 was 207. The RaoSoft.com software was used to determine the sample size of SAC, with the margin error of 5%, confidence interval of 99% and the response distribution of 50% (see page 62). The total population of women whose children were sexually abused were 207 in year 2011, therefore, the sample size was 158, but to account for the loss, 180 participants were interviewed.

- ❖ The sample size n and margin of error E are given by (<http://www.raosoft.com/samplesize.html>).

$$X = z^2 (c/100)^2 r(100-r)$$

$$n = N \times / ((n-1)E^2 + X)$$

Where:

N is the population size;

r is the fraction of responses that you are interested in; and

$z(c/100)$ is the critical value for the confidence level.

3.6 Data Collection

A structured interview guide was developed for this study and consisted of previously validated instruments to ensure that all participants were asked exactly the same set of questions in the same sequence. The interview guide comprised of five sections: demographic characteristics of participants, Beck Depression Inventory (BDI), PTSD Checklist specific version (PCL-S), Brief Cope and Social Support Grid.

- ❁ **The first section was the demographic questionnaire** which was used to assess the age, ethnicity, marital status, employment and educational status, monthly income of the mother of CSA, sexual abuse and social support received. The mother of SAC was also asked who the perpetrator was - a family member, acquaintance or friend and if the perpetrator did penetrate or not. The mother was also asked if the sexual abuse was happening for the first time or not.
- ❁ **The second section was the BDI Scale** that was used to measure depression. The BDI is composed of 21 items (questions), each with 4 responses, assigned a score responding from zero to three. Each score

indicates the severity of the symptom (Beck, Steer, & Garbing, 1988:79). The scale assesses questions such as mood, permissiveness, self-accusations, suicide ideas, crying, irritability, social isolation, body image changes, low level of energy, deference to take decision, experiences of loss of weight and appetite, fatigue and body aches. The scale was designed and developed to assess, detect and monitor changes in depressive symptoms among people in a psychiatric setting (Beck et al., 1988:79). The scale usually takes approximately 10 minutes to complete. In this study it was used to examine the relationship between depressions, PTSD, coping strategies and social support symptoms that the mothers of SAC displayed.

- **The third section was the Brief Cope Inventory (Brief Cope).** Cooper; Katona and Livingston (2008:836) reported that the Brief Cope is a self-completed questionnaire measuring coping strategies. It comprises 14 subscales for which psychometric properties are described. The Brief Cope has predicted clinically relevant outcomes across the globe; problem-focused and dysfunctional coping have proved useful in clinical research and have content validity (Cooper et al., 2008:834). The scale assesses patient coping situations and population (Cooper et al., 2008:834). The 14 subscales are: self-destruction, active coping, denial, substance use, use of emotional support, use of instrumental support, behavioural disengagement venting, positive refraining planning humour acceptance and religion self-blame of two items each. Participants were asked to

respond on a four-point Likert scale, indicating what they generally do and feel following CSA disclosure of their children-related stressful events. The higher the score on each coping strategy, the greater the use of the specific coping (Cooper et al., 2008:834).

✿ **The fourth section was post-traumatic stress disorder** (Blanchard, Jones-Alexander, Buckley & Forneris, 1996:670). This is a specific version (PCL-S) (Blanchard et al., 1996:670). PTSD symptoms comprised 17 items that corresponded to the key symptoms of PTSD. It is a 5-point scale. It is based on DSM-V criteria and takes 5-7 minutes to complete. The scale is a standardized self-reporting rating scale for assessing.

✿ **The fifth section was the Social Support Grid** which measures social support in stressful environment and to assess support received (Blanchard et al., 1996:670) by mothers of SAC from professionals, family and friends. Scores resulting from the past use of these instruments demonstrated reliability.



The social support scale (see indicators below) was used to measure the support mothers of SAC received from a network of family and friends, friends or other people that availed themselves of support either for a day, week or a month and the frequency of availability. It measured the number of relatives who visited. Social support helps people find solutions to problems, directs the affected individual to helpful information and provides comfort. This is the physical and emotional comfort given to a person by the family, friends and co-workers. People share viewpoints and

at the end a person can develop a better understanding and meaning of life. Social support decreases the level of stress that is experienced by the victim (Cohen & Wills, 1985:1).

❖ Indicators

- C1** The relatives who had the most contact
- C2** The visits of close friends or hearing from them; those who talked about private matters
- C3** The number of close friends who visited or seen at least in one month and include also friends who had the most contact
- C4** The close friend that the participant has the most contact with, how often she has seen or heard from that person
- C5-C14** It has a scale with 5 items ranging from none of the time to all of the time

This social support helps people find solutions to problems, directs the individual to helpful information and provides comfort. This is the physical and emotional comfort given to a person by the family, friends and co-workers. People share view points and at the end a person can develop a better understanding and meaning of life. Social support decreases the level of stress that is experienced by the victim (Cohen & Wills, 1985:310).The purpose of the scale was to investigate interaction in stressful situations.

3.7 Validity and Reliability

The validity and reliability of the instruments used are described below, namely, BDI, PTSD, Checklist specific version (PCL-S), Brief Cope and Social Support Grid. The BDI has been used extensively by researchers for its well-established standard to test psychological and physical depressive symptoms (Beck et al., 1988:79).It has been successfully used to test internal consistency in studies in many populations. It has

shown validity and reliability with clinicians rating depression (Beck et al., 1988:79). It is highly reliable regardless of the population and it is able to differentiate depressed from non-depressed people (construct validity). It is reported for high validity with coefficient alpha of 0.85 and it specifically assesses DSM-V symptoms of depression. It is extensively used worldwide for validity and reliability (Bumberry, Oliver & McClure, 1978:150). The brief cope scale has good internal consistency and test-retest reliability, and concurrent validity has been established. The scale was used in several studies to test participants' level of coping (Cooper et al., 2008:834). The PTSD checklist specific version (PCL-S) has an excellent test-retest reliability over a 2-3 month period. Internal consistency is very high for each of the groups of items corresponding to DSM-1V the items as well as the full item scale (Blanchard et al., 1996:670).

❖ Scoring

Respondents rated each item from 1 ("not at all") to 5 ("extremely") to indicate the degree to which they have been bothered by that particular symptom over the past month (Blanchard, et al., 1996:670). The PCL has shown good utility diagnosis.

3.8 Data Analysis and Interpretation

In this study data were analysed using the Statistical Package for Social Sciences (SPSS) version 21. Descriptive statistics was used to describe and summarize demographic data and experiences of the sample of mothers of SAC (Polit & Hungler, 1993:365). Pearson Chi-Square was employed to examine the association between the socio-demographic factors, depression, coping skills, PTSD and social

support. It is used to analyse nominal data to determine significant differences between observed frequencies (the actual frequency that is obtained from the sample) within the data and frequencies that could be expected (Burns & Grove, 2009:499).

The Chi-Square test of association does not explain the strength and the direction of association, if there is any. Therefore, Cramer's V which is a measure of association appropriate when both variables are nominal or when there is a nominal and ordinal variable was used if there is any association detected. Chi-Square is non-parametric, which means that no assumption has been made of a normal distribution of values in the population from which sample was taken (Polit & Beck, 2008:421). Bryman and Cramer's (1999:58) interpretation of the strength of association was adapted which suggests that: 0.19 or less is very low association, 0.2 to 0.39 is low association, 0.4 to 0.69 is modest, 0.7 to 0.89 is high and at least 0.9 is very high (David & Sutton, 2011:518-519).

The non-parametric Spearman's rho was used when the scores are already ranked (both variables ordinal scaled or for ordinal and ratio scaled variables). It varies from -1.0 (a perfect negative relationship) through 0 (no relationship) to 1.0 (a perfect positive relationship) (Morgan, Griego & Gloeckner, 2000:96). The Spearman's rank correlation coefficient was used to test the correlation between the ordinal socio-demographic variables and depression, coping skills, PTSD and social support and all other bivariate ordinal correlations.

The report of this study will be published in peer-review journals and feedback will be

given to the study participants and to the professionals concerned.

3.9 Summary

The chapter provided an in-depth description of the methodology of the study. Particular attention was given to the research design and methods, data collection and analysis, as well as interpretation of data, trustworthiness, validity and reliability. Ethical considerations were also discussed.

CHAPTER 4

FINDINGS OF THE QUALITATIVE STAGE

4.1 Introduction

This chapter focuses on the analysis and discussion of the findings of qualitative design stage. Data were collected through fieldwork at TTCC and at the participants' residential areas in the NWP. The method of data collection was unstructured in-depth interview which was based on a central question **"What were your experiences after the child's sexual abuse disclosure?"** This question was followed by probing as indicated by (De Vos, 1998:318).

Data saturation was reached after interviewing 17 participants (n=17). Fifteen (15) of the 17 participants' children were females while 2 of the 17 participants' children were males. Three (3) mothers were married, 12 single and 2 widowed. Nine mothers were employed and seven were unemployed while one was a pensioner. The ages of mothers ranged from 23 to 59 years. The ages of children ranged from 18 months to 16 years. Ten (10) mothers out of 17 were not supported (Table 4.1).

4.2 Discussion and Literature Control

Data was analysed using Tesch's eight steps of data analysis according to Creswell (2009:148). The Table 4.2 provides an analysis of themes, categories and sub-categories that emerged from the data of the experiences of mothers of SAC.

Table 4.1: Profile of mothers of sexually abused children

No.	Mother's Age (Years)	Marital Status of the mother	Age of sexually abused children	Gender of abused children	Employment status of mothers	Relationship of the mother to the perpetrator	Support Received
1.	42	Widow	18 months	Female	Employed	Cousin	Parents
2.	36	Single	16 (twins)	Females	Unemployed	Mother's cousin	No
3.	29	Single	10	Female	Employed	Stranger	No
4.	30	Single	12	Female	Employed	Stranger	Yes
5.	44	Married	10	Female	Employed	Stranger	Yes
6.	50	Divorced	16 (pregnant)	Female	Unemployed	Cousin and his friend (gang rape)	No
7.	59	Widow	16	Female	Pensioner	Strangers (2boys)	No
8.	32	Single	5	Female	Self-employed	Brother	No
9.	30	Married	7	Female	Employed	School care taker	Yes
10.	30	Single	5	Female	Employed	Neighbour (15years)	Yes
11.	35	Single	10	Female	Self-employed	Neighbour	No
12.	38	Single	4	Female	Unemployed	Neighbour	No
13.	23	Single	4	Male	Unemployed	Neighbour	Family
14.	40	Single	7	Male	Unemployed	Community member	No
15.	51	Widow	14 (pregnant)	Female	Unemployed	Gang rape (6 boys)	No
16.	24	Single	10	Female	Self-employed Selling	Cousin, brother	No
17.	39	Married	15	Female	Unemployed	School mate	Supported by professional, but not the husband

The following three broad themes emerged: (1) reaction of the participants to disclosure of child sexual abuse, (2) effects of sexual abuse on a child as viewed by mothers, and (3) experiences regarding the support participants received both formally and informally. Categories and sub-categories that emerged from each theme are discussed separately.

4.2.1 Theme 1: Reaction of the Participants to Disclosure of Child Sexual Abuse

Mothers of SAC expressed that they were suffering secondary trauma immediately when they became aware that their children were sexually abused. The secondary trauma was displayed by guilt feelings and self-blame, the anger experience of deep emotional pain, depression, suicidal ideation, self-isolation, financial constraints and psychological. From this theme, the following categories emerged: emotional and psychological reactions, socio economic reactions and spiritual reactions.

4.2.1.1 Category 1.1: Emotional and Psychological Reactions

Discussions with participants revealed that they suffered emotional and psychological trauma. This is discussed under the following sub-categories: guilt feelings and self-blame after discovering CSA, experience of emotional and psychological pain post-disclosure, depression as a result from disclosure of CSA and suicidal ideation.

4.2.1.1.1 Sub-Category 1.1.1: Guilt Feelings and Self-Blame After Discovering CSA

During the interviews, participants expressed experiences of guilt feelings and self-blame when discovering that their children were sexually abused.

Table 4.2: Themes, categories and sub-categories that emerged from the qualitative data analysis

Theme	Category		Sub-Category	
1. Reaction of the participants to disclosure of child sexual abuse	1.1	Emotional and psychological reactions	1.1.1	Guilt feelings and self-blame after discovering CSA
			1.1.2	Experience of emotional and psychological pain post-disclosure
			1.1.3	Depression as a result from disclosure of CSA
			1.1.4	Suicidal ideation
	1.2	Socio-economic reactions	1.2.1	Social reactions
			1.2.1.1	Self-isolation to protect the child
			1.2.2	Financial constraints
	1.3	Spiritual reactions	1.3.1	Coping through religious beliefs
			1.3.2	Coping through believing in supernatural powers
2. Effects of sexual abuse on a child as viewed by mothers	2.1	Physical and psychological trauma observations	2.1.1	Physical trauma observed by mothers
			2.1.2	Child experiences of psychological trauma
	2.2	Need to take revenge on perpetrators	2.2.1	Revenge on perpetrator

Continued/...

Table 4.2: Themes, categories and sub-categories that emerged from the qualitative data analysis (continued)

Theme	Category		Sub-Category	
3. Experiences regarding support participants received, both formally and informally	3.1	Experiences related to medical support	3.1.1	Experiences regarding the interaction with the multidisciplinary team that attended to their children
	3.2	Experiences related to legal support	3.2.1	Views about support received from police and the judiciary
	3.3	Experiences related to societal support	3.3.1	Views about support received from family
			3.3.2	Neighbours' willingness to support
			3.3.3	Community members' willingness to support
			3.3.4	The need to form support groups

They expressed that this becomes worse when the perpetrator is a family member. Some mothers reported that they blamed themselves and regretted having accommodated relatives who turned into perpetrators to their children. Many participants were suffering from enduring feelings of self-blame because they thought they were not alert enough to detect the sexual abuse being committed. Participants found it very difficult to believe that their relatives (the perpetrators) were responsible for sexual abuse. The mothers shifted the blame of CSA from the perpetrator to themselves.

One participant had this to say following her 18-month old baby's sexual abuse by her nephew:

The perpetrator is my sister's son - he is 22years old. I felt pity for him, he was not employed. I accommodated him so that I can help him to look for a job. I really feel guilty to have done that. He got the job, now he has sexually abused my baby (18-month old baby, tears rolling down her cheeks).

Plummer (2006:120), Hébert et al. (2007:807), Ullman (1999:354) and Massat and Lundy (1998:385) supported the participant's response by reporting that a mother's relationship to the perpetrator is linked to her emotional and psychological responses and outcomes. The same authors indicated that the perpetrator's identity is an abuse-related variable that independently correlates to the mother's distress score reaching a high clinical level. Pretorius et al. (2011:9) argued that when CSA occurs the mother is seen as a failure because of allowing the child to be victimized. They continued to say that blaming may unintentionally shift from the perpetrator to the mother.

The mother who requested a relative's son to come and live with them said this after he had abused her daughter:

Yes I ask myself questions. Why did I call Ndaba (not his real name) to come and live with me? I feel like I am irresponsible. I am angry with myself right now. I am hurting. (Crying hiihiii). In fact, I do not believe that this is happening second time around to my second child. I wish what happened to my baby could have happened to me, but not to an innocent soul (mentioning the name of the child). These days I am so forgetful. I did not think that he can do such a thing.

The quotation of the participant is supported by Smith (b) et al. (2010:264) who highlighted that parents of SAC may experience feelings of guilt, sadness, and worthlessness. The same phenomenon was mentioned by Plummer (2006:105) and Hamber and Lewis (1997:20). Emotional and behavioural responses of mothers of SAC after CSA disclosure include confusion, depression and uncertainty and difficulty of how to channel anger. Likewise, Elliot and Carnes (2001:320) reported that empirical studies have confirmed that parents experience higher levels of stress and self-blame. Many studies of CSA have demonstrated signs of self-blame and this was associated with poor psychological adjustment (Ullman, 1999:349; Smith (b) et al., 2010:264; Plummer, 2006:105; Hamber & Lewis, 1997:20).

In this study, the mothers demonstrated confusion, high levels of stress and anger because of not noticing that the child had been raped. Mothers shifted the blame from the perpetrators to themselves. They blamed themselves that they did not do enough to take care or protect their children from abuse. They felt that they were betrayed by family members and/or neighbours. Willingham (2007:15) found that parents experience difficulty in coping with their children's disclosure; they

experience anger and loss of trust towards the perpetrator.

4.2.1.1.2 Sub-Category 1.1.2: Experience of Emotional and Psychological Pain Post-Disclosure

The discussions held with participants revealed that they suffered emotional pain. Most participants endured emotional pain following their children's sexual abuse. The participants stated that it was not easy to forget what they had experienced. During the in-depth interviews, participants spoke about experiences of emotional and psychological pain following CSA disclosure. The pain experienced after CSA disclosure is expressed by participants in the following quotations.

One participant said this, when her child was sexually abused by a stranger:

It's a pain to discover that your child has been raped. It is a pain that will never heal. What makes me very sad is that the child is afraid and scared. At night she would take the couch (sofa) and close the sliding door with it, even if the sliding door is closed. She is afraid to go out at night. She's even afraid to go to the toilet inside the house all by herself. This is an unexplainable and unforgettable pain in me.

Carvalho, Galvao and Cardoso (2009:500) concurred with the quotation that mothers presented with inhalable pain as evidenced by difficulty in overcoming the experience of seeing their daughters being victimized. The authors further found that mothers experienced a range of feelings in which pain is highlighted.

This mother's twins were raped by her cousin, a 52-year-old traditional healer who is her cousin. A mother said this after the disclosure:

My twins, both of them, 16 years old confessed that they have been sexually abused by the same person... my cousin, my aunt's son - and a traditional healer for that matter. I

decided to lay charges against him and while the case was on my twins were still meeting him ...eh.. .one of them dropped the case. This is painful because my father says I should not have gone to police because he is my cousin. Ke setlhabimo go nna.

Fontes and Plumber (2010:508); Spataro et al., (2004:148) found that informal reporting and solving of CSA incest by family members enforce family separation. They further reported that alternative responses of not reporting the incest to the authority such as police aggravated the psychological pain experienced by mother of SAC (Fontes and Plumber 2010:508 & Spataro et al., 2004:148). In this study it is evident that cultural norms affected the decision taken by the mother of SAC which divided the family .The mother did not follow the culture of discussing first with the family before laying charges against her cousin (Fontes & Plumber 2010:508).

4.2.1.1.3 Sub-Category 1.1.3: Depression as a Result from Disclosure of CSA

Almost all participants expressed that they experienced uncontrollable anger against the perpetrator and other stakeholders who were unsupportive and failed to treat the child and mother professionally. They reported signs of depression and PTSD such as flashbacks, crying episodes and fear after being aware that the children were sexually abused. The response below is from a participant who reported the trauma she endured after her fourteen year old child was abused sexually by a group of six boys:

I am traumatized, I felt like my heart was beating faster and would stop for a moment. I think I was over-traumatized and not crying makes the heart weak. I felt like my vessels on the head were engorged, I had difficulty putting my head on the pillow. I had a headache. Imagine a 14 year old pregnant girl being raped by six boys.

Another participant had this to say after her six year old son was sodomized:

When I heard I became traumatized; it was the first time I heard and experienced this incident. I didn't know that a boy can be raped ...eh...!

In support of the above participants' quotations, Lewin and Bergin (2001:365) indicated that upon hearing that the child has been sexually assaulted the non-offending mother may experience severe emotional trauma. The mother may develop a variety of symptoms, such as: clinical depression, anxiety; and severe guilt for not noticing that her child was being sexually abused. In this study, many mothers presented with a change in sleep patterns.

The mothers exhibited high avoidant symptoms of depression and lowered self-esteem and self-worth. They were tearful and reported not to be coping with the emotional trauma. Participants were preoccupied by what happened to their children. They were distressed because they were faced with multi-tasks of protecting the children, from being attacked by the perpetrator; support the child during the healing process and to deal with their own psychological and emotional status created by CSA disclosure.

4.2.1.1.4 Sub-Category 1.1.3: Suicidal Ideation

Many mothers of SAC expressed feelings of wanting to commit suicide as a form of self-punishment because they felt guilty of failing to protect their children from being sexually abused or failure to observe that CSA is taking place in the immediate environment.

A participant recounted the sexual abuse of her 16 year old pregnant daughter who was abused by her (the girl's) cousin and another boy:

I didn't go with her to the hospital - I was traumatized and crying. Her stepfather is the one who went with her. I nearly killed myself. I was at work when I heard that the child had been raped. When I heard, she was already at Thuthuzela. She phoned me and said "mom I am raped, my panty is on the doorway you will see it." Indeed when I got home I found the panty at the door. She was raped and she is pregnant. She was raped by her cousin and his friend.

Another participant echoed the same sentiment:

I felt like someone who is mentally disturbed, I was stressed. I kept thinking a lot of things, this was the first time I experienced something like this, I felt like killing myself or wished I was dead. I felt better after talking to the police and the nurses at Thuthuzela. I told myself that as long as my child is alive and still going to school, it is better.

In line with the above expressions of the participants, Hill (2001:38) reported that CSA is a crisis with disruptive long-term effects on the mother's life. The mother may develop suicidal ideation, self-blame, low self-esteem and even psychological distress. Hill (2001:38) is supported by Plummer (2006:105) who found that mothers of SAC demonstrated a wide range of psychological difficulties that included anger, hostility, poor self-esteem, suicidal ideation, homicide, self-destructive behaviour, PTSD symptoms, somatic complaints and behavioural problems.

In this study, the distress experienced by mothers of SAC was related to the social support the mothers received and coping strategies they employed to deal with their environment. Their predisposition to committing suicide was to avoid experiencing future pain and suffering of their children caused by bad CSA outcomes.

4.2.1.2 Category 1.2: Socio-Economic Reactions

During the discussions of this category, participants expressed socio-economic reactions. This is discussed under the following sub categories: Self-isolation to protect the child and financial constraints.

4.2.1.2.1 Sub-Category 1.2.1: Social Reactions 1.2.1.1 Self-Isolation to Protect the Child

Few mothers expressed that they isolated themselves from the family, friends and community because they did not want to be blamed, stigmatized or ostracized for something that they could not account for. Some of the reactions were behavioural such as being withdrawn and a mother isolating herself.

A participant said this with bitterness:

I was scared, telling myself firstly that he could have killed him; it is only by luck that he is still alive and the perpetrator is a quiet person. He could have killed and hide him somewhere, those are the things that went through my mind. Those are the things that make me isolate myself from the rest of the society. How can I live in such conditions of being seen as an irresponsible parent who cannot protect an innocent soul..eh...a mother who is not looking after her child. People are not friendly anymore.

The quotation from this participant is supported by Alaggia and Kirshenbaum (2005:232) and Hamber and Lewis (1997:33) that the experience of stagnated dependency reduced the level of social integration, and increased the social disintegration, which produced the potent factors that contribute to suicidal ideation.

In this study, mothers isolated themselves with the aim of protecting the child from the abusive environment and from being treated as an outcast. Participants reported

feelings like hiding from public after the CSA disclosure. Other mothers moved away from their communities because of the stigma that community members attached to their SAC. Mothers were affected by different environments such as family, community influences, cultural and societal attitudes. They did not open up to anybody because the disclosure of their CSA has affected their intimate relationship with the rest of the family members, neighbours and even friends. Parents isolated themselves with the aim of protecting the child from the abusive environment (Celano et al., 1996:1; Alaggia and Kirshenbaum, 2005:232; and Hamber & Lewis, 1997:33).

This citation again is supported by Allaggia (2010:32) when indicating that mothers are affected by different environments such as family, community influences, cultural and societal attitude and that mothers of SAC usually feel isolated, withdrawn, lonely after the disclosure of CSA because they belief that friends, community and some family members may blame them for being irresponsible or responsible for sexual abuse.

4.2.1.2.2 Sub-Category 1.2.2: Financial Constraints

Participants expressed lack of finances as a barrier to travel to different institutions where the child is required to go, to obtain an identity document as well as to buy food for the family as they are unemployed. Most of them expressed not to be receiving social support from anybody.

An unemployed mother who did not have transport money to take the child for appointment at TTCC said:

Yes! I was hurt because those people caused me many problems as I'm unemployed, my children do not receive any grants and I don't have identity documents. My children and myself cannot receive social grants because I do not have ID, so I am running after piece jobs so that I can have money to buy food. If I am to take her to the clinic (meaning TTCC) where will I get the money from? Am I to leave behind my blind father to run after this police case again? They even deprived me of my job and they messed up with my children's food. (Ba senya papa ya banake). This situation gives rise to more financial problems.

The other participant said this after her daughter was sexually abused while she was out to do a piece job (sekoropo):

If I can get money next week, I will call that other police officer who gave me his numbers and said I should call him when things get delayed or if I want to go to the clinic. If I don't get money I will not go the clinic, the option will be to leave these children alone again to look for a job, and this exposes them to sexual abuse again.

The quotations above strongly suggest that poor socio-economic conditions contributed to mothers not honouring appointments given by professionals at TTCC. Similar to the findings of this study, Richter and Dawes (2008:86) reported that the high levels of unemployment in South Africa results in family stresses. In the same vein, Madu and Peltzer (2000:264) indicated that lack of job opportunities in the mothers' vicinity make many parents to leave their children alone or with relatives to find work, thereby leaving their children vulnerable to all sorts of abuse, including sexual abuse. Smith (b) et al. (2010:258) concurred with Madu and Peltzer (2000:264) and Richter and Dawes (2008:86) that orphaned or neglected children whose parents leave them at home to travel long distances to work are also at an increased risk of CSA. This study identified that most participants live in poverty, mainly due to unemployment; as a result they do not take their children to the health services for

follow -up visits. They leave their children alone to look for temporary jobs (matogo/skrop). Leaving children alone puts them at risk of being sexually abused. Mothers borrow money to take their children to health services. CSA has a significant socio-economic and emotional impact resulting in a range of responses from mothers. The study found that the impact of CSA disclosure and financial constraints rendered the mother ineffective to take decision or to prioritize her needs.

4.2.1.3 Category 1.3: Spiritual Reactions

During the discussions of this category, participants expressed different experiences. This is discussed under the following sub categories: coping through religious beliefs and coping through believing in supernatural powers

4.2.1.3.1 Sub-Category 1.3.1: Coping Through Religious Beliefs

During interviews mothers expressed that they would be helped by God in whatever is happening to them. Some wanted to know what they have done to suffer secondary trauma of their CSA disclosure.

One participant said:

God help me to pass through this and to concentrate on the children, to take care of them and not let them go far from my sight, eh! why me. Taking her to TTCC will not change what has happened. God will help?

Spiritual reaction was reflected during an interview when one of the participants said:

I relied on reading the bible that is where I received comfort. After scripture reading I felt relieved...Oh the tension...eh ijooo ... the emotional pain.

The experiences expressed by these mothers were confirmed by Willingham (2007:16) when reported that mothers had mixed feelings and conflicts due to their cultural and religious beliefs. Meichenbaum (2008:7) indicated that spiritual beliefs interfere with medical seeking behaviours, undermine adaptive coping and the healing process, these findings are contrary to the findings of Willingham (2007:16) and Meichenbaum (2008:7) further added that religious beliefs can reinforce prejudicial stereotypes and contribute to intolerance. The same author also indicated that God is viewed as being punitive, vengeful and withholding this can contribute to higher levels of stress. Contrary to Meichenbaum (2008:7) and Willingham (2007) Murray-Swank and Pargament (2007:192) conducted a study to examine if spirituality brief intervention could be a resource to address the spiritual struggle in females coping with sexual abuse. Consistent with the findings of this study some mothers of SAC experience spiritual struggle with their children's sexual abuse disclosure, anger at God and spiritual isolation. They further added that women moved from the struggle of anger to spiritual changes in the use of positive religious coping.

Meichenbaum (2008:7), Jones and Trotman Jemmott (2009:94) also found that religion is an important aspect of life to the majority of respondents and this is considered throughout the country. Pugh (2012:18) also contradicted Meichenbaum (2008:7) by indicating that religion gives meaning, hope and comfort. He further advocated that the minister of religion must give spiritual care and the family, friends and community must offer them spiritual care. Pugh (2012:19) further said the survivors must be listened to, allowed mourning the losses they have experienced and try to be patient with their emotional status. Chaplains are to offer spiritual care

and respect the beliefs of the people. The spiritual care that should be given should include touch, listening, valuing patients and also the presence of the nurse is very important.

This study revealed that religion and spirituality are linked to our identity as human beings. Mothers in this study questioned God about their children's experiences. It was also found that stress can decrease if a prayer is used as a form of pleading to God. By analogy, mothers did not taking their children to TTCC or failed to lay charges against perpetrators in the hope that God would intervene on their behalf. Mothers expressed that God is their comforter and protector, especially when they experienced serious problems and that they intended abiding with His promises of love and protection. They said they believed that God would always be on their side.

4.2.1.3.2 Sub-Category 1.3.2: Coping Through Believing in Supernatural Powers

During interviews, some mothers indicated that they were directed or told by ancestors or supernatural powers to take particular actions. They claimed to be hearing voices that gave them direction about how to handle the perpetrators. Some of them concluded that perpetrators are bewitched.

A participant whose child was abused sexually by one of the community members, not living far from her said:

I wanted to lay charges against him but...eh then because I believe in ancestors, they (ancestors) they told me not to lay charges against him. I asked for help from them (ancestors) and they told me to take him to the social workers, but not to the police.

One of the participants said:

I told myself that I'm fine even though this man raped my child ... I will no longer lay charges against him, I will withdraw this case because I kept on hearing the voices of my ancestors telling me not to fight them or lay charges against the perpetrator.

Andrew, Gray and Snowden (2008:1414) conducted the study to examine the relationship between trauma (child sexual abuse) and belief about hearing voices. The findings suggested that the important factor in determining beliefs about voices might be the persisting effects of psychological trauma (Andrew et al., 2008: 1415). They further alluded that CSA disclosure is a trauma that might contribute towards depression and beliefs about voices (Andrew et al., 2008:1415). This is evident that mothers were already exhibiting with symptoms of PTSD.

A mother whose son raped his biological five year old sister said:

I don't know why this boy is doing this, are ancestors punishing me or is it witchcraft? A badimo ba nkwatlhaya kgotsa ke boloi ,motho ga a rape kgaitsadie eh eehee"but ehee my son raping his sister?...eh ke eh ...When I experienced this I thought I would get support from people, telling me that this was a mistake and I should forgive my son, no one came to me. I was shocked, I denied, but it had happened.

Contrary to quotations above there is dearth of literature that supports the perception that CSA perpetrators do it because of witchcraft or that voices can determine the actions to be taken by guardians. A study conducted in KwaZulu-Natal about the views of traditional healers on CSA reveals that, to a limited degree, traditional healers do treat both families and victims of CSA (Schoubben-Hesk, 1997:96). Schoubben-Hesk (1997:97) further indicated that treatment is predominantly through medication and purging and it is seldom that psychological

support is included. Nothing is mentioned about incest being related to witchcraft.

Other participants claimed that God and ancestors helped them to take decisions. This study revealed that mothers of CSA were experiencing and enduring unexplainable psychological pain as well as maladaptive coping skills post-sexual abuse disclosure. The pain expressed is a fundamental characteristic of the emotive life which evidences the certainty of permanent trauma. It is difficult to overcome it because it remains after disclosure and destroys a person's emotional, physical, psychological, spiritual and socioeconomic well-being.

Mothers need support from various stakeholders so that they can overcome the pain of guilt, of not being supported by stakeholders, of not having finances that would enable them to take their children to health services, of being stigmatized by community members, that lead to shattered coping skills, of loss of their children's virginity, and pain of not enjoying childhood as well as pain, experiencing family violence, especially if the perpetrator is a family member.

4.2.2 Theme 2: Effects of Sexual Abuse on a Child as Viewed by Mothers

During data collection, mothers expressed that their children suffered various types of trauma such as psychological and physical trauma, and behavioural reactions. Two categories emerged from this theme, namely, physical and psychological trauma observations, and need for revenge on perpetrators.

4.2.2.1 Category 2.1: Physical and Psychological Trauma Observation

Participants expressed to be observing signs of psychological and physical trauma in their children. This is discussed under the following sub-categories: physical trauma observed by mothers and child experiences of psychological trauma

4.2.2.1.1 Sub-Category 2.1.1: Physical Trauma Observed by Mothers

A mother said this, after her girl was sexually abused several times by an adult male stranger:

I saw yellowish discharges on her panty; I asked her, she cried, the brother told me that not only discharges but also some faeces as well as urine on the panty. I asked my sister to come and talk to her. She refused to tell my sister. My sister took her to her home, there, she related the whole story. My sister reported to the police and myself ultimately we ended up at TTCC. The doctor says the child is torn, the vagina and the urinary bladder are damaged, and I don't know where the faeces come from. I am told that operation is very expensive. (Crying, covering head with dress, standing up and sitting down, very restless). The doctor very empathetic ... tears rolling on her cheeks. My daughter ... her genital is torn, this is a life-time trauma on me and involves eh eh (crying) ...I am hurting. It is unbelievable, my 10year old child.... Her vagina is torn; the doctor says she needs reconstructive surgery.

A participant had said this to say after her six year old son was sodomised:

Yes because he couldn't walk properly. He was showing that something was wrong. This is hurting.

One of the participants articulated this after her baby was sexually abused:

The private parts were red, swollen and bruised. The baby did not want me to touch her to remove the pampers (meaning a napkin). The first suspect is my nephew, because he

*volunteered to take care of the baby, he did not want the child to go to crèche.
(Crying, tears dribbling on her cheeks).*

In support of these quotations, Allnock (2010:2) and Kisanga, Emmelia, Urassa and Nystrom (2012:16) found that mothers of SAC expressed that their children experienced physical trauma at an age that no one can believe and accept. Allnock (2010:5) reported to be shocked by the degree of force used by the perpetrator, which ended up causing internal lacerations, bleeding and other types of physical trauma on the child. According to Allnock (2010:3), children die due to physical trauma to the genitalia or rectum and vagina. Allnock (2010:16) added that in severe cases, damage to internal organs occurs, which, in some cases, may cause infections and sexually transmitted infections.

In this study, the effects of CSA are worrying and are far-reaching because it impacts negatively on the family, mother, child, the relationship with the community as well as the society. It is concluded that it is better to leave children alone rather than to leave them with ungodly family adult members. It is also realized that mothers are tortured by observing physical trauma suffered by their children.

4.2.2.1.2 Sub-Category 2.1.2: Child Experiences of Psychological Trauma

In an interview held with mothers of SAC, they reflected that their children experienced psychological trauma. The trauma experienced by these children is illustrated as follows:

One participant said:

The other thing, she is afraid of men. She runs away when she sees them, right now my father and mother are here to support, me but she hates seeing my father. The old man outside the house is my father. She hides herself behind my mother when my father is approaching her.

A participant whose five year old son was sodomized said after the disclosure:

I can't say there aren't any changes because he was doing fine at school then after the incident he became forgetful, right now he failed his grade. He was not like this. He is sometimes in deep thoughts, even when he is eating. He is no longer performing well at school.

Another participant echoed this:

Yes she has changed, she is trying to make herself strong, but I can see she is no longer like before. Sometimes when she is alone sitting, it seems like she experiences flashback and she would get scared, and when I ask her she would say it is nothing. When I see her like that I experience emotional pain. (Crying)

These quotations are supported by the study conducted by Spataro, Mullen, Burgess, Wells and Moss (2004:418) that revealed a subtle difference that existed in the responses to CSA and also found that both genders show equal adverse mental health outcomes. In this study, mothers observed that their children presented with frightening memories, constant danger and they were unable to trust people, especially men. The mothers also experienced that CSA affects children's education; and mental status because they could not concentrate in class, as evidenced by the failure rate at school. Children felt vulnerable, helpless, unsafe, and they experienced trauma, and were anxious and withdrawn from other children. The findings of this

study are consistent with Astbury (2013:1) and Spataro et al. (2004:18), in their study found that CSA trauma alter the child's psychological well-being and may present with the following PTSD major symptoms that may include self-blame, guilt, self-destructive behaviour, poor performance at school and sexual disturbance.

4.2.2.2 Category 2.2: Need to Take Revenge on Perpetrator

Mothers expressed that the majority of children were bribed and threatened to be killed by perpetrators. They also noticed that the young children are frequently abused by people that are known such as neighbours. Only one sub-category emerged from this category, namely, revenge on perpetrator.

4.2.2.2.1 Sub-Category 2.2.1: Revenge on Perpetrator

During an interview, participants reiterated that the perpetrators are heartless persons who are merciless and ungodly because they harmed innocent souls. The mothers felt that the perpetrators did not deserve to live. Mothers said perpetrators should be brought to book.

A participant said this with tears dribbling on her cheeks:

The solution is to kill this man, he is a dog. I want him dead. Imagine almost every day taking the child to an RDP house to abuse her sexually.

A furious participant had this to say:

I just want to see him behind bars because I don't know his motives, as there are chances that he might come and rape her again.

Another participant said:

I don't want this case to be dropped because at the end of the day they are going to kill my child. Their parents wanted to give us money so that the boys can be released, the father of my child refused and I also refused. I don't want this case to be dropped. Let him stay and rot (a a bolele ko tronkong) in jail - that is where he belongs.

Jones and Trotman Jemmott (2009:16) concurred with the mothers' utterances that perpetrators should be severely punished and that law enforcement is seen to be ineffective because perpetrators of CSA are not apprehended. Richter and Dawes, (2008: 87) supported Jones and Trotman Jemmott (2010:16) by asserting that a large proportion of perpetrators of CSA involve teenagers who live in the same households with the child, or nearby, and are known to the child.

Willingham (2007:15) found that parents experienced difficulty in coping with their children's disclosure; they experience anger and loss of trust towards the perpetrator. Jones and Trotman Jemmott (2010:11) argued that survivors are abused by cousins, uncles, school caretakers and young men in the community. If the CSA was incest, the mother may experience a feeling of helplessness, impending financial hardship, betrayal and depression (Fong & Walsh-Bowers, 1998:30).

In this study, it is found that perpetrators were merciless and that the majority of them were known by survivors, family members and community. The findings of this study are corroborated by Kisanga et al. (2012:16) who indicated that rapists were known to survivors and that the majority of perpetrators were family members, neighbours, followed by strangers who were among the common perpetrators.

Mothers usually felt like revenging, they suffered anguish, and expressed anger and rage towards the perpetrators and their family members. Perpetrators are to be prosecuted, not to be seen on the street and are to be reported to police officers, as well as community policing forums. Perpetrators were granted bail by the justice system and there is general leniency towards sexual offenders.

4.2.3 Theme 3: Experiences Regarding Support Participants Received, Both Formally and Informally

This theme emerged from data analysis of the experiences of mothers of SAC in relation to the support they received from stakeholders. From this theme, three categories were identified, namely, experiences related to medical support, experiences related to legal support and experiences related to societal support.

4.2.3.1 Category 3.1: Experiences Related to Medical Support

During interviews, mothers reported their experiences of delays in receiving assistance from health professionals. The health professionals did not provide them with information and support. From this category, the following sub-category emerged: experiences related to the interaction with the multidisciplinary team that attended to their children. This sub category is discussed below.



4.2.3.1.1 Sub-Category 3.1.1: Experiences Regarding Interaction with the Multidisciplinary Team that Attended to Their Children

Participants expressed that they wanted their children to be seen and examined by a multidisciplinary team such as social workers, psychologists, counsellors, nurses and doctors, but in most cases the team was composed differently. Mothers reported that

some professionals were good while others did not show much interest in examining the child.

Mothers had this to say:

When we explained our problem to them, we never stood in the queue. The person who was testing her was heartbroken that she was raped sleeping in the house.

They took a list of children names of SAC sent to them from the school where our children are attending. My child was not the only one. It was a group, especially those who are overweight (Ba ba mafuranyana). The parents of children who experienced this received letters from the school and appointments at Thuthuzela were made according to dates. We went to Thuthuzela, we waited for a long time - it took long because it seemed as if no one cared. They knew that we were coming, but when we arrived there it was as if no one knew. We were there the whole day; we took the child to lunch and went back to wait. The time was 16:00 when we were helped. Everything happened slowly there.

Smith^(b) et al., (2010:263) indicated that participants who reported unprofessional treatment by nurses or not receiving information concerning the status of physical examination, may be victimized and therefore not likely to be engaged in help-seeking behaviour. Kim et al. (2010:621) supported Smith^(b) et al., (2010:263) that professionals who work with mothers of SAC may need to assess the current psychosocial functioning and childhood parenting practices. Such interventions for the mothers of sexually abused daughters may increase the possibility for resilience in the SAC. Mothers expressed various types of interpersonal relationship experiences with multidisciplinary teams. Some mothers reported to have received good care from the multidisciplinary team while others were complaining about the negative attitudes of health professionals.

A mother said this, when she was relating what she experienced at clinical services:

It's a social worker, she saw her, and told me s/he is still busy, but since then she never came back to me she just left me like that.

Plummer and Eastin (2007:778) concurred with the participants' quotations that mothers received unfair treatment, they were judged and blamed, received unsolicited instructions on mothering and were accused for promoting false allegations of CSA. Smith ^(b) et al., (2010:263) argued that participants who reported unprofessional treatment may be victimized.

This study revealed poor interpersonal relationships among the multidisciplinary team and participants. Such a scenario makes participants to avoid asking professionals questions concerning the whole process of treatment. Lack of trust in professionals made mothers not to open up. Mothers restrained their emotional responses to satisfy professionals due to their negative experiences with professionals; many mothers used maladaptive coping skills to avoid professional help. Atoro, Jones, Magnuson, Shadion and Walsh (2010:298) the idea that the professionals do not seriously address the needs of the non-offending caregivers, they further expressed disappointment with the way the professionals interact with them. Atoro et al., (2010:289) further reported that they were not adequately informed about the proceedings and services to be rendered post CSA disclosure. Carnes, Amy and Shaidoin (2006:14) reported that care givers were to have knowledge about CSA at baseline, though mostly misinformation was evident. They further indicated that misinformation was related to items about investigatory process of CSA, legal and medical procedures and this concur with the findings of this study.

4.2.3.2 Category 3.2: Experiences Related to Legal Support

Participants expressed different views regarding the support they received from the legal fraternity. Some expressed that the police were supportive while others indicated the contrary. This is discussed under the following sub-category: views about support received from police and judiciary.

A participant, who was happy about how the police officers responded, said:

I would like to thank our police officers in cases like this, because when I notified them about an incident of gang rape, they responded immediately. They didn't waste any time, they made sure we go to the doctor. They really supported me, even the nurses and doctors at the hospital. They advised me and tried to comfort me about what had happened. Even today when I arrived here they (nurses) advised me how to handle this case. Eh ... my daughter being raped by six people.

Another participant said:

I met the nurse and the police. The police explained everything to me, how things were going to be done and that the perpetrator is going to be arrested if he's found guilty. They gave me support.

Yet another participant had this to say:

The police did the investigations; they called the forensics experts to take photos where the incident took place. They also called the perpetrators so that they could examine their urine to check if it would match. They brought them here to the hospital to examine them.

4.2.3.2.1 Sub-Category 3.2.1: Views About Support Received from Police and the Judiciary

Different views were expressed by mothers during interviews, including that most of the police officers were cruel and not supportive; they also mentioned that the

judiciary released perpetrators unlawfully.

One mother said this after her child was sexually abused:

He is arrested, but I have lost confidence in our judiciary, even police, they will release him saying there is no evidence. They did that with another daughter of mine.

The pain is aggravated by the fact that the police officer who is handling this case has never shown up, he keeps on sending SMSs saying he will come, look at this SMS (showing the researcher).It is two months now, but nothing is happening.

A mother whose child was several times abused sexually by a stranger:

I am bitter about the police, they are prolonging the investigation, and meanwhile I experience more traumas. I am having sleepless nights. I do not like going to work anymore. I wish I could take my child to and from school, sometime I feel like killing myself. (Crying)

The participants' quotations are supported by Hamber and Lewis (1997:6) who reported that members of the police service dealing with victims often do not regard rape and domestic violence as crimes. Furthermore, Hamber and Lewis (1997:6) indicated that police avoided arresting the perpetrators, but requested the victims to reconcile with perpetrators. Hamber and Lewis (1997:6) are supported by Jewkes and Abrahams (2002:1240) with regard to the poor services by police and other professionals which seemed to intensify the mothers' emotions, particularly outrage, isolation, vulnerability and helplessness and that the government and legal systems often fail to respond to sexual assault and that only a small number of rape cases are tried in court. Judges and magistrates tend to offer light sentences to perpetrators

(Jewkes & Abrahams, 2002:1240). Contrary to the above, this research provides evidence that some police officers were supportive to the mothers of SAC.

This study revealed that some police officers were supportive. The judiciary disadvantaged mothers of SAC because it is always said that there is no evidence. Mothers gave evidence when they caught the perpetrator in action, but still the judiciary did not take that as evidence. It has been observed that only few cases of CSA reach the judiciary and apparently only few cases of sexual abuse offenders reach trial.

The court is viewed as an important institution to help both the mother and the child and yet mothers see the court as harsh because it fails to communicate the outcome of the court proceedings to them. Dissatisfaction experienced by mothers is high since they are not given information or feedback about the court proceedings.

4.2.3.3 Category 3.3: Experiences Related to Societal Support

During interviews, the participants indicated that they really need to be supported by all stakeholders of various services. Their experiences are discussed in the following four categories: views about support received from family, neighbours' willingness to support, community members' willingness to support and the need to form support groups.

4.2.3.3.1 Sub-Category 3.3.1: Views about Support Received from the Family

Mothers of SAC expressed lack of support by some family members as a major

concern. The scenario becomes worse when there is incest. Participants reported that they experienced a poor relationship between the family members. There is little support that is given to alleviate the needs of mothers of SAC.

Participants said:

The day I came here, I was with my aunt. She stayed with us for some days.

My family is supporting me, my husband, sisters they phone nearly after every two days.

My sister visited me and she went back on Saturday. My family keeps on calling me to hear about how the case is going.

Her father too is supporting me; he comes regularly to check up on her.

Yes, my brother asked me to accept; even if they are not arrested (6 boys) it will get better as time goes on, because now they are giving the child a tough time at school. I wish the teachers could engage the police in matters like this. They bully her,...eh, it would be better to call the police when they do this.

Smith^(b) et al. (2010:266) concurred with the participants quotations that a family systems approach, which is supplemented by the Western perspective, should be adapted to address the needs of South African CSA survivors. It is important that therapists and counsellors remain aware of Ubuntu (Smith ^(b) et al., 2010:266). Campbell, Dworkin and Cabral (2009:233) confirmed Smith ^(b) et al. (2010:266) in that social support from family, friends and intimate partners facilitates sexual assault survivors' recovery.

Many participants during interviews articulated that family members were not supportive and passed remarks. They said family members blamed them for laying charges against perpetrators before the matter is discussed within the family.

A participant articulated this:

I told her to leave her here with my twins, she said to me: 'I don't trust your twins, do you want them to take our brother's child to Chris (not his real name) so that he can rape her as he did to them. These remarks caused me distress.

Other participants said:

The father doesn't show any interest and the child is ours, he doesn't make any effort. I just told myself that I will deal with the matter alone without the father even though the kids are not mine alone.

My mother came and stayed with us for a while, she was also complaining that I should have called her first before I opened a police case for my son who sexually abused his 5-year old sister.

This incident caused a misunderstanding between me and my husband. He thinks I allow this child to do as she pleases.

The participants' quotations in this study are in agreement with the findings of the study conducted by Elliot and Carnes (2001:320) who found that the victims' families experienced numerous stress-inducing changes following a child's disclosure of sexual abuse. Parents and family members of sexually abused children may experience feelings of guilt, sadness and worthlessness (Smith ^(b) et al., 2010: 264).

This study substantiated the need to support mothers of SAC. If an appropriate intervention is not employed, families may continue in dysfunctional environments. Family cohesion is important to help mothers and the SAC to cope with the trauma and unbelievable experiences. There is a need to strengthen family support. The researcher suggests that parents should support each other and that no one should blame each other.

4.2.3.3.2 Sub-Category 3.3.2: Neighbours' Willingness to Support

Mothers reflected on having experienced a lot of support from neighbours. The neighbours were really willing to assist where necessary. Mothers reported unbecoming behaviour only from the parents and relatives of neighbours who abused their children.

Participants said:

Actually when the child was raped, she ran to that shack there (pointing), she told the lady who lives in that shack and the lady called the police. When I knocked off duty I was stopped by the police and that was when we went to the police station, after that we took her to the doctor at the...

Neighbours checked why I was screaming.

The next door neighbour is the one who chased those boys away when they were busy raping her. He says he saw them clearly and can even identify them.

Plummer and Easton (2007:781) confirmed that mothers are often blamed by the society, community, neighbours and friends that they interact with. Being blamed often makes them to feel guilty and even withdraw from family members, friends and significant others. Plummer and Easton's (2007:781) results are contrary to the findings of this study as neighbours were very supportive.

4.2.3.3.3 Sub-Category 3.3.3: Community Members' Willingness to Support

Most participants during interviews reported receiving positive support from community members. Community helped to report perpetrators of sexual abuse to mothers and family members.

Participants said:

They saw her when she was leaving her aunt's house, as she was entering our gate they approached her. They got hold of her and snatched her. They took her to the railway line where they raped her. Their intention was to take her to the female initiation school. While they were busy raping her, an old man approached them. That old man told them that they can't take her to initiation school when they have already raped her; he told them to take her to her home. They then took her home. As she got home we called the police.

Community members caught the perpetrator and brought him to our house I hope he will be brought to book.

Teachers observed that the child is withdrawn, does not write, talk, always crying and poor school progress.

Bein (2011:13) supported the idea that the community must support the mother of SAC by advocating that institutions such as churches, schools, should support the survivors by engaging in some activities. Institutions should prepare professionals to serve survivors from a wide range of communities by providing education that focuses on victims practices, share information about other community systems and services, participate in community activities, as well as interact with all systems so as to know and convey the local practices of the institutions and professionals so that the victims assisted can take informed decisions (Bein, 2011:13). In this study the community supported the mothers of SAC.

4.2.3.3.4 Sub-Category 3.3.4: The Need to Form Support Groups

During the interviews, mothers expressed that they needed support of other mothers who had experienced the same ordeal. They expressed that talking to other mothers

would make them feel and cope better. Talking to them would equip them with coping skills.

Participants said:

I want to meet people like me who experienced the same trauma so that we can hold some group discussion so that one can get an idea of how others coped.

I believe that speaking to people who experienced the same ordeal will motivate me, or who will tell me that such incidence does exist, perhaps after talking to them I will be better.

Yes, then we would know what to do and the parents must also receive counselling. Her father doesn't talk much, so you can't know what is in his mind or maybe he has made up his mind to do something, or he blames me for not taking care of his children, so it will really help us if we parents receive counselling.

In this study, findings revealed that mothers sought professional counselling services after disclosure of CSA. Counselling should include individuals, groups and family members. Professionals should provide sessions of psychotherapy and counselling to debrief the mother so that healing and closure could be facilitated for the mother. It is imperative to find strength to support and reassure the mother of SAC after the CSA disclosure.

Plummer and Easton (2007:784) argued that non-offending caregivers, after disclosure of CSA need fair and impartial treatment from professionals; more tangible assistance with perceived financial needs; good legal counsel; support groups and/or counselling; and clear, consistent messages from the various assisting professionals.

Studies suggest that cognitive-behavioural treatment that combines parent and child

interventions may lead to better adjustment in both the child and the parent (Elliott & Carnes, 2001:321). Parental support programmes available include social, legal psychological and financial support after disclosure of CSA. Studies have found that support systems for mothers of SAC are very limited (Hébert et al., 2007:809). Non-offending mothers in South Africa appeared to have very few institutional and social support resources available to them (Hamber & Lewis, 1997:41). In this study, mothers clearly need support from all stakeholders so that they, in turn, can support their children during their traumatic stage, but they themselves are not recognized as secondary victims of CSA.

4.3 Summary

This chapter provided the analysis and findings of the qualitative design and the relevant literature control. The qualitative data were analysed and grouped into three themes that emerged during data analysis. This stage provided the following significant responses from mothers of SAC post sexual abuse disclosure: reaction of participants to the disclosure, effects of sexual abuse on a child as viewed by the mothers, and participants expressed their experiences regarding the care they received, both formally and informally. The next chapter covers the findings of the quantitative design stage.

CHAPTER 5

FINDINGS OF THE QUANTITATIVE STAGE

5.1 Introduction

This chapter focuses on the quantitative results of the study and the discussion. The objective of the quantitative stage of the study was: to examine the relationship between socio-demographic factors and social support, coping strategies, depression and PTSD. This chapter will hence present the overview of the demographics of the participants, the prevalence of social support, coping strategies, depression and PTSD, which were found through the use of frequency distribution. Lastly, these variables were compared using cross-tabulation Chi-Square analysis.

5.2 Overview of the Demographic Factors

Table 5.1 summarizes the demographics of the participants. The number of participants was 180 and the majority were Blacks. The results showed that 90% of participants were Black compared to 10% Coloured. In addition, the majority of the participants were Batswana (51%) followed by Southern Sotho (11%), then by Xhosas and Coloureds (each at 10%), Zulus (8%), Shonas (7%) and Northern Sotho (3%). The majority (118; 66%) of the participants were employed and 62 (34%) were unemployed. Concerning marital status of the participants, 76 (42.2%) were married, 75 (41.7%) were single and the remaining 29 (16.1%) were separated, widowed or divorced.

Table 5.1:The demographic data of mothers of SAC

Characteristic	Frequency (n)	Percentage (%)
Racial Group		
Black	162	90
Coloured	18	10
Ethnicity		
Tswana	91	51
Shona	12	7
Xhosa	18	10
Zulu	16	8
Southern Sotho	20	11
Northern Sotho	5	3
Coloured	18	10
Education Level		
Never attended school	11	6.1
Grades 1-4	13	7.2
Grades 5-8	29	16.6
Grades 9-12	105	58.3
Diploma or undergraduate degree	22	12.2
Employment		
Employed	118	66
Unemployed	62	34
Age Group		
19-29	58	33
30-40	63	35
41-50	35	19
51 and above	24	13
Marital Status		
Married	76	42.2
Single	75	41.7
Separated/divorced/widowed	29	16.1
Total	180	100

The ages of the participants ranged from 19 to 70 years with 63 (35%) of them ranging between 30 and 40, 58 (33%) between 19 and 29, 35 (19%) between 41 and 50, and 24 (13%) were 51 years of age and older. Most of the mothers of SAC (105; 58.3%) who participated in the study completed Grades 9 to 12, 29 (16.6%) Grades 5 to 8, 22 (12.2%) had a diploma or an undergraduate degree, 13 (7.2%) Grades 1 to 4, and 11 (6.1%) were unschooled.

5.3 Prevalence of Depression and PTSD of Mothers of SAC

This section outlines the prevalence of post-traumatic distress disorder (PTSD), depression, social support and coping strategies of the participants. These variables were rated differently.

5.3.1 Level of Depression among Mothers of SAC

Table 5.2 demonstrates the prevalence of depression among mothers of sexually abused children. All the participants reported the presence of depressive symptoms to a varying level. Sixty-five (36.1%) reported a little of the depressive symptoms, 65 (36.1%) moderate depression, 38 (21.1%) quite a bit of depression and 12 (6.7%) extreme depression.

Table 5.2: Level of depression among mothers of SAC

BDI Scale	Frequency	Percent
A Little Bit	65	36.1
Moderate	65	36.1
Quite a Bit	38	21.1
Extremely	12	6.7
Total	180	100

5.3.2 Level of PTSD Among Mothers of SAC

The mothers of SAC who participated in the study also reported experiencing PTSD symptoms as much as 86 (47.8%) experienced extreme PTSD symptoms, 72 (40%) reported quite a bit, 17 (9.4%) moderate and only 5(2.8%) a little bit of the PTSD symptoms (Table 5.3).

Table 5.3: Level of PTSD among mothers of SAC

PTSD Scale	Frequency	Percent
A Little Bit	5	2.8
Moderate	17	9.4
Quite a Bit	72	40.0
Extremely	86	47.8
Total	180	100

5.3.3 The Level of Coping of Mothers of SAC



Most of the participants (137; 76.1%) indicated that they were not coping while only 43 (23.9%) indicated that they did. Of the 137 participants who reported inability to cope, 85 reported quite a bit to extreme inability to cope. On the other hand, of 43 who were coping, 26 indicated that they were coping well (Table 5.4).

Table 5.4: The level of coping of mothers of SAC

Coping Scale		Frequency	Percent	Valid Percent	Cumulative Percent
Not coping	Valid	A little bit	9	6.6	6.6
		Moderate	43	31.4	38.0
		Quite a bit	60	43.8	81.8
		Extremely	25	18.2	100.0
		Total	137	100.0	100.0
Coping	Valid	A little bit	4	9.3	9.3
		Moderate	13	30.2	39.5
		Quite a bit	16	37.2	76.7
		Extremely	10	23.3	100.0
		Total	43	100.0	100.0

5.4 Relationship between PTSD and Demographic Factors

This section delineates the correlation between PTSD and demographic factors such as age, marital and employment status. The statistical tests used included cross-tabulation, Pearson Chi-Square and Spearman's rho (Table 5.5). The significance level was set at a p-value of 0.05 in all the tests, and the strength and the nature of the relationship was tested where a significant relationship was found.

Table 5.5: The mothers' age in relation to level of PTSD

Mothers age in years* level of PTSD		Age in years	PTSD scale
Spearman's rho	Age in Years	Correlation Coefficient	1.000
		Sig. (2-tailed)	0.136
		N	180
	PTSD Scale	Correlation Coefficient	0.136
		Sig. (2-tailed)	0.068
		N	180

The p-value of 0.068 is greater than the significance level of 0.05; therefore, the null hypothesis was not rejected, thus concluding that there is no statistically significant correlation between the age of the mother of SAC and their PTSD level. The p-value corresponding to the Pearson's Chi-Square statistic (0.586) is greater than the significance level of 5%, therefore, the null hypothesis was not rejected, thus concluding that there is no statistically significant association between marital status and PTSD level (Table 5.6), suggesting that the differences occurred by chance.

Table 5.6: The mothers' marital status in relation to level of PTSD

Marital status* Level of PTSD			PTSD Scale				Total
			A little bit	Moderate	Quite a bit	Extremely	
Marital status	Married	Count	3	9	33	31	76
		Expected Count	2.1	7.2	230.4	36.3	76.0
	Single/never married	Count	2	7	27	39	75
		Expected Count	2.1	7.1	30.0	35.8	75.0
	Divorced/ widowed/ separated	Count	0	1	12	16	29
		Expected Count	.8	2.7	11.6	13.9	29.0
	Total	Count	5	17	72	86	180
		Expected Count	5.0	17.0	72.0	86.0	180.0

The p-value corresponding to the Pearson's Chi-Square (0.492) is greater than the significance level of 0.05 (Table 5.7). Therefore, the null hypothesis was not rejected, thus concluding that there is no statistically significant association between the employment status and the PTSD level of the mother of the abused child, and that the differences were merely due to chance.

Table 5.7: The mothers' employment status in relation to level of PTSD

Statistic	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	2.410 ^a	3	0.492
Likelihood Ratio	2.329	3	0.507
Linear-by-Linear Association	0.020	1	0.889
Number of Valid Cases	180		

5.5 Relationship between Depressive Disorder and Demographic Factors

The study demonstrated the relationship between the depressive disorders and demographic factors. The demographic factors included age, marital and employment status. The results in tables 5.8, 5.9 and 5.10 show that there is no relationship between mother's age, marital status and employment status and the level of depression.

The p-value of 0.670 in Table 5.8 is greater than the significance level of 0.05; therefore, the null hypothesis was not rejected, thus concluding that there was no statistically significant correlation between the age of the mother of SAC and their depression level.

Table 5.8: The mothers' age in relation to level of depression

Mother's age* Level of depression		Age in years	Depression level
	Age in years	Correlation Coefficient	1.000
		Sig. (2-tailed)	0.670
		N	180
	BDI Scale	Correlation Coefficient	0.032
		Sig.(2-tailed)	0.670
		N	180

The p-value corresponding to the Pearson's Chi-Square statistic (0.002) is less than the significance level of 5%, therefore, the null hypothesis was rejected, thus concluding that the differences in Table 5.7 were not due to chance, but there is a statistically significant relationship between the marital status and the social support level that the mother of the abused child received. The p-value (0.741) corresponding to the Pearson's correlation statistic in Table 5.9 is greater than the significance level of 5%, therefore, the null hypothesis was not rejected, thus concluding that there is no statistically significant association between the marital status and the depression level of the mothers of the abused child and that the differences occurred by chance.

Table 5.9: The mothers' marital status in relation to level of depression

Marital Status*Level of Depression	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	3.522 ^a	6	0.741
Likelihood Ratio	3.724	6	0.714
Linear-by-Linear Association	0.293	1	0.589
Number of Valid Cases	180		

The p-value corresponding to the Pearson's Chi-Square (0.929) is greater than the significance level of 0.05 (Table 5.10); therefore, the null hypothesis was not rejected, thus concluding that there is no statistically significant association between the employment status and the depression level of the mother of the abused child, and the differences were merely due to chance.

Table 5.10: The mothers' employment status in relation to the depression level

Employment Status*Level of Depression	Value	Df	Asymp. Sig. (2-Sided)
Pearson Chi-Square	0.451 ^a	3	0.929
Likelihood Ratio	0.445	3	0.931
Linear-by-Linear Association	0.000	1	0.995
Number of Valid Cases	180		

5.6 Correlation Between Social Support, Levels of PTSD and Depressive Disorder

There is no relationship between social support, PTSD level and depressive disorder. The p-value of 0.363 is greater than the significance level of 0.05 (Table 5.11), therefore, the null hypothesis was not rejected, thus concluding that there is no statistically significant correlation between the PTSD level and the social support level received by mothers of SAC.

Table 5.11: The mothers' social support in relation to PTSD

		PTSD scale	Social Support Level
Spearman's rho	PTSD Scale	Correlation Coefficient	1.000
		Sig. (2-tailed)	0.068
		N	180
	Social Support Level	Correlation Coefficient	0.068
		Sig. (2-tailed)	1.000
		N	180

The p-value of 0.540 is greater than the significance level of 0.05 (Table 5.12); therefore, the null hypothesis was not rejected, thus concluding that there is no

statistically significant correlation between the social support level and the depression level of the mothers of SAC.

Table 5.12: The mothers' depression level in relation to social support level

			Depression Level	Social Support Level
Spearman's rho	Depression level	Correlation Coefficient	1.000	-0.046
		Sig. (2-tailed)		0.540
		N	180	180
	Social support Level	Correlation Coefficient	-0.046	1.000
		Sig. (2-tailed)	0.540	
		N	180	180

5.7 Correlation between Coping Skills, Levels of PTSD and Depressive Disorder

The study determined the correlation between coping skills levels of depression disorders PTSD. The variables include coping skills, in relation to depression and PTSD. Therefore the table 5.13 depicts the correlation between coping skills to PTSD. The results showed that there is no statistical significance of mothers of SAC.

The p-value of 0.576 is greater than the significance level of 0.05 (Table 5.13); therefore, the null hypothesis was not rejected, thus concluding that there is no statistically significant correlation between the PTSD level and the coping level of the mothers of SAC.

Table 5.13: The mothers' coping skills in relation to PTSD

		PTSD Scale	Coping Scale
Spearman's rho	PTSD Scale	Correlation Coefficient	1.000;2
		Sig. (2-tailed)	0.576
		N	180
	Coping Scale	Correlation Coefficient	-0.042
		Sig. (2-tailed)	0.576
		N	180

The p-value of 0.648 is greater than the significance level of 0.05 (Table 5.14); therefore, the null hypothesis was not rejected, thus concluding that there is no statistically significant correlation between the depression level and the coping level received by mothers of SAC.

Table 5.14: The mothers' coping skills in relation to level of depression

		Coping Scale	Depression Level
Spearman's rho	Coping Scale	Correlation Coefficient	1.000
		Sig. (2-tailed)	-0.034
		N	180
	Depression Level	Correlation Coefficient	-0.034
		Sig. (2-tailed)	0.648
		N	180

5.8 Summary

This chapter presented the statistical analysis of data obtained from the quantitative stage of the study. The chapter also discussed the results according to the objectives, namely, association between socio-demographic factors, depression, PTSD, coping skills and social support, the relationship between the levels of PTSD, depression and

the coping skill. All the participants reported the presence of depressive symptoms to varying levels and most of them were not coping well.

CHAPTER 6

INTERPRETATION AND APPLICATION OF THE CONCEPTUAL FRAMEWORK TO THE FINDINGS

6.1 Introduction

The chapter is divided into two sections. The first section of this chapter discusses the integrated results of both quantitative and qualitative stages according to the objectives and the second section discusses the application of the adapted model: An ecological model of the impact of sexual assault on women's mental health by (Campbell et al., 2009). The model argued that the mental ill health of a human being is moderated by support. In the qualitative stage, the participants were asked about their experiences and the support they expected to receive from the stakeholders after disclosure of their CSA. In the quantitative stage the correlation between socio-demographic characteristic of mothers of SAC and the level of depression, PTSD, coping strategies and social support were examined.

Initially, qualitative and quantitative findings were separated and now they are combined so that a more composite picture of experiences of mothers of SAC could be reflected. Congruence between quantitative statistical analysis and emergent qualitative themes and constructs are examined. The methods complemented each other to give a more complete picture of the experiences, processes and findings that informed the investigations (Polit & Beck, 2010:285).

6.2 Interpretation and Discussion of the Findings of the Study

6.2.1 Level of Depression and PTSD, and Exploration and Description of the Experiences of Mothers of SAC

One of the objectives of this study was to describe the level of PTSD and depression as well as to explore and describe the experiences of mothers of SAC. The data revealed that 43% of mothers of SAC suffered depression after CSA disclosure while 57% of them were not depressed post-disclosure. In addition the results showed that 87.8% had high levels of PTSD and 12.2% low levels after disclosure of CSA. These quantitative results concur with the qualitative results, where mothers experienced a range of emotions such as self-blame, suicidal ideation and psychological pain after finding out that their children were sexually abused.



These findings are in line with the literature that shows that mothers of SAC experienced extreme signs and symptoms of PTSD post-disclosure (Willingham 2007:71). Mothers experienced PTSD after their children disclosed CSA, they blamed themselves for not noticing that sexual abuse is going on or that they failed to protect their children. They felt that they should have known that the perpetrator was dangerous (Myrick & Green, 2013:194). Furthermore, Myrick and Green (2013:194) reported that mothers usually feel stuck with the sense of danger and disconnected from reality which results in difficulty managing daily situations.

Other factors that affected the mothers of SAC were finances, employment and marital relationships. In addition, some mothers of SAC presented with avoidant coping such as remembering the CSA disclosure (Myrick & Green, 2013:194). These aforementioned signs and symptoms revealed by Myrick and Green (2013) are

supported by Elliot and Carnes (2001:320) who reported that mothers of SAC expressed significant levels of distress following CSA disclosure. They experienced elevated levels of stress, but variety of distress symptoms were seen as evidenced by the mothers being restless, sitting and standing (Elliot & Carnes, 2001:320). Based on both qualitative and quantitative results it is concluded that rape can be regarded as one of the predisposing factors of PTSD and depression of mothers of SAC.

6.2.2 Correlation Analysis

6.2.2.1 Correlation among Coping Skills, Levels of PTSD and Depressive Disorder

This study examined the relationship between the levels of PTSD, depression and the coping skills of mothers of SAC. The results showed that there was no relationship between these variables, suggesting that the levels of depression or PTSD of these mothers, whose children were sexually abused, do not necessarily depend on either adaptive or maladaptive coping skills. By contrast, quantitative results differed with the qualitative data because mothers of SAC expressed that they coped through religious beliefs and supernatural powers (Murray-Swank & Pargament 2007:192).

Even though they have stated that they could cope through these means they still presented with maladaptive coping following CSA disclosure because they presented with signs and symptoms of PTSD and depression such as isolation anger, frustration and self-blame. These aforementioned signs and symptoms are diagnostic of avoidant coping. Therefore, this result are contrary to the findings of the review done by Hill (2001:340) which revealed that women felt that they did not provide enough care for their children as the mothers and they also had a guilt feeling. The

symptoms mentioned above showed that these mothers used maladaptive coping skills; hence they have developed depression and PTSD following their children's sexual abuse.

6.2.2.2 Correlation among Social Support, Levels of PTSD and Depressive Disorder

The study hypothesized that no relationship exists between social support and either PTSD or depression. The quantitative results revealed that there was no statistically significant correlation between social support, levels of PTSD and depressive disorder. The qualitative results also corroborated that mothers did not receive social support from the majority of service providers such as police and judiciary services, and health professionals, but received some measure of social support from family members, neighbours and the community. In addition, mothers of SAC expressed that financial constraints, difficulty in accessing clinical services due to lack transport to take SAC for medical appointments at clinical services, lack or inadequate information concerning the procedures to be followed post-disclosure, what to expect, when and how, were some of the serious problems encountered during their interaction with stakeholders.

They also mentioned continuous lack of support from police officers. Mothers of SAC experienced family disorganization and exhibited signs and symptoms of depression, PTSD and maladaptive coping. These results are discordant with the findings of Xu and Wei (2013:13) who reported that social support was negatively correlated with anxiety and depression in that lower levels of social support were associated with greater increases in depressive symptoms. The same authors' further stated that this

could be explained by the fact that survivors would be feeling a significant sense of loss and the assistance deemed urgent. The findings of Kelly (1990:26) who stated that mothers of SAC were at a greater risk of developing depression due to a more negative self-image are also incompatible with the results of this study. Hence, based on the findings of this study and those reported in the literature it is concluded that social support alone cannot account for development of PTSD depression.

6.3 The Relationship among Socio-Demographic Factors, Depression and PTSD

The results of this study showed that there is no statistically significant correlation among depressive disorder, age and employment status, but a correlation does exist between marital status of the mother of SAC and their depression levels. Zimba (2013:50) concurred with the findings of this study that different ages had no significant bearing on the level of depression. These results disagree with the findings of Xu and Wei's (2013:4) which revealed that demographic characteristics were seen as significant in the cases of depression, except in age.

Furthermore Xu and Wei (2013:6) stated that the population of trauma subjects with low levels of income were likely to show depression. Those with lower household income correlated with high psychological morbidity. Xu and Wei (2013:6) also stated that depression may be due to the fact that most of woman in his study were unemployed, did not receive financial support from any source and yet had to travel to different health facilities for care of their children post-CSA disclosure. This notion may also be true in this study since 66% of the participants were employed.

Furthermore, Santa-Sasa, Steer, Deblinger and Ruyon (2013:917) revealed that one important factor of demographics that influence the level of depression is marital status, especially the role of the father in parenting and supporting the mother. Such a precept may also explain the results of this study which showed that there is relationship between marital status and depressive disorder. Therefore, it can be concluded that the level of depression observed in this study did not depend on age or employment status, but it can hinge on marital status.

6.4 Application of the Conceptual Framework to the Results of this Study

This section discusses the study findings in relation to the conceptual framework depicted in Chapter 2, Figure 2.1, on *Ecological Model of the Impact of Sexual Assault on Women's Mental Health* (Campbell et al 2009). The discussion is based on the empirical findings of this study found in Chapters 4 and 5 with the aim of developing a conceptual framework.

6.4.1 Description of the Process of the Application of the Findings to the Conceptual Framework

It should be noted that the model conceptualized by Campbell et al. (2009:227) focuses on the woman who was sexually assaulted while this study focuses on a woman whose child was sexually assaulted and it is therefore, a secondary victim of sexual assault. This model is deemed relevant because the literature has shown that a mother of SAC needs support and also undergoes psychological and emotional traumas due to the sexual assault of her child and experiences social, economic and health-related adverse trauma which are almost similar to those who are primary victims of sexual assault (Newberger et al., 1993:100; Myrick, 2013:198;

Kouyoumdjian, 2009:45). The mothers of the SAC reacted differently to various levels of the model.

According to Campbell et al. (2009:229) there are six systems that affect the recovery of the victim. The indicated that the survivor of violence responds negatively to disclosure of violence, but if the individual is supported the response could be positive. The interaction of the individual with other stakeholders is the one variable that determines the way the survivor of assault will respond.

The application of the conceptual model to this study is based on three themes that emerged during data analysis as well as to the six cyclic levels of the ecological model, namely, individual, assault, microsystem, mesosystem, macrosystem and chronosystem. The themes were as follows: reaction of the participants to the disclosure of sexual abuse, effects of sexual abuse on a child as viewed by the mother of SAC and participants expressed their experiences regarding the support they received, both formally and informally.

6.4.1.1 Individual-Level Factor

According to Campbell et al. (2009:230), the recovery of the survivor of sexual assault is influenced by the five intrapersonal factors, namely, socio-demographics, personal factors, pre-existing mental health conditions, genetic and biological factors that may increase the likelihood of the individual to become a victim or to recover from trauma post-sexual assault.

6.4.1.1.1 Socio-Demographic Factors

Socio-demographic factors such as age, race/ethnicity/social class, income level and education status could influence the recovery process of the assaulted survivor (Campbell et al., 2009:233). The recovery process from the disclosure is influenced by self-blame, employment and income status, marital status, education, depression, PTSD and maladaptive coping.

- ✿ In this study, age did not influence the level of depression, PTSD and anxiety, but these afflictions were found to be general in all age groups. Mothers of SAC suffered more depression when the child was under the age of 14years, but these variables were not influenced by the mother's age.
- ✿ In this study, the employment status or income level was associated with the effects of CSA disclosure. Those who were economically challenged, experienced increased stress post-CSA disclosure. The mothers who were unemployed post-CSA expressed to be having more distress post-CSA. Distress post-CSA increased the psychological sequelae of the mother, thus leading to self-blame, depression and PTSD.
- ✿ In this study, the level of education was neither seen to be influencing the reactions of mothers of SAC post-disclosure nor was it seen to be associated with post-CSA stress such as PTSD and depression.
- ✿ Ethnicity, race and social class were not seen to influence the recovery process of the mother of SAC post-disclosure.

6.4.1.1.2 Personality Characteristics

Personal characteristics such as anxiety, impulsiveness and depression may predict PTSD post-sexual assault disclosure (Campbell et al., 2009:234). In this study, mothers of SAC who were anxious developed more distress post-CSA disclosure.

6.4.1.1.3 Pre-Existing Mental Health Conditions

In this study, some mothers of SAC who had previous experience of sexual abuse were found to have a pre-existing mental health condition which was attributed to sexual assault of the child and prolonging justice system processes. These mothers suffered heightened depression, anxiety, self-blame and PTSD that were associated with CSA disclosure.

6.4.1.1.4 Genetic and Biological Factors

In this study no genetic or biological factors were identified as predictors of post-CSA disclosure, distress, self-blame, PTSD and maladaptive behaviour. This concurred with the findings of the Campbell et al.,(2009) model.

6.4.1.1.5 Coping Responses

The mothers who received negative social support from stakeholders post-CSA disclosure, presented with increased distress and they used avoidant coping and ended up with increased PTSD and maladaptive coping. Maladaptive coping was evidenced by mothers of SAC isolating themselves from the family, staying at home when they were supposed to bring their sexually abused children for follow-up visits. In this study, the individual-level factors, all aspects of the model, emerged since the

mothers of SAC expressed self-blame, anxiety and they were observed to be exhibiting signs of depression, PTSD and maladaptive coping post-CSA.

6.4.1.2 Assault Related Factors

Campbell et al. (2009:230) highlighted that the victim of sexual assault recovery is dependent upon who the perpetrator is. The sexual assault by a partner has been found to a predictor of PTSD, depression and self-blame (Campbell et al., 2009:232). In this study, the assault is the disclosure of the CSA to the mother. The factors that could improve the recovery or increase post-sexual abuse disclosure assault on the mother of a SAC are physical injuries and the extent of those injuries on the child and the relationship of the child to the perpetrator. The mother's recovery process might affect her negatively if the perpetrator is a family member and the extent of an injury - which may lead to expensive surgical procedures on the victim.

The assault-related factors of the model have emerged in this study such as mothers reporting that their children were abused sexually by brothers and cousins. The mothers developed depression and maladaptive coping due to the injury incurred as a result of sexual assault caused by family members. The findings are also similar to that of the adapted model that women suffer PTSD post-sexual assault. In this study, the results revealed that 87.8% of mothers of SAC had suffered high levels of PTSD. In the qualitative stage of the study, mothers expressed to be experiencing emotional pain, suicidal ideation or extreme symptoms of PTSD post-CSA disclosure. All mothers reported the presence of depressive symptoms post-CSA disclosure. About 76.1% reported that they were not coping post-CSA while only 23.9% indicated that

they did. In qualitative phase, the mothers indicated that they isolated themselves, reported suicidal ideation and were observed to be tearful.

The results revealed that there is no relationship between PTSD, depression, coping strategies and self-blame post-disclosure. The findings also indicate that maternal support is crucial and that intervention is inevitable post-disclosure. The mothers also blamed themselves for not protecting the child, they also expressed that the type of injuries the children sustained increased their trauma, fear that the child could contract HIV/AIDS and they experienced psychological pain, anxiety, maladaptive coping, symptoms of depression and PTSD. The researcher concluded that CSA must be immediately reported and treated.

6.4.1.3 Microsystem Factors

According to the ecological model by Campbell et al. (2009:233), the individual may be affected by her relationship with aggressive peers, family environment that is economically unsupportive or physically violent. At the relationship level mothers expressed to have received various types of support from friends, peers and significant others; others were negative while few had good interpersonal relationships with the mothers. They also expressed to be blamed by husbands for not taking care of children prior CSA. Good interpersonal relationships improved the mother's coping skills, decreased the level of depression and PTSD while negative interactions such as blaming her for the abuse made her to be depressed, exhibit avoidant coping strategies as well as signs of PTSD.

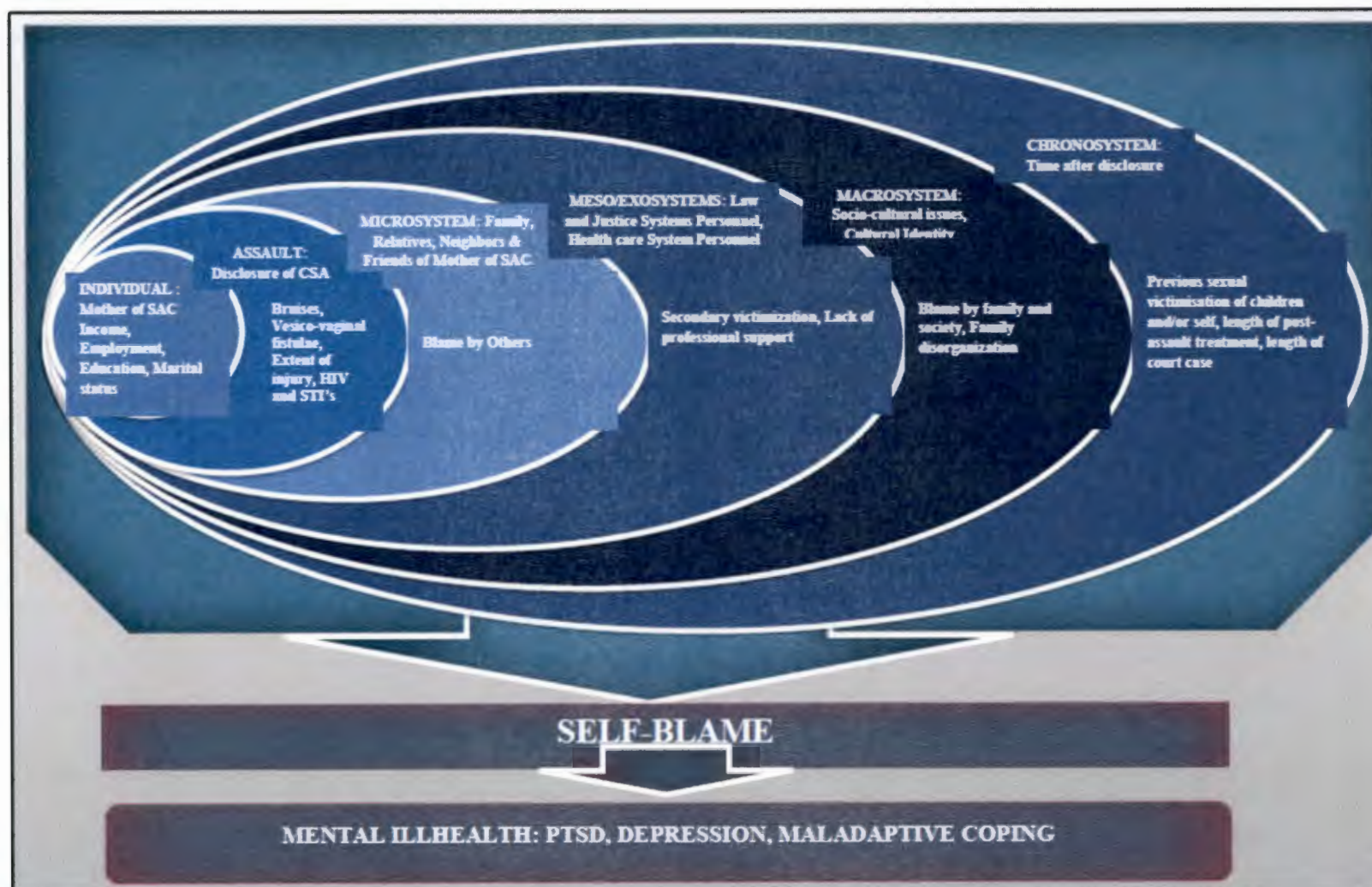


Figure 6.1: Ecological model of sexual assault as applied to this study

In this study, the supportive relationship from friends and peers were explored and described and the relationship of the model became apparent such as peers and friends not supporting the mother. The mother is being labelled by friends, family members as well as peers for allowing the child to be sexually abused. She is stigmatized by friends as a person who is not protective. The mother also experienced rejection from family members because she laid charges against the family member who is a perpetrator without consulting the family first.

The mother is also labelled for rejecting the family norms and beliefs of gender inequality or of male dominancy. In this study mothers blamed themselves, because they felt they should not have accommodated their family members who perpetrated the child sexually and the sexual cultural orientation made them to accept the blame and blame from others. The self-blame made them to suffer depression, PTSD and maladaptive coping.

6.4.1.4 Meso/ExosystemFactors

According to Campbell et al. (2009:233), the recovery of the post-assault victims is negatively or positively affected by social support that is provided by social systems such as police, medical care, mental health systems and the community advocacy systems such as crisis centres which may increase or decrease the recovery process of the survivor post-assault (Campbell et al., 2009:233). Campbell et al. (2009:232) highlighted that sexual assault is the predictor of PTSD, depression and decreases anxiety and increases coping strategy. In this study the mothers of SAC experienced negative attitudes from professional, such as not providing them with the procedures

to follow when the child is sexually abused. They regarded police officers as unreliable because they failed to arrest the perpetrators and judiciary released the perpetrators without trial. If the mother does not receive needed services and is treated insensitively then the systems can magnify the mother's feeling of powerlessness, shame and guilt and self-blame as a result, she could suffer depression, PTSD and maladaptive coping.

6.4.1.5 Macrosystem Factors

Campbell et al. (2009:233) reported that research is very limited for macrosystem factors and that they could not find any difference in the post-rape symptoms. They did not find differences in their cultural attribution. The women were attributed to cultural self-blame. The macrosystem in this study is the mother of SAC who post-disclosure takes the blame for CSA on behalf of the perpetrator and for socio-cultural identity by blaming herself for not obeying cultural and traditional values, issues and beliefs that instructed her not to lay charges against the perpetrator, especially if the perpetrator is a family member (Campbell et al., 2009:233). The recovery of the mother of SAC is negatively influenced by socio-cultural identity when the mother is forced to apply them against her will.

The mother started isolating and blaming herself. Self-blame made the mother to suffer depression, PTSD, maladaptive coping as well as family disorganization following CSA disclosure. The mothers expressed to have experienced lack of support regarding inequality, and cultural beliefs that are imposed on them. These experiences made mothers not to cope well, to be angry and anxious. In this study,

the factors indicated in the ecological model of this level emerged during data collection and analysis such as: lack of policies to protect mothers against cultural beliefs that promote oppression of women, male dominance and inequalities.

6.4.1.6 Chronological Factors

These include dimensions of time as they are related to the mothers' environment. The elements in this system could be external, such as the time of disclosure, where a mother could not have noticed this for some time and the history of previous assault (Campbell et al., 2009:233). The time of the woman's previous sexual assault history could improve or affect her mental well-being negatively (Campbell et al., 2009:233). The woman may experience emotional pain, blame herself for being high when she was sexually assaulted or could be blamed by others, she could also present with anxiety, depression and PTSD symptoms as well as maladaptive coping. In this study, mothers of SAC whose other siblings were once abused sexually and whose court cases were prolonging were more depressed than those court cases did not take long and whose children were abused for the first time or without prior history of CSA. The mothers of SAC blamed themselves for the action of the perpetrator that they failed to protect the child, the blame made them to suffer depression, PTSD and maladaptive coping.

6.5 Summary

This chapter discussed the conceptual framework of Campbell et al (2009) within which the study was based and three themes that emerged during data collection and analysis of this study. Through supportive interaction with different stakeholders,

the mother may recover or develop coping skills, which may help her to care and protect her child (Bronfenbrenner, 1978-1995). This model shows that supporting the mother of SAC is important for the survival of the mother. Following the CSA disclosure the mother found herself within a clinical environment which is complex and dynamic, occurrences of different continuous interactions with different stakeholders such as professionals and non-professionals. The skilled and non-skilled personnel interacted with the mother to promote supportive relationship to equip the mother with skills that could assist her to cope with the secondary trauma caused by CSA disclosure or to blame and stigmatize her. All these experiences are elements of a facilitative process that must enhance interaction. If the interaction by the stakeholders is not healthy the mother develops depression, PTSD, and maladaptive coping.

CHAPTER 7

GUIDELINES FOR SUPPORT TO MOTHERS OF SEXUALLY ABUSED CHILDREN

7.1 Introduction

This chapter provides a description of the guidelines developed in this study that would assist different stakeholders, namely, medical, legal, health and educational systems, individuals, families, communities, government and the society with strategies to support and empower mothers of SAC to cope with the secondary trauma they experienced following CSA disclosure.

The guidelines for support to mothers of SAC were developed based on the literature reviewed in chapter two, findings of this study and the ecological model of the impact of sexual assault on women's mental health by Campbell et al. (2009). Guidelines were developed to enable the stakeholders to plan and create an ecological environment in clinical and societal settings and coordinate a set of multi-sectorial interventions to respond to sexual abuse disclosure.

These guidelines are to be implemented by the stakeholders who come into contact with the mothers of SAC following disclosure. These guidelines must be available and accessible to all stakeholders because they recommend specific key interventions to support the mothers of CSA and they are applicable in any relevant setting. These guidelines must be included in the in-service training programmes of both public and private hospitals, governmental and non-governmental organizations, community workers, lay counselors, home-based caregivers so that they, in turn, can empower

individuals, families, communities and societies regarding support of mothers of SAC.

7.2 Guidelines

Clinical practice bears reference to these guidelines to support mothers of SAC as set out in the objectives of this research. The ecological model of the impact of sexual assault on women's mental health by Campbell et al. (2009) was used as a framework for the development of guidelines.

7.2.1 Description of the process of guidelines formulation

The researcher conducted literature review prior to conducting research so as to orientate herself with what is already known about the experiences of mothers of SAC and the support they received from the stakeholders. During literature review and Ecological model of the impact of sexual assault on women's mental health Campbell et., al. (2009) was identified as relevant to this study as it discusses the impact of sexual assault on women's mental health. The mental health of mothers of SAC was placed at stake by the sexual abuse of their children's disclosure and thereby become secondary victims of this sexual abuse. On the basis of the above argument the model is viewed as relevant to guide this study. The researcher then conducted a concurrent convergence mixed methods. Qualitative method was used to explore and describe the experiences of mothers of SAC, to explore the kind of support they received and quantitative method was used to examine the relationship among depression, coping skills, social support and PTSD.

7.2.1 Individual –Level Factors

In these guidelines the individual factors of Ecological Model of the impact of Sexual Assault on Women's Mental Health is evident. The five socio-demographic variables that can influence recovery of the mother of SAC are evident at the first level of these guidelines: namely, personal factors, pre-existing mental health conditions, genetic and biological factors and coping responses.

7.2.1.1 Socio-demographic variable

Mothers of SAC should be referred to the psychologist and social worker for counselling emotional, psychological and social support. Social support post CSA reduces suicidal ideation, PTSD, depression and maladaptive behaviour.

7.2.1.2 Personality factors

The following needs to be done:

- ☼ Provide mother with information to prevent maladaptive behaviours which involves certain level of avoidance such as; substance abuse, social isolation, disengagement. The maladaptive behaviour is associated with longer recovery period, levels of depression and PTSD.
- ☼ Provide mothers of SAC with adaptive strategies that will help them to express their feelings, about social support they receive. These adaptive strategies reduce stress and are related to faster recovery, less level of PTSD and depression. The social support received predicts adjustment.



- ✿ Encourage mothers of SAC to appreciate unconditional support provided to reduce emotional and psychological trauma of self-blame as well as to improve the coping skills. Self-blame at this level is associated with PTSD and depression, if the mother is supported it will take a shorter time to recover from the secondary trauma.
- ✿ A one-stop centre should be made effective and accessible to all mothers of victims of sexual violence by stakeholders to support them, reduce the stigma attached as well as to regain from the lowered self-esteem. This is done to help them open up, talk, not to feel isolated, betrayed to work over panic disorders
- ✿ Professionals are to make mothers of SAC to do self-introspection because this decreases levels of depression and anxiety. Individual adjust easily if they are aware of their strength and weaknesses.

7.2.1.3 Pre-existing mental health conditions

Refer to mothers who had some sort of depression prior CSA disclosure, suicidal history to psychiatric institutions. Pre CSA disclosure depression may be associated with post disclosure distress.

- ✿ Mothers who attempted suicide pre-assault experienced significantly more post-assault depression and anxiety must be referred to relevant professionals for assistance than those who did not have pre-existing conditions.

7.2.1.4 Coping responses

Provide mothers of SAC with emotional support, coping orientation over time to deal with stress. Coping orientation deal with stress especially in a supportive environment: such as social support from the family, friends, neighbours, colleagues and other stakeholders. The lack of social support is likely to make people to use avoidance coping, increase level of PTSD symptoms.

7.2.2 Assault-Related Factors

In these guidelines the assault level is evident and this merely shows that the model that guides the study is implicit in the guideline.

- ✿ Community based groups or NGOs must engage communities in assisting identifying resources for child care. This will assist the mother to overcome the: psychological and emotional pain and trauma caused on her by disclosure of CSA.
- ✿ Provide unconditional support in managing the injuries incurred as a result of CSA. Emotional trauma and pain resulting from CSA disclosure is related to post assault distress, PTSD and maladaptive coping.
- ✿ Post CSA disclosure mothers are to be provided with information on how to report the CSA, what will happen during the process, how are the injuries going to be treated. Lack of support and information could predispose a mother to present with depressive symptoms.

- ✿ The professionals must provide the mothers of SAC with support and counselling sessions post disclosure of CSA. Counselling reduces maladaptive behaviour, depression, PTSD as well as making the environment responsive.

7.2.3 Microsystem Factors

The family, friends, peers and significance others are positive in this level of the model. This merely shows that the model that guides the study is implicit in the guideline

- ✿ Friends, family, peers and significant others must promote support to mothers of SAC by encouraging mothers to talk about the trauma with those who they can trust because communication and interaction with friends facilitate emotional healing. Peer support moderates the relationship between traumatic stress and PTSD.
- ✿ Families and friends must provide intensive family support and parenting interventions to the mothers who need support. Family members should stop being judgmental and instead support mothers and their children.

7.2.4 Mesosystem/Exosystem Factors

The professionals and community involve the following formal and informal systems: the legal system, the medical system, the mental health system and the advocacy community such as; chaplains, community counsellors, community leaders, traditional healers, community developers, community organizations, and NGOs. The professionals and community are positioned in third level of the ecological model of

the impact of sexual assault on women's mental health as a meso/exosystem level. It is thus evident that the model guides this study in the context of professional and community support to mothers of SAC as follows.

- ✿ All professionals must help mothers to regain control in situations where they are helpless by giving them practical information on what to do in case their children are sexually abused such as: not bathing the child and keeping the underwear unwashed to facilitate the assessment and forensic procedures that should be undertaken, controlling the turmoil and giving information that will assist the mother to regain the self-concept, body image, self-identity and self-esteem.
- ✿ Professionals are to formulate support group platforms where the mothers of SAC can be enabled to ventilate and talk about their fears so that they can develop coping skills. Ventilation prevents the two types of self-blame that involves one's, own character for the negative event as well as behaviour self-blame that involves blaming one's own actions.
- ✿ Forensic nurses and psychologists must provide crisis intervention initiatives for mothers of SAC post-disclosure. This is done to prevent depression and maladaptive coping.
- ✿ Sessions of debriefing must be employed by the resident psychologist in TTCC to ensure that mothers whose children have sustained injuries during sexual abuse receive support to reduce the impact of trauma and flashbacks

that are experienced by mothers of SAC. Psychological intervention is important to reduce psychological pain, anxiety and suicidal ideation.

- ✿ Police officials must display positive attitudes and facilitate a caring environment when attending to mothers of SAC because negative attitudes hinder the therapeutic responses that are needed to recover from trauma, disbelief and shock.
- ✿ Police and judiciary must collaborate with authorities and the sexual violence working group to establish strategies to remove or reduce obstacles to arrest and prosecution of perpetrators.
- ✿ Involve the traditional leaders in the community programmes to teach and analyse the traditional and cultural values.
- ✿ Make community aware that rape, sexual violence and any other form of gender -based violence are war criminal acts.
- ✿ The chaplain must reinforce spiritual beliefs and prayer to the mothers because collaboration and self-directedness and being prayerful have been found to be an adaptive form of coping. Religion is also an important aspect of life to the majority of people and the chaplains must listen to mothers to allow them to mourn their losses and to be patient with their emotional status. It is important to give spiritual support to a person who is emotionally hurt because emotions and memory live like any other parts of a human being.

- ✿ The traditional leaders must be involved in the community programmes to teach the mothers of SAC to analyse and choose the traditional and cultural values that often stigmatize the mother, such as asking permission from other people such as family members before laying charges against the perpetrator.
- ✿ Community counsellors and community health workers (CHW) must be trained on how to render services to mothers of SAC, which include crises intervention services to offer to the victims, short- and long-term rape counselling and support to be offered to provide social support. The community must have knowledge of these services so that it could impart information to mothers of SAC and other community members.
- ✿ Community-based groups or NGOs must engage communities in assisting with identifying resources for child care to support the mother to overcome the psychological trauma caused by the child's physical and emotional injuries.
- ✿ Community-based groups must identify resources that may contribute to providing protection/prevention and response to mothers of SAC to receive support immediately.
- ✿ Formal and informal systems to conduct advocacy campaigns for organizations and institutions should be implemented to share information with the entire society such as school teachers and the mothers' workplace.
- ✿ Community, NGOs and the government must provide enough resources that

could support and sustain services to mothers of SAC.

- ✿ The curriculum must include basic sensitization, competency in identifying mothers of SAC who have experienced lack of support post-disclosure and competency in medico-legal rape examination and victim support.
- ✿ Education institutions must include in all their curriculum programmes modules about the support of mothers of SAC post-disclosure or gender violence issues.
- ✿ Teachers, police, social workers and psychologist institutions of learning should include in their curriculum issues related to gender violence and child sexual abuse.
- ✿ Universities and nursing colleges must offer forensic nursing courses in their programmes. Forensic nursing is important because nursing students will be equipped with counselling skills to recognize and identify a person who needs forensic assistance.
- ✿ Colleges and universities should also offer short courses for other stakeholders who are not nurses. If the community is equipped with skills and knowledge related to forensic nursing and gender violence the needs of mothers of SAC will be easily met.



7.3.5 Macrosystem Factors

This is the macrosystem level of the model which is represented by cultural-specific

beliefs, such as: the culture that condones male violence against women.

- ✿ The stakeholders must make the community aware that rape, forced prostitution, sexual violence and any other form of gender-based violence are criminal acts that must be reported to the police.
- ✿ The traditional leaders must be involved in the community programmes to teach the mothers of SAC to analyse and choose the traditional and cultural values that often stigmatize the mother, such as asking permission from other people such as family members before laying charges against the perpetrator.
- ✿ The culture sensitive information should be disseminated to all service providers. This will assist those who are providing culture specific intervention programmes for mothers of SAC from different cultures.

7.2.6 Chronosystem Factors

- ✿ Ensure legislation protecting CSA is not compounded by failure of criminal justice; such as taking too long to convict the perpetrator or court proceedings taking long thus leading to mother's depression
- ✿ Policy makers must adhere to guidelines that are nationally developed to support mothers of SAC and they are to ensure quality services in TTCC.
- ✿ Policy developers must ensure that legislation to protect SAC is effective and adequate and not compounded by the failure of the criminal justice systems.

- ☀ Policy makers must include management of mothers whose children have been sexually abused in the primary health care (PHC) package. The following must be included in the package: identification and management of mothers of SAC, secondary victimization at the clinical services, trauma due to lack of support, health promotion and society or families that discourage the mother to report and lay charges against rape.

7.4 Summary

This chapter discussed the guidelines for support to mothers of SAC which are based on the findings of the literature, both qualitative and quantitative findings of this study and the ecological model by Campbell et al. (2009). The next chapter wraps up with the limitations, justification, and contribution of the study, recommendations and conclusion of the study.

CHAPTER 8

LIMITATIONS, JUSTIFICATION, RECOMMENDATIONS AND CONCLUSION OF THE STUDY

8.1 Introduction

The study explored and described the experiences of mothers of SAC as well as the examination of the correlation between depression, social support, PTSD and coping skills of these mothers post-disclosure. This chapter evaluates whether the purpose and objectives of the study have been met and if the questions have been answered. The chapter also provides the summary, justification, limitations, recommendations and conclusion of the study.

8.2 Summary of the Study

Sexual violence against children and infants was noted to be increasing at a shocking rate in South Africa (Meier, 2001:1). In 2000, over 52,400 cases of rape and attempted rapes were reported to police. Of these cases, 21,438(41%) were minors under the age of 18 years and 7,898(15%) were between the ages of 7 and 11 years. In 2009, the NWP reported an average of about 5,039 incidences of rape cases annually (SAPS2008/2009). These statistics indicate how serious the problem is throughout South Africa, including the NWP. When CSA was disclosed to mothers it caused them severe emotional distress. This state of affairs made the researcher to explore and describe the experiences of these mothers post-CSA disclosure.

In addition, an examination of the correlation among the levels of PTSD, social support, depression and coping skills was undertaken. The findings of the study indicated that the mothers of SAC presented with a variety of symptoms such as clinical depression, sleeping and eating disorders, anxiety, self-blame and severe guilt for not noticing that her child was sexually abused. Some mothers also reported that the family, friends and police officers were giving complete support to mothers. The formal stakeholders did not avail themselves of the expected support due to unavailability of resources. These experiences which were revealed in this study demonstrated the dire need for the researcher to develop guidelines for support to mothers of SAC with the aim of empowering stakeholders that come into contact with these mothers to create a climate that will support the mothers comprehensively.

8.2.1 Purpose of the Study

The main purpose of this study was to explore and describe the experiences of the mothers of SAC following disclosure with the aim of developing guidelines for support to mothers' post-disclosure of CSA. For the researcher to address the experiences of mothers of SAC, the following questions were asked "What are your experiences following your CSA disclosure? And what kind of support do you expect? Quantitatively a survey based on the use of a questionnaire from the four instruments namely: BDI, Brief COPE, Social Support Grid scale and PSL PTSD scale were administered.

8.2.2 Objectives of the Study

In order to achieve the purpose of the study the following objectives were set: to

explore and describe the experiences of mothers of SAC in the NWP, to examine the association between socio-demographic factors and depression, coping skills and PTSD ,to examine the correlation between levels of PTSD and social support, to examine the correlation between levels of PTSD and coping skills, to examine the correlation between levels of depression and coping skills, to examine the correlation between levels of depression and social support, to describe the conceptual framework within which guidelines for support to mother SAC are discussed, and to develop the guidelines for support to mothers of SAC in the NWP.

8.2.3 Research Design



The research design utilized was the concurrent convergence triangulation method to explore and describe the experiences of mothers of SAC following CSA disclosure in the NWP. The unstructured in depth interview was used in stage one to collect data and audiotape and field notes were taken during interviews. Data saturation was reached after 17 participants were interviewed. Transcripts were analysed using Tesch's (1994:155) open-coding method for qualitative data.

In stage two a descriptive, cross-sectional design was utilized and 180 participants were interviewed using four instruments namely: BDI, Brief COPE, Social Support Grid scale and PSL PTSD scale. Data were analysed by using the Statistical Package for Social Sciences (SPSS) version 21. The study was guided by Campbell et.al. (2009) An Ecological Model of the Impact of Sexual Assault on Women's Mental Health. The conceptual framework was developed based on the findings of the research study. Guidelines to support mothers of SAC were based on the ecological model and the

research findings. The study findings and guidelines have important implications and applications for clinical nursing practice, nursing research, nursing education and policy making. The in-depth experiences of mothers of SAC were explored and described. The depression, PTSD, social support levels and coping strategies of mothers of SAC were examined and guidelines for support to mothers of SAC were developed based on the findings of the study as well as the theoretical framework.

8.2.4 Summary of the Research Findings

It is apparent from this study that mothers of SAC experience various predicaments such as lack of social support from stakeholders and exhibited symptoms of depression, PTSD and maladaptive coping strategies. The lack of social support has necessitated the researcher to investigate how mothers of SAC could be supported following their CSA disclosure. The findings of this study enabled the researcher to develop guidelines to support mothers of SAC. The developed guidelines could give stakeholders insight into improving care to mothers of SAC, as well as how to cope post-CSA disclosure. The integrated holistic support guidelines that were developed illustrate the comprehensive facilitative process that is to be displayed by both formal and informal stakeholders during sensitive and responsive interactions with mothers of SAC.

8.3 Justification of the Study

The incidence of child sexual abuse in NWP is shocking and the consequences thereof affect non-offending mothers negatively. The researcher observed that the province lacks facilities to support mothers of SAC following CSA disclosure, and this led many mothers of CSA to present with psychological trauma, depression, PTSD

and maladaptive coping. The family did not provide the mothers of SAC with full support following CSA disclosure. The situation was exacerbated by cultural beliefs, traditional practices and attitudes. The mothers had no rehabilitation facilities such as counselling and crime crisis centres; they were also not referred to psychologists and social workers.

The strength of this study lies in the fact that it was conducted at the time when CSA in the country as well as in the NWP was escalating and this will helped the researcher to give feed back to the stakeholders based on the valid evidence. Moreover, the study explored experiences of the mothers of SAC following disclosure, an issue for which there is a dearth of information in the province and country. In addition, the study examined the type of support the mothers of SAC expected following the sexual abuse of their children and how lack thereof affected them and influenced the developed guidelines for support.

Previous research focused predominantly on the experiences of these mothers, but previous research did not fully assess their emotional and psychological well-being and how they can be supported after such trauma. Another persuasive and contemporary quality of the study is the use of the mixed methods approach where the strengths of qualitative and quantitative methods are blended together to provide a rich form of data which is uncommon in the previous studies.

8.4 Contribution of the study to the body of knowledge

It is anticipated that stakeholders and mothers of SAC will find this study helpful as it makes an original contribution to the body of knowledge on sexual violence, especially

with regard to the support of mothers of SAC post-disclosure, an issue not always acknowledged by the stakeholders.

The study contributed to the body of knowledge as guidelines for support to mothers of SAC have been developed as currently there has been literature scarcity about the experiences of mothers of SAC post disclosure and unavailability of guidelines and programmes for support in North West Province as well as the country.

The guideline develop would address the plight of mothers of SAC on areas such as: self-blame, distractive behaviour, stigma attached, labelling and rejection because the stakeholders could see the need to improve the intervention strategies for mothers of SAC in the NWP.

The guidelines form a tool that will be used as reference by future formal and informal stakeholders that are in contact with mothers of SAC. The study has also contributed significantly to the practice because the legal system, health professionals and community advocacy group will see the need to support mothers of SCA.

8.5 Limitations of the Study

The study only focused on mothers of SAC post-disclosure as compared to fathers. This state of affairs makes it difficult to know the effects of CSA on both parents. The researcher could have interviewed the fathers because according to sexual assault register found in TTCC some children were accompanied by their fathers and some of these fathers were single parents. Only mothers of SAC in the NWP participated in the study, therefore the findings cannot be generalized to other provinces, but the

study could be replicated.

8.6 Recommendations

The specific recommendations of this study are discussed according to research, clinical practice, education and policy making in the subsections that follow.

8.6.1 Research

- ✿ More research is needed in the NWP to investigate the other strategies that could be put in place to assist mothers of SAC to cope with the secondary trauma.
- ✿ Research should be conducted among different health professionals and the legal system to examine their feelings and perception as to why they are not sensitive to the needs mothers of SAC.
- ✿ Guidelines or a programme for support to children who were sexually abused should be developed.
- ✿ Research should evaluate if the guidelines for support are effective.
- ✿ The experiences of fathers regarding CSA should be explored, this is important because during data collection it was noted that some SAC were accompanied by their fathers to TTCC.

8.6.2 Clinical Practice

- ✿ The TTCC in the province should collaborate with other institutions to develop a simple, standardized and integrated multidisciplinary approach

to support mothers of SAC.

- ✿ The providers and implementers of these guidelines are to develop evaluation tools to ensure that the support is effective, sustainable and adequate in supporting mothers of SAC.
- ✿ Collaborative inter-professional and inter-disciplinary strategies are to be developed to ensure that mothers of SAC are supported and the guidelines are understood.
- ✿ Professionals are to assist mothers of SAC to understand the procedures that are followed in health service and what is happening during court proceedings.
- ✿ Forensic nurses and physicians are to be employed so that screening of sexually abused persons can be conducted according to the protocol.
- ✿ Multidisciplinary teams should work with perpetrators and their families to decrease the time for court proceedings and to prevent perpetrators to re-offend.
- ✿ Health professionals should create a therapeutic environment that is conducive to the provision of support to mothers of SAC following disclosure.
- ✿ Professionals should employ therapeutic use of self so that mothers of SAC feel accepted, relaxed and able to make decision and open up.

- ✿ All Thuthuzela care centres should be provided with forensic-trained nurses, doctors and sexual assault counsellors.
- ✿ Service hours are to be extended in all TTCC to 24 hours so that clients should be examined and counselled by experts at any time.
- ✿ One stop centres are to be made effective by ensuring that all services are accessible to clients.

8.6.3 Education

- ✿ Include introduction of forensic module in undergraduate programmes such as support of non-offending mothers of SAC following disclosure. Forensic nursing knowledge will assist health practitioners to support mothers.
- ✿ Teach and train professionals such as doctors, teachers, parents, police officers and advocates who are attending to SAC and their mothers, on how to screen for CSA and take appropriate action.
- ✿ Counselling should be a compulsory module in all undergraduate studies. The module should include communication, listening skills, understanding of cultures and values regarding CSA and the support that is related to mothers of SAC.
- ✿ The basic school curriculum should include gender violence studies.
- ✿ Ministers of religion, traditional leaders and police officers should attend

short courses on gender violence issues.

8.6.4 Policy Makers

- ✿ Policy developers must review support policies for non-offending mothers.
- ✿ Policies to manage mothers of SAC post-disclosure must be included in the primary health care package.
- ✿ Policies to manage perpetrators must be in place and accessible to all stakeholders.
- ✿ Service hours for all TTCC in the province must be extended to 24 hours in all centres.

8.7 Summary

The chapter discussed the justification, limitations, recommendations and conclusion of the study. One of the major points that emerged is that mothers were not supported and there are no supporting structures. One of the recommendations is that more research must be done on child abuse and on this subject matter.

The findings showed that mothers expressed various types of trauma. They also blamed themselves for not taking care of their children, and demonstrated a wide range of psychological difficulties and lack of support from stakeholders. The age of participants ranged between 19 to 70 years, with the majority of respondents in the 30-40 years bracket at 35%. The results also showed extreme PTSD 47.8%, little

support 38.8%, not coping 76.1% and little depression 36.1%. The relationship between variables indicated the following: PTSD and social support P-value 0.363, depression and social support P-value 0.540, coping skill and PTSD P-value 0.576, coping and depression P-value 0.648. There was no statistical significance among the variables because the P-values are more than the significance level of 0.05.



REFERENCES

- Alaggia, R., & Kirshenbaum, S. (2005). Speaking the Unspeakable: Examining the Impact of Family Dynamics on Child Sexual Abuse Disclosures. *Families in Society: The Journal of Contemporary Social Services*, 86(2), 227-234.
- Allnock, D., & Start, N. F. (2010). Children and young people disclosing sexual abuse: An introduction to the research. *Child Protection Research Department, NSPCC*.
- Andrew.E.M.,Gray,N.S & Snowden,R.J.,(2008). The relationship between trauma and beliefs about hearing voices: a study of psychiatric and non-psychiatric voice hearers. *Psychological medicine* (2008),38 1409-1417.@2008 Cambridge University Press doi:10.17003329170700253x.
- Astbury, J., (2013). Violating children's rights: the psychological impact of sexual abuse in childhood. *The Bulletin of the Australian Society LTD*, 35(5)1-11
- Atoro, K. E., Cross, T. P., Jones, L. M., Magnuson, S., Shadoin, A. L. & Walsh, W. (2010). Non-offending caregiver and youth experiences with child sexual abuse investigations. *Journal of Interpersonal Violence*, 25(2),291-314.
- Avery, L.,Massat, C. R., & Lundy, M., (1998). The relationship between parent and child reports of parental supportiveness and psychopathology of sexually abused children. *Child and Adolescent Social Work Journal*, 15(3), 187-205.
- Bassett, C. (2006). *Qualitative research in health care*. John Wiley & Sons.
- Beck, A. T., Steer, R. A., & Carbin, M. G., (1988). Psychometric properties of the Beck Depression
- Beers, M. H., Fletcher, A. J., Jones, T. V., Porter, R., Berkwitz, M., & Kaplan, J. L. (2003). *The Merck manual of medical information*. Merck Research Laboratories.
- Bein,K.(2011).National Sexual Assault Coalition Resource Sharing Project:Working Together To End Sexual Violence.
- Bennett, L., Dawe, D., & Power, J. (1999). Children's needs in shelters: mother's perceptions. *Canadian Journal of Community Mental Health (Revue canadienne de santé mentale ecommunautaire)*, 18(1), 57-76.
- Brink, H., Van der Walt, C., & Van Rensburg, G. (2006). *Fundamentals of research methodology for health care professionals*. Juta and Company Ltd.
- Benton, D. C., & Cormack, D. F. (2000). Reviewing and evaluating the literature. *The Research, Process in Nursing Process* 77-88
- Blanchard, E. B., Jones-Alexander, J., Buckley, T. C., & Forneris, C. A. (1996).Psychometric properties of the PTSD Checklist (PCL). *Behaviour research and therapy*, 34(8), 669-673.
- Breiding, M. J., Reza, A., Gulaid, J., Blanton, C., Mercy, J. A., Dahlberg, L. L., & Bamrah, S. (2011). Risk factors associated with sexual violence towards girls in Swaziland. *Bulletin of the World Health Organization*, 89(3), 203-210.
- Brink, H., Van der Walt, C., & Van Rensburg, G. (2006). *Fundamentals of research methodology for health care professionals*. Juta and Company Ltd.

- Brink, H., Van der Walt, C., & Van Rensburg, G. (2012). *Fundamentals of research methodology for health care professionals*. Juta and Company Ltd.
- Bronfenbrenner, U. (1997). Ecological models of human development. *Readings on the development of children*, 5.
- Bryman, A., & Cramer, D. (1999). Quantitative data analysis with SPSS Release 8 for Windows. *A guide for social scientists*. London and New York: Taylor & Francis Group.
- Bumberry, W., Oliver, J. M., & McClure, J. N. (1978). Validation of the Beck Depression Inventory in a university population using psychiatric estimate as the criterion. *Journal of Consulting and Clinical Psychology*, 46(1), 150.
- Burns, N., & Grove, S. K. (2009). *The practice of nursing research*. Saunders.
- Campbell, R., & Raja, S. (1999). Secondary victimization of rape victims: Insights from mental health professionals who treat survivors of violence. *Violence and Victims*, 14(3), 261-275.
- Campbell, R., Dworkin, E., & Cabral, G. (2009). An ecological model of the impact of sexual assault on women's mental health. *Trauma, Violence, & Abuse*, 10(3), 225-46.
- Carvalho, Q. C. M., Galvão, M. T. G., & Cardoso, M. V. L. M. L. (2009). Child sexual abuse: the perception of mothers concerning their daughters' sexual abuse. *Revista latino-americana de enfermagem*, 17(4), 501-506.
- Celano, M., Hazzard, A., Webb, C., & McCall, C. (1996). Treatment of traumagenic beliefs among sexually abused girls and their mothers: An evaluation study. *Journal of Abnormal Child Psychology*, 24(1), 1-17.
- Child Network Gravity at Girl Child Sexual Abuse 2011
- Chinn, P. L., & Kramer, M. K. (2008). *Theory and nursing: A systematic approach*. St Louis, Missouri: Mosby.
- Cohen, S., & Wills, T. A. (1985). Stress, social support, and the buffering hypothesis. *Psychological Bulletin*, 98(2), 310.
- Cooper, C., Katona, C., & Livingston, G. (2008). Validity and reliability of the brief COPE in carers of people with dementia: the LASER-AD Study. *The Journal of Nervous and Mental Disease*, 196(11), 838-843.
- Corcoran, J. (1998). In defence of mothers of sexual abuse victims. *Families in Society*.
- Creswell, J. (2009). *Research design: Qualitative, quantitative, and mixed methods approaches*. Sage
- Creswell, J. W. (2013). *Research design: Qualitative, quantitative, and mixed methods approaches*. Sage.
- Creswell, J. W., & Clark, V. L. P. (2007). *Designing and conducting mixed methods research*. Sage
- Cyr, M., Wright, J., Toupin, J., Oxman-Martinez, J., McDuff, P., & Thériault, C. (2002). Predictors of maternal support: The point of view of adolescent victims of sexual abuse and their mothers. *Journal of Child Sexual Abuse*, 12(1), 39-65.
- David, M., & Sutton, C. D. (2011). *Social research: An introduction*. Sage.
- De Jong, A. R. (1988). Maternal responses to the sexual abuse of their children. *Pediatrics*, 81(1), 14-21.
- De Vos, A. S., Strydom, H., Fouché, C. B., & Delport, C. S. L. (2006). Research at grass roots for social and human science professions.

- De Vos, A. S., Strydom, H., Fouché, C. B., & Delport, C. S. L. (2005). *Research at Grass Roots. A Primer for the Caring Profession*.
- De Vos, A. S., Strydom, H., Fouche, C. B., Poggenpoel, M., & Schurink, E. (1998). *Research at grass roots: A primer for the caring professions*. Pretoria: JL van Schaik.
- Democratic Nursing Organisation of South Africa. (1998). Ethical standard for Nurse Researchers. Position Paper. DENOSA: Pretoria.
- Dennison, R. P., & Koerner, S. S. (2008). A look at hopes and worries about marriage: The views of adolescents following a parental divorce. *Journal of Divorce & Remarriage*, 48(3-4), 91-107.
- Dolores M. & Tongo C (2007). Ethnobotany Research and Applications Purposive Sampling as a Tool for Informant Selection. *A journal of Plants, People, and Applied Research*.
- Edmond, T., Sloan, L., & McCarty, D. (2004). Sexual abuse survivors' perceptions of the effectiveness of EMDR and eclectic therapy. *Research on Social Work Practice*, 14(4), 259-272.
- Elliott, A. N., & Carnes, C. N. (2001). Reactions of non-offending parents to the sexual abuse of their child: A review of the literature. *Child Maltreatment*, 6(4), 314-331.
- Esparza, D. (1993). Maternal support and stress response in sexually abused girls ages 6-12. *Issues in Mental Health Nursing*, 14(1), 85-107.
- Finkelhor, D. (1997). The international epidemiology of child sexual abuse. *Child Abuse & Neglect*, 18(5), 409-417.
- Flick, U. (2014). *An introduction to qualitative research*. Sage.
- Fong, J., & Walsh-Bowers, R. (1998). Voices of the blamed: Mothers' responsiveness to father-daughter incest. *Journal of Family Social Work*, 3(1), 25-41.
- Fontes L.A. & Plumber. (2010). Cultural Issues in Disclosures of Child Sexual Abuse. *Journal of Child Sexual Abuse* 19(5), 491-518
- Guba, E. G. (1979). Naturalistic inquiry. *Improving Human Performance Quarterly*, 8(4), 268-376.
- Gwirayi, P. (2010). The role of macro-systemic contexts in understanding the aetiology and epidemiology of child sexual abuse in Southern Africa. *Journal of Sustainable Development in Africa*, 12(2), 253-268.
- Hamber, B., & Lewis, S. M. (1997). *An overview of the consequences of violence and trauma in South Africa*. Centre for the study of violence and reconciliation.
- Hébert, M., Daigneault, I., Collin-Vézina, D., & Cyr, M. (2007). Factors linked to distress in mothers of children disclosing sexual abuse. *The Journal of Nervous and Mental Disease*, 195(10), 805-811.
- Hébert, M., Lavoie, F., & Parent, N. (2002). An assessment of outcomes following parents' participation in child abuse prevention program. *Violence Victims*. 17, 355-372.
- Henning, E., Van Rensburg, W., & Smit, B. (2004). *Finding your way in qualitative research*. Van Schaik Publishers.
- Herman, J. L. (1997). *Trauma and recovery*. Basic books.

- Hicks, C. M. (2009). *Research methods for clinical therapists: applied project design and analysis*. Elsevier Health Sciences.
- Hiebert-Murphy, D. (1998). Emotional distress among mothers whose children have been sexually abused: The role of a history of child sexual abuse, social support, and coping. *Child Abuse & Neglect*, 22(5), 423-435.
- Hill, A. (2001). 'No-one else could understand': Women's Experiences of a Support Group run by and for Mothers of Sexually Abused Children. *British Journal of Social Work*, 31(3), 385-397.
- Holloway, I., & Wheeler, S. (2013). *Qualitative research in nursing and healthcare*. John Wiley & Sons. 79, 358-369.
- Jewkes, R., & Abrahams, N. (2002). The epidemiology of rape and sexual coercion in South Africa: an overview. *Social Science & Medicine*, 55(7), 1231-1244.
- Jewkes, R., Penn-Kekana, L., & Rose-Junius, H. (2005). "If they rape me, I can't blame them": Reflections on gender in the social context of child rape in South Africa and Namibia. *Social Science & Medicine*, 61(8), 1809-1820.
- Jones, A. D., & Jemmot, E. T. (2010). Child sexual abuse in the Eastern Caribbean: perceptions of, attitudes to, and opinions on child sexual abuse in the Eastern Caribbean. UNICEF.
- Jones, A., & Trotman-Jemmott, E. (2009). Child sexual abuse in the eastern Caribbean. *New York: UNICEF*.
- Joyce, P. A. (2007). The production of therapy: The social process of construction of the mother of a sexually abused child. *Journal of Child Sexual Abuse*, 16(3), 1-18.
- Kelly, S. J. (1990). Parental stress response to sexual abuse and ritualistic abuse of children in day-care centers. *Nursing Research*, 39(1), 25-29.
- Kim, K., Noll, J. G., Putnam, F. W., & Trickett, P. K. (2007). Psychosocial characteristics of non-offending mothers of sexually abused girls: Findings from a prospective, multigenerational study. *Child Maltreatment*, 12(4), 338-351.
- Kim, K., Trickett, P. K., & Putnam, F. W. (2010). Childhood experiences of sexual abuse and later parenting practices among non-offending mothers of sexually abused and comparison girls. *Child abuse & neglect*, 34(8), 610-622.
- Kinard, E. M. (1996). Social Support, self-worth, and depression in offending and non-offending mothers of maltreated children. *Child Maltreatment*, 1, 272-283.
- Kisanga, F., Emmelin, M., Urassa, D., & Nyström, L. (2012). Child sexual abuse among secondary school students in urban Tanzania: prevalence, risk factors and consequences. Umeå University Medical Dissertation, <http://www.diva-portal.org/smash/get/diva2:572246/FULLTEXT01.pdf>.
- Kouyoumdjian, H., Perry, A. R., & Hansen, D. J. (2009). Non-offending parent expectations of sexually abused children: predictive factors and influence on children's recovery. *Journal of Child Sexual Abuse*, 18(1), 40-60.
- Lalor, K. (2008). Child sexual abuse and HIV transmission in sub-Saharan Africa. *Child Abuse Review*, 17(2), 94-107.

- Lalor, K., &McElvaney, R. (2010). Overview of the nature and extent of child sexual abuse in Europe.
- Lewin, L., & Bergin, C. (2001). Attachment behaviors, depression, and anxiety in non-offending mothers of child sexual abuse victims. *Child Maltreatment*, 6(4), 365-375.
- Lewis, S. (1997). Theoretical and Therapeutic Aspects of Extrafamilial Child Rape in the South African Context: A Preliminary Exploration. *Centre for the Study of Violence and Reconciliation*, University of the Witwatersrand.
- Lewis, S. (1999). An adult's guide to childhood trauma: understanding traumatised children in South Africa. New Africa Books.
- Lincoln, Y. S. (1985). *Naturalistic inquiry* (Vol. 75). Sage
- Lipton, M. (1997). The effect of the primary caretaker's distress on the sexually abused child: A comparison of biological and foster parents. *Child and Adolescent Social Work Journal*, 14(2), 115-127.
- LoBaido, A. C. (2001). Child rape epidemic in South Africa. Retrieved May, 6, 2004.
- Madu, S. N., &Peltzer, K. (2000).Risk factors and child sexual abuse among secondary school students in the Northern Province (South Africa). *Child Abuse & Neglect*, 24(2), 259-268.
- Masho, S. W., & Ahmed, G. (2007). Age at sexual assault and post-traumatic stress disorder among women: Prevalence, correlates, and implications for prevention. *Journal of Women's Health*, 16(2), 262-271.
- Massat, C.P & Lundy.M.(1998). "Reporting costs" to non-offending parents in cases of intra-familial child sexual abuse. *Child Welfare*; 77(4): 371-88.
- Mathoma, A. M., Maripe-Perera, D. B., Khumalo, L. P., Mbayi, B. L., &Seloilwe, E. S. (2006). Knowledge and perceptions of parents regarding child sexual abuse in Botswana and Swaziland. *Journal of Pediatric Nursing*, 21(1), 67-72.
- Meichenbaum, D. (2008). Trauma, spirituality and recovery: Toward a spiritually integrated psychotherapy. *Unpublished paper, The Melissa Institute for Violence Prevention and Treatment, Miami, Florida*.
- Meier, E. (2002). Child rape in South Africa. *Pediatric Nursing*, 28(5), 532.
- Michael R. R., (2009).The Bureau of Justice Statistics is the statistical agency of the U.S. Department of Justice. NCJ 227777 <<http://www.ojp.usdoj.gov/bjs/pub/pdf/cv08.pdf>>
- Morgan, G. A., Griego, O. V., &Gloeckner, G. (2000). *SPSS for windows: An introduction to use and interpretation in research*. L. Erlbaum Associates Inc.
- Mosby. (1998). Mosby medical and nursing dictionary. St Louis: Mosby Company.
- Mouton, J. (1996). *Understanding social research*. Van Schaik Publishers.
- Murray-Swank, N.A., &Pargament (2003).God Where are you: Evaluating Spiritually Intervention for Sexual Abuse. *Mental Health, Religion & Culture*.<http://www.tandfonline.com/loi/cmhr> 20.
- Myrick, A. C., & Green, E. J. (2013). A play-based treatment paradigm for non-offending caretakers: Evidence-informed secondary trauma treatment. *International Journal of Play Therapy*, 22(4), 193-206.

- Neville, H. A., & Heppner, M.J. (1999). Contextualizing rape: Reviewing sequelae and proposing aculturally inclusive ecological model of sexual assault recovery. *Applied and Preventative Psychology, 8*,41-62
- Newberger, C. M., Jeremy, I. M., Waternaux, C. M., &Newberger, E. H. (1993). Mothers of sexually abused children: Trauma and repair in longitudinal perspective. *American Journal of Orthopsychiatry*,63(1), 92.
- Pereda, N., Guilera, G., Forns, M., & Gómez-Benito, J. (2009). The prevalence of child sexual abuse in community and student samples: A meta-analysis. *Clinical Psychology Review, 29*(4), 328-338.
- Pifalo, T. (2009). Mapping the maze: An art therapy intervention following disclosure of sexual abuse.*Art Therapy, 26*(1), 12-18.
- Pintello, D., & Zuravin, S.(2001). Intrafamilial Child Sexual Abuse: Predictors of Post-disclosure in maternal belief and protective action. *Child Maltreatment, 6*(4),344-352.
- Plummer, C. A. (2006). Non-abusive mothers of sexually abused children: The role of rumination in maternal outcomes. *Journal of Child Sexual Abuse, 15*(2), 103-122.
- Plummer, C. A., & Easton, J. A. (2007).System intervention problems in child sexual abuse investigations: the mothers' perspectives. *Journal of Interpersonal Violence, 22*(6), 775-787.
- Polit, D. F., & Beck, C. T. (2004). *Nursing research: Principles and methods*. Lippincott Williams & Wilkins
- Polit, D. F., & Beck, C. T. (2010).*Nursing research: Principles and methods*. Seventh Edition Lippincott Williams & Wilkins. USA
- Polit, F. &Hungler, B. (1993). Nursing Research Principles and Methods. Philadelphia: J.B. Lippincott Williams & Wilkins.
- Powel, L. & Cheshire A. (2010). A Preliminar Evaluation of A Massage Program for Children Who Have Been Sexually Abused and their Non-offending Mothers*Journal of Child Sexual Abuse*,19(2),141-155.
- Pretorius, G., Chauke, A., & Morgan, B. (2011). The lived experiences of mothers whose children were sexually abused by their intimate male partners.*Indo-Pacific Journal of Phenomenology, 11*(1).*Process in Nursing. Oxford: Blackwell Science*.
- Pugh,J.F. (2012). "Conceptual and Clinical Perspectives Culture Brain and Analgesia: Understanding and Managing Pain in Diverse Population. (2012):12
- Ryan.P.L.,(1998) Spirituality among adult survivors ofchildhood violence: a literature review. *The Journal of Transpersonal Psychology, 1998, Vol. 30, No.1*
- Pugh, J.F. (2012). "Conceptual and Clinical Perspectives Culture Brain and Analgesia: Understanding and Managing Pain in Diverse Population.(2012):12
- Reilly, J. M., &Gravdal, J. A. (2012). An ecological model for family violence prevention across the life cycle. *Family Medicine, 44*(5), 332-5.
- Republic of South Africa (2007). Child Care Act of 1983 as Amended
- Republic of South Africa.(2006). Criminal Law (Sexual Offences and Related Matters) Act, no. 23 of 2007.

- Republic of South Africa.(2007). Children's Act, no. 38 of 2005.
- Richter, L. M., & Dawes, A. R. (2008). Child abuse in South Africa: rights and wrongs. *Child Abuse Review*, 17(2), 79-93.
- Robertson, M. (1998).An overview of rape in South Africa.*Continuing Medical Education Journal*, 16(2),139-140).
- Santa-Sasa, E.J., Steer, R.A., Deblinger, E and Ruyon, M.K. (2013). Depression and Parenting by Nonoffending Mothers of Children Who Experienced Sexual Abuse. *Journal of Child Sexual Abuse*,22(8),915-930.
- Sarantakos, S. (2005). Social Research Third Edition. Palgrave Macmillan.
- Schoubben-Hesk, S. 1997. Traditional Healers Views on Child Sexual Abuse. University of Zululand Unpublished Thesis.
- Smith ^(a). D. W., Sawyer, G. K., Jones, L. M., Cross, T., McCart, M. R., & Ralston, M. E. (2010). Mother reports of maternal support following child sexual abuse: Preliminary psychometric data on the Maternal Self-report Support Questionnaire (MSSQ). *Child Abuse & Neglect*, 34(10), 784-792.
- Smith^(b). K., Bryant-Davis, T., Tillman, S., & Marks, A. (2010). Stifled voices: barriers to help-seeking behavior for South African childhood sexual assault survivors. *Journal of Child Sexual Abuse*, 19(3), 255-274.
- South African Police Service Report (2008/2009)
- South African Police Service Report (2011) Crime Statistics overview 2011/2012,The South African Police Service,Department of Police presentation available at <http://www.saps.gov.za.statisticreport/crimestats/2012/crime-stats.htm> (accessed 10th Oct2012).
- South African Police Service.(2006).Document:Statistics (Rape)
Available:<http://www.saps.gov.za/statistics/reports/crimetats/2005/categories.htm>,accessed August 2010.
- Spataro, J., Mullen, P. E., Burgess, P. M., Wells, D. L., & Moss, S. A. (2004).Impact of child sexual abuse on mental health Prospective study in males and females.*The British Journal of Psychiatry*, 184(5), 416-421.
- Speck, P. (2011). Spiritual religious issues in care of the dying.*Care of Dying.A pathway to excellence*, 106-126.
- Speizer, I. S., Goodwin, M., Whittle, L., Clyde, M., & Rogers, J. (2008). Dimensions of child sexual abuse before age 15 in three Central American countries: Honduras, El Salvador, and Guatemala. *Child Abuse & Neglect*, 32(4), 455-462.
- Speziale, H. S., Streubert, H. J., & Carpenter, D. R. (2011). *Qualitative research in nursing: Advancing the humanistic imperative*. Lippincott Williams & Wilkins.

- Stauffer, L.B., & Deblinger, E. 1996. Cognitive behavioral groups for non-offending mothers and their young sexually abused children: a preliminary treatment outcome study. *Child Maltreatment*, 1, 65-76.
- Stotenborgh, M. Van Ijzendoorn, M.H., Euser, E.M., & Bakermans-Kramnenburg (2011). A Global Perspective on Child Sexual Abuse: Meta-Analysis of Prevalence Around the World. *Child Maltreatment* 16(2)79http://an.sagepub.com.
- Tavkar, P. (2010). Psychological and support characteristics of parents of child sexual abuse victims: Relationship with child functioning and treatment. A Dissertation Presented to the Faculty of The Graduate College at the University of Nebraska
(http://digitalcommons.unl.edu/psychdiss/17/).
- TedlieMoskowitz, J., Folkman, S., &Acree, M. (2003). Do positive psychological states shed light on recovery from bereavement? Findings from a 3-year longitudinal study.*Death Studies*, 27(6), 471-500.
- Townsend, L., & Dawes, A. (2004). Individual and contextual factors associated with the sexual abuse of children under 12: A review of recent literature. *Sexual abuse of young children in Southern Africa*, 55-94.
- Tshabalala-Msimang, M. (2003) Department of health: The National Management Guidelines for Sexual Assault.
- Tufford, L., & Newman, P. (2012). Bracketing in qualitative research. *Qualitative Social Work*, 11(1), 80-96.
- Ullman, S. E. (1999). Social support and recovery from sexual assault: A review. *Aggression and Violent Behavior*, 4(3), 343-358.
- Willingham, E. U. (2007). Maternal perceptions and responses to child sexual abuse. *Counselling and psychological services dissertations*.
- World Bank.(2011). International rape statistics.www.sexualassaultservice.gmu.edu. Accessed 02.06.2011.
- World Health Organisation. (2010). Preventing intimate partner and sexual violence against woman. Taking action and generating evidence/ World Health Organization\ 1 and London School of Hygiene and Tropical Medicine.
- Xu, J., & Wei, Y. (2013). Social Support as a Moderator of the Relationship between Anxiety and Depression: An Empirical Study with Adult Survivors of Wenchuan Earthquake. *PloS one*, 8(10), e79045.
- Zimba, W. (2013).Psychological impact of child sexual abuse on primary caregivers in Lusaka, Zambia.

ANNEXURE A

Ethical Clearance



NORTH-WEST UNIVERSITY
YUNIBESITHI YA BOKONE BOPHIRIMA
NOORDWES-UNIVERSITEIT

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Ethics Committee

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Email: Ethics@nwu.ac.za

Prof M Maselesele and Margaret Masilo

Ethics Approval of Project

2012/04/24

The North-West University Ethics Committee (NWU-EC) hereby approves your project as indicated below. This implies that the NWU-EC grants its permission that, provided the special conditions specified below are met and pending any other authorisation that may be necessary, the project may be initiated, using the ethics number below.

Project title: Support Guidelines for Mothers of Sexually Abused Children in North West Province	
Project leader: Prof M Maselesele	
Student: Margaret Masilo	
Ethics number	N W U - 0 0 0 1 0 - 1 2 - A 9
Approval date: 17 April 2012	Expiry date: 18 April 2017

Special conditions of the approval (if any): None

General conditions:

While this ethics approval is subject to all declarations, undertakings and agreements incorporated and signed in the application form, please note the following:

- The project leader (principal investigator) must report in the prescribed format to the NWU-EC:
 - annually (or as otherwise requested) on the progress of the project,
 - without any delay in case of any adverse event (or any matter that interrupts sound ethical principles) during the course of the project.
- The approval applies strictly to the protocol as stipulated in the application form. Would any changes to the protocol be deemed necessary during the course of the project, the project leader must apply for approval of these changes at the NWU-EC. Would there be deviation from the project protocol without the necessary approval of such changes, the ethics approval is immediately and automatically forfeited.
- The date of approval indicates the first date that the project may be started. Would the project have to continue after the expiry date, a new application must be made to the NWU-EC and new approval received before or on the expiry date.
- In the interest of ethical responsibility the NWU-EC retains the right to:
 - request access to any information or data at any time during the course or after completion of the project,
 - withdraw or postpone approval if:
 - any unethical principles or practices of the project are revealed or suspected,
 - it becomes apparent that any relevant information was withheld from the NWU-EC or that information has been false or misrepresented,
 - the required annual report and reporting of adverse events was not done timely and accurately,
 - new institutional rules, national legislation or international conventions deem it necessary.

The Ethics Committee would like to remain at your service as scientist and researcher, and wishes you well with your project. Please do not hesitate to contact the Ethics Committee for any further enquiries or requests for assistance.

Yours sincerely

Prof Amanda Lourens
(Chair NWU Ethics Committee)

ANNEXURE B

Request for Permission to Conduct the Study

P.O. BOX 6656

Mmabatho

10 April 2012

The Chief Director
The Department of Health Research Unit
North-West Province

Sir/Madam

Request to conduct research in the North-West Province Thuthuzela Care Centre

This communiqué serves as a request for conducting research in the NWP. The study will focus on **Guidelines for Support to mothers of sexually abused in North-West Province**. The purpose of this study is to develop guidelines for support to mothers of sexually abused children by exploring and describing the experiences of mothers whose children were sexually abused. The results of the study will guide the researcher to develop guidelines for support to mothers of sexually abused children in North-West Province.

The objectives of the study are:

- To explore and describe the experiences of mothers of sexual abused children following disclosure
- To examine the association between demographic factors and depression, coping skills, PTSD and social support
- To examine correlation between levels of PTSD and social support
- To examine the correlation between levels of PTDS and coping skills
- To examine the correlation between levels of depression and coping skills
- To examine correlation between levels of depression and social support
- To describe the conceptual framework within which guidelines for support to mothers of sexually abused children can be develop; and
- To develop guidelines for support to mothers of sexually abused children.

The research findings of the experiences of mothers to sexually abused children in the North-West Province would guide the researcher to design guidelines that would assist policy developers to ensure that the mothers are supported while they are accompanying their children to health facilities.

Permission from the Ethics Committee of North-West University is attached.

The promoter for the study is Prof M. Davhana-Maselesele, Rector North-West University -Mafikeng Campus

Yours faithfully

GM.Masilo



ANNEXURE C

Permission to Conduct Research



health
Department of
Health
North West Province
REPUBLIC OF SOUTH AFRICA

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Mafikeng 9741
Private Bag 42188
MABATHO 0110

Tel: 018 521 4011
info@nwhealth.gov.za
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POLICY PLANNING, RESEARCH, MONITORING AND EVALUATION

To Ma M. Masilo

From Policy, Planning, Research, Monitoring & Evaluation

Subject Research Approval – Support guide for mothers of sexually abused children in North West Province.

Purpose

To inform MS. M. Masilo that permission to conduct the research has been granted by the North West Provincial Health Services. The application of the research has been approved by the Department of Health, North West Province, and the research has been approved by the Department of Health, North West Province.

The research project is a management of sexually abused children and their mothers. The research project is a management of sexually abused children and their mothers. The research project is a management of sexually abused children and their mothers.

Researcher


Director of Policy, Planning, Research, Monitoring & Evaluation
North West Province

DEPARTMENT OF HEALTH

1000 BUILDING

12, ROBERT LUTHULI DRIVE

MAFIKENG 9741

PRIVATE BAG 42188

MABATHO 0110

SUPPLEMENTARY GENERAL



FOR A BETTER WORLD

ANNEXURE D

Letter to the Manager of Mafikeng Provincial Hospital Thuthuzela Care Centre

North-West University
Private /Bag x 2046
Mafikeng Campus
2745

10th April 2012

Sir/Madam

**Request to conduct a research (data collection) at the following facility: Mafikeng Provincial
Hospital Thuthuzela Care Centre.**

I am a student at the North-West University (Mafikeng Campus) and I am currently registered for a PhD Degree in Community Nursing Science under the supervision of Prof M. DavhanaMaselesele.

I have been granted permission to undertake the research in the North-West Province by the Department of Health in the North-West Province. My research topic is: **Guidelines for support to Mothers of Sexually Abused Children in North-West Province.** The purpose of this study is to develop guidelines for support to mothers of sexually abused children by exploring and describing the experiences of mothers whose children are sexually abused. The results of the study will guide the researcher to develop guidelines for support to mothers of sexually abused children in the North-West Province.

Dates and times for the data collection and interviews will be decided upon by the facility managers and the researcher.

The approval letter from North-West Department of Health is attached.

Thanking you in anticipation.

Yours truly,

Mrs

G.M.

Masilo

ANNEXURE E

Informed Consent Form

You are asked to participate in a research study conducted by Gaboipolelwe Margaret Masilo in the NWP at Thuthuzela Care Centre. The study will focus on experiences of mothers of sexually abused children in NWP. You are selected to participate in the study because you are a non-offending mother of a sexually abused child who is under the age of 17 years. It is voluntarily to participate in this study.

The aim of the study is to describe and explore the experience of these mothers after being aware that their children are sexually abused and to develop guidelines for support. Many children, under the age of 17 are sexually abused in our communities. The mothers of these sexually abused children's experiences are not known. Therefore, I want to investigate more about their experiences

If you volunteer to participate in this study, the researcher will conduct an in-depth individual interview that will contain the following:

Questions about your age, age of the child, marital status, your level of education, your employment status, your monthly income and the support you receive from stakeholders will be asked. One question will be asked such as: What are your experiences ever since your child is sexually abused? Other questions will emanate from the answers you give.

The study will take about 1 hour to 1h30 minutes. The researcher may interview you again after data analysis. The study will be tape recorded.

Potential risks or discomfort that can be anticipated

Some questions may make you feel uncomfortable; you may also feel some distress in discussing your child's sexual abuse

The interview may be too long for you

During interview you may disclose sensitive issues that are personal such as your family members being the perpetrator

The researcher will ensure confidentiality in any information that will come to her

You might feel distressed in discussing your Child Sexual Abuse

Potential benefits

The information you give will help us to understand your needs. Your needs and the result of this study may assist the professionals find better methods of supporting you while you bringing the child for sexual examination.

It will also help with the development of guidelines for support to non-offending mothers of CSA. This will also help other mothers in the community who have experienced the same problem.

Confidentiality will be maintained

The information that will be obtained from you will be confidential, it will only be disclosed when you permit me to do so.

The information about you and other participants will be kept private.

The following measures will be employed. The screening and consent forms will be the only documents containing your particulars.

These two documents will be kept under lock and key.

The rest of the interview information will not have your information

A code will be used to label the information; this is done to ensure that any unauthorized person trying to obtain information will not succeed.

Withdrawal from the participation is allowed.

You can withdraw at any time. Withdrawing from the study will not affect any services that you receive from this institution. You may also refuse the questions that you do not want to answer and still remain participating in the study.

All questions about this study should be directed to:

Mrs.Gaboipolelwe Margaret Masilo

North-West University (Mafikeng Campus)

P/Bag x 2046

Mmabatho.

2735

Email:Margaret.masilo@nwu.ac.za

Signature of study participant

I understand the procedures described above. My questions have been answered, and I agree to participate in this study. I have been given a copy of this form.

Name of participant_____

Date_____

Future use of data:

Please check the appropriate box below and initial:

I agree to have my data stored for future use by the researcher-----

I do not want my data stored for future use by the researcher-----

Signature of person obtaining consent

I, in my judgment, the participation is voluntary and knowingly giving informed consent to participate in this research

Name of person obtaining consent_____

Contact no_____

Signature of person obtaining consent_____

Date_____

ANNEXURE F

Screening Tool for Participant Recruitment

Gaboipolelwe Margaret Masilo (Researcher)
Department of Nursing Science
North-West University (Mafikeng Campus)
Mafikeng
2735
Tel: 018 3892571
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Email: Margaret.masilo@nwu.ac.za

I am a PhD student conducting a study among mothers of sexually abused children in the North-West Province. I request you to participate in this study if you are a care giver of a child who is sexually abused.

Purpose of the study

The purpose of this study is to develop guidelines for support to mothers of sexually abused children by exploring and describing the experiences of mothers whose children are sexually abused. The information will be used to develop guidelines to help mothers of children whose children are sexually abused.

Inclusion Criteria:

The mother will be the primary female caretaker of any race of a sexually abused child between ages of 0-16years, not accused of sexual abuse herself.

The sexual abuse must have occurred within one year.

The sexual abuse must have occurred within the North-West Province.

The sexual abuse will include oral, vaginal or anal penetration or unclothed touching to a child from an adult perpetrator including incest

The sexually abused child will either be a male or a female.

ANNEXURE G

Survey Questionnaire

SECTION I: MOTHER'S SOCIO-DEMOGRAPHIC CHARACTERISTICS

How old are you? _____

Racial group:

- ☐ Black
- ☐ White
- ☐ Coloured
- ☐ Others (specify) _____

If Black/African, what is your ethnicity? _____

What is the highest grade you have completed? _____

How many children do you have? _____

Are you employed? _____yes/no_____

If yes, what is your job? _____

Does your job require you to travel? _____yes/no_____

If yes, who cares for your child(ren) in your absence? _____

How much money do you earn per month? _____

What is your marital status? _____

PROMPT: give options for marital status if participant does not understand the question

- ☐ Married
- ☐ Single/ never married
- ☐ Divorced/widowed/separated

☐ Other (specify)

If MARRIED, how many times have you been married? _____

How long have you been in your current marriage? _____

Do you cohabit with your current partner? _____

PROMPT: partner is a boyfriend or other

How old is your partner? _____

Is he currently employed? _____

What is his monthly income? _____

SECTION II: INFORMATION ABOUT THE SEXUALLY ABUSED CHILD

How old is the child? _____

What is the child's gender? _____

Is the child attending school? _____

In which grade is the child currently enrolled? _____

SECTION III: INFORMATION ABOUT CHILD'S SEXUAL ABUSE

When the child was sexually abused? _____ (MM/YYYY)

PROMPT: Need month and year

When did you find out about the child's sexual abuse? _____ (MM/YYYY)

PROMPT: Need month and year

How old was the child when the abuse happened? _____

Has the child been previously abused? _____

If YES, how many times has the child been sexually abused? _____

Has child received previous support services? _____

Have you received you received previous support services? _____

If Yes, how many times did you receive it? _____

How did you find out about the child's sexual abuse? _____

PROMPT: referring to the most recent abuse

What is the child's relationship with the perpetrator? _____

PROMPT: choices can include father, stepfather, uncle, brother, neighbour, teacher, family friend, other

What type of sexual abuse did the child experience?

PROMPT: choices can include: noncontact, contact, intercourse (penetration or attempted)

BECK DEPRESSION INVENTORY (BDI)

Rating from 0- lowest score to 3- highest

	0	1	2	3
	Never	1-2 days	3-4days	Most days-3-7
1. Sadness				
2. Pessimism				
3. Sense of failure				
4. Dissatisfaction				
5. Guilt				
6. Expectation of punishment				
7. Dislike of self				
8. Self-Accusation				
9. Suicidal ideation				
10. Episodes of crying				
11. Irritability				
12. Social withdrawal				
13. Indecisiveness				
14 Change in body image				
15. Retardation				
16. Insomnia				
17. Fatigability				
18. Loss of appetite				
19. Loss of Weight				
20. Somatic preoccupation				
21. Low level of energy				

Section B: PTSD Checklist (PCL)

The following is a list of problems and complaints that people may experience after stressful experiences. Please read each one carefully and indicate how much you have been bothered by that problem in the past month.

No.	Response	1	2	3	4	5
		Not at all	A little bit	Quite a bit	Moderately	Extremely
1.	Repeated, disturbing memories, thoughts, or images of stressful events in the past?					
2.	Repeated, disturbing dreams of stressful experience from the past?					
3.	Suddenly acting or feeling as if stressful events in the past and the aftermath of the events were happening again (as if you were reliving it)?					
4.	Feeling very upset when something reminded you of stressful events in the past?					
5.	Having physical reactions (e.g., heart pounding, trouble breathing, sweating) when something reminded you of stressful events in the past and the aftermath of the events?					
6.	Avoiding thinking about or talking about stressful events in the past and the aftermath of the events or avoiding having feelings related to these events?					
7.	Avoiding activities or situations because they reminded you of stressful events in the past and the aftermath of the events?					
8.	Trouble remembering important parts of stressful events in the past and the aftermath of the events?					
9.	Loss of interest in activities that you used to enjoy?					
10.	Feeling distant or cut off from other people?					

No.	Response	1	2	3	4	5
		Not at all	A little bit	Quite a bit	Moderately	Extremely
11.	Feeling emotionally numb or being unable to have loving feelings for those close to you?					
12.	Feeling as if your future somehow will be cut short?					
13.	Trouble falling or staying asleep?					
14.	Feeling irritable or having angry outbursts?					
15.	Having difficulty concentrating?					
16.	Being "super alert" or watchful or on guard?					
17.	Feeling jumpy or easily startled?					

Brief COPE Scale

	1	2	3	4
	Not at All	Quite a Bit	Moderate	Extremely
Self-distraction, items 1 and 19				
Active coping, items 2 and 7				
Denial, items 3 and 8				
Substance use, items 4 and 11				
Use of emotional support, items 5 and 15				
Use of instrumental support, items 10 and 23				
Behavioural disengagement, items 6 and 16				
Venting, items 9 and 21				
Positive reframing, items 12 and 17				
Planning, items 14 and 25				
Humour, items 18 and 28				
Acceptance, items 20 and 24				

Religion, items 22 and 27				
Self-blame, items 13 and 26				

Social Support Grid

Social support is the network of family, friends, or other people that are available to you when you need any kind of help, someone to talk to or someone to listen to you.

C1. How many relatives including in-laws do you see/visit/hear from at least once a month?

C2. Tell me about the relative with whom you have the most contact. How often do you visit/see/hear from that person?

Less than once a month -----

Monthly -----

A few times a month -----

Weekly -----

A few times a week -----

Daily -----

C3. How many close friends do you see/visit/ hear from at least once a month? Friends, with whom you feel at ease, can talk to about private matters or can call on for help.

Number of friends -----

C4. Tell me about the friend with whom you have the most contact. How often do you visit/see/hear from that person?

Less than once a month -----

Monthly -----

A few times a month -----

Weekly -----

A few times a week -----

Daily -----

People sometimes look to others for companionship, assistance, or other types of support. How often is each of the following kinds of support available to you if you need it?

Your responses are: None of the time, A little of the time, Some of the time, Most of the time and All of the time. Choose the response that best answers the question.

How often is there	None	A little	Some	Most of	All of
--------------------	------	----------	------	---------	--------

	of the time	of the time	of the time	the time	the time
C5. Someone to help if you were confined to bed					
C6. Someone who shows you love and affection.					
C7. Someone to take you to the doctor if you needed it.					
C8. Someone to confide in or talk about yourself or your problems.					
C9. Someone who hugs you.					
C10. Someone to get together with for relaxation.					
C11. Someone to help you with daily chores if you were sick.					
C12. Someone to turn to for suggestions about how to deal with a personal problem.					
C13. Someone to love and make you feel wanted					
C14. Someone to help you with your child(ren)					

ANNEXURE H

Interview Transcript

Interviewer	Hello mama, I am working at the North-West University. I am conducting a research on mothers whose children were sexually abused.
Participant	Ok mama
Interviewer	Like I have already asked you to talk to you about the incidence that happened to your child, here I am.
Participant	The aim of this study is to develop guidelines which will specifically support the mothers of SAC. The development of guidelines entirely depends on the information I will receive from you today. I will only be able to develop the guidelines for support I am talking about with your help, by explaining to me how you felt after becoming aware that your child is abused sexually, and what kind of help did you receive from everybody that helped you including your family as well as the type of support you expected.
Participant	Ok mma (but looking sad).
Interviewer	What we are going to talk about will be strictly confidential. I will not tell anybody except the professor who is supervising me. Can we start?
Participant	Yes Mama
Interviewer	How old are you mama?
Participant	I am 42 years old
Interviewer	Ok, How old is the baby?
Participant	She is 18 months and her perpetrator is 22 years old (crying) my nephew for that matter.
Interviewer	Your nephew?
Participant	Yes, he did not go to work that day and I had already prepared the child for crèche, telling them to put her on the taxi. I left the child with the hope that she will go to crèche as usual. (Crying bitterly)
Interviewer	So the child never went to the crèche.
Participant	Yes, this is a curse; my 17 year old girl was sexually abused when she was 9 years by a 52 year old man in 2003. Now, this one is 18 months and is abused by a relative.

(Crying)

Interviewer Mm, (nodding the head)

Participant The case was reported to the police, this case has been dragging for about 8 years, and it came to an end this year. The perpetrator is not found guilty. They say the evidence was not enough yet they have doctor's report but court proceedings took years.

Interviewer Mm..... What about this 18 months old baby?

Participant The perpetrator is my sister's son he is 22years old. I felt pity for him, he was not employed, I asked him to come and stay with me so that I can help him to look for a job. He got the job, now he has abused my baby (crying). He is in jail but I know for sure that very soon he will be released; the law of this country is not fair to children. He must rot in the prison, I don't care whether he is a family member or not.

Interviewer Oh he is in jail?

Participant Yes I think I am cursed, my husband died of HIV because he did not want to take treatment. I am also positive but I am on treatment, fortunately my girls are both negative. What have I done to suffer like this? (Crying) Every time a man comes to my house, the child runs away, I also feel jumpy. I only think funny things; in fact I cannot think straight I am depressed I can't sleep. Right now I am on night duty, when I am about to go to work I think twice. The child does not allow anybody to touch her. She is afraid of men.

Interviewer She is afraid of men, how did you discover that she is sexually abused?

Participant: I went to work in the morning having instructed everybody in the house including the perpetrator to put the child into the taxi for crèche. The perpetrator was off duty on that particular day.

Interviewer Yes

Participant When I came back from work I tried to change the baby's napkin but she cried kicking me, I insisted to remove it. I asked the other children if she came crying from crèche, the 11 year old one told me that the child did not go to crèche because uncle told them that there is no need to take her to crèche because he will take care of her. He continued to say that uncle changed the pampers while they were playing soccer outside. (Crying)

Interviewer How did the child look like when you ultimately remove the napkin?

Participant The private parts were red, swollen and bruised. She did not want me to touch her. The first suspect is my nephew, because he volunteered to take care of the baby, he did not want the child to go to crèche.

Interviewer So he is the first suspect?

Participant Yes, I took her to the clinic and the clinic referred me to TTCC. The child was examined by the doctor and confirmed that the child is raped. The police were at TTCC and I laid a charge against him.

Interviewer Was the child only seen by the doctor and the police officers?

Participant No, the counsellors, nurses and police officers attended her. I am told to take her to

the psychologist next week and I wonder if she will be able to talk to the child because she is too young to talk.

Interviewer To the psychologist?

Participant Yes the psychologist. The other thing she is afraid of men. She runs away when she sees them, right now my father and mother are here to support me but she hates seeing my father. The old man outside the house is my father. She hides herself behind my mother when my father is approaching her.

Interviewer Participant: Yes I did..ehMmm..nodding

Interviewer So you laid the charges against the perpetrator

Participant Yes he is...crying.....pause

Interviewer Where is the perpetrator now?

Participant He is arrested, but I have lost confidence in our judiciary even police, they will release him saying there is no evidence. They did that with my other daughter.

Interviewer What is your experience after the disclosure of your child's sexual abuse?

Participant This thing makes me mad, myself and my big daughter cry almost every day. This is hurting, it causes stress and trauma. I spent sleepless nights. I am hurting, panicking because they took blood from the baby for HIV she was negative, again they took it and they said I should come for results next week. I hope the next test will be negative too. (Crying)

Interviewer You are panicking?

Participant Yes I ask myself questions. Why did I call Ndaba (not his real name) to come and live with me .I feel like I an irresponsible mother. I am angry with myself right now. I am hurting and guilty (crying). In fact, I did not believe that this is happening to me for second time, my first daughter now the my second child, a baby. I wish what happened to my baby could have happened to me but not to an innocent soul (mentioning the name of the child), this days I am so forgetful.

Interviewer You are forgetful?

Participant Yes, I am. It is because I only think of the trauma I am experiencing.

Interviewer You are experiencing trauma but at the hospital how were you supported by the professionals?

Participant Oh! They were very nice, the clinic transferred me to the hospital, I was quickly attended to by the doctor and the nurses. I am having an appointment with the psychologist. The police were polite but now they are delaying the case. I am waiting for police officers to visit as promised.

Interviewer They were nice, what about the support from the family and neighbours?

Participant Yes, my father and mother are here for that. They are outside the house. I told my parents and they phoned my sister in Johannesburg, the mother of the perpetrator, my sister is complaining that I did not tell her, but I was shocked and confused by what her son did. She is not supportive instead she is blaming me, I think it is because it's her son who raped the child and I reported the case to the police.

Perhaps she thought I would say this case should be a family matter. (Crying)

Interviewer Did she say anything about her child's arrest?

Participant No, but from her talks she is not happy, she asked me why couldn't we discuss it at home.

Interviewer Do you think that she is eh eh.... not supportive?

Participant Yes, she is not. She is not asking about the child's conditions or surprised or shocked about what her son did. I think that she takes it to be a minor issue, I am sure she wants me to drop the case but over my dead body. I am hurt.....eh a pause

Interviewer Is there any experience or support that we have not talk about it?

Participant I think I have told you everything but I am angry with my nephew, I will not forgive him. I feel like killing him. He is a dog or a pig. I am angry, I feel like dying. Otherwise I have nothing more to tell you.

Interviewer If you have nothing more to tell allow me to take this opportunity to thank you for your time. Thank you, I hope you will receive assistance from the police officers and judiciary. I hope to see some time to give you the outcome of this study. Bye bye mama.

ANNEXURE I

Confirmation by Language Editor and Typesetter



UNIVERSITY of the
WESTERN CAPE

FACULTY OF NATURAL SCIENCES

DEPARTMENT OF MEDICAL BIOSCIENCES

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12 September 2015

To Whom it May Concern

This serves to confirm that I have edited the language, spelling, grammar and style of the PhD thesis by **Gaboipolelwe Margaret Masilo**, titled: **"Guidelines for Support to Mothers of Sexually Abused Children in North-West Province."** The manuscript was also professionally typeset by me.

Sincerely Yours

A handwritten signature in black ink, appearing to be 'D. Hiss'.

Dip. Freelance Journalism, Dip. Creative Writing, MSc (Medicine), PhD