

A proposed support strategy for sexually abused boys in their middle childhood placed in a clinic school

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Thesis submitted for the degree *Doctor Philosophiae* in
Psychology at the Potchefstroom Campus of the North-West
University

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November 2014

I dedicate this study to Harmony,
a four year old leukaemia patient.

Thank you for sharing your journey of life with me.

You show me what the meaning of real courage is.

DECLARATION BY RESEARCHER

I hereby declare that this research manuscript, **A proposed support strategy for sexually abused boys in their middle childhood placed in a clinic school**, is my own effort. I furthermore declare that all the sources used in this report have been referenced and acknowledged.

I also declare that this dissertation was edited and proofread by a qualified language editor as prescribed. Finally, I declare that this research was submitted to *Turn-it-in* and a satisfactory report was received.

A handwritten signature in black ink, reading 'H. Steyn', is written over a horizontal line.

Helga Steyn

ACKNOWLEDGEMENTS

I wish to acknowledge all the people who contributed to the completion of this study.

Most importantly, I am abundantly grateful to my **Heavenly Father**, for His endless grace and love. As long as I shall live, I will testify of your love.

Kobus, my husband and best friend, without whom I could never have made this journey. You made me who I am.

Annie and Heleen, my two beautiful daughters. You are the greatest reward in my life.

Dr Carlien Van Wyk, my promoter, who guided me in such a supportive manner. Your encouragement and guidance inspired me throughout this exciting, yet challenging research.

Dr Ansie Kitching, my co-promoter who gave such valuable inputs throughout this research.

The **principals of the schools** where the research was conducted. Thank you for the allocated time and space to complete the research.

All the **learners, teachers, child and youth care workers, social workers, psychologists and counsellors** who contributed to this research. Thank you for trusting me with your life experiences.

Marietjie Nelson for your excellent work as language editor.

All my **colleagues** at Moreletapark Dutch Reformed Church. Thank you for encouraging me to complete this study with success. The following persons need special mention: Louise Ehlers and Mathilda Breytenbach.

My **family and friends** who supported me throughout this research.

Louise, my special friend. Words can never be enough. Thank you for your endless support and the way in which you share life with me.

I hereby acknowledge the financial support provided by the North-West University (Potchefstroom Campus). The opinions expressed and the conclusions reached in the publication are those of the authors and do not represent those of the funders.

SUMMARY

Boys in their middle childhood placed in clinic schools experience severe emotional and behavioural problems. Most of these boys have been sexually abused. The trauma of this sexual abuse may contribute to their problem behaviour. If the learners can be effectively supported in addressing the trauma of the male child sexual abuse during their time at the clinic school, some of their emotional and behavioural problems may also be addressed. Without these emotional and behavioural problems they may be able to develop without hindrance of the male child sexual abuse and may be integrated into the mainstream educational setting before they reach the age of twelve years.

This study consisted of three phases. During the first phase the experiences of seven sexually abused boys placed in clinic schools in Gauteng Province in South Africa were explored in order to develop a better understanding of their support needs. It was achieved by means of three in-depth interviews with each participant. For the purpose of the first phase a qualitative design was used, which was of a phenomenological, descriptive and exploratory nature in order to explore and describe the phenomenon of male child sexual abuse. To obtain a clear picture of the unique view and subjective experiences of a participant in a clinic school, the phenomenon of male child sexual abuse was investigated. From the results it was clear that sexually abused boys placed in clinic schools exhibit intensified emotional reactions, as well as certain problems associated with male child sexual abuse. The intensified emotional reactions include a deep sense of sadness and helplessness, a sense of guilt and shame, a sense of dissociation and numbness, avoidance of situations associated with male child sexual abuse, fear of recurring incidents and the re-experiencing of the trauma. The problems associated with male child sexual abuse include concerns regarding

their own sexuality, difficulties in interacting with other people, dealing with anger and aggression, displaying self-destructive behaviour and difficulties to cope with schoolwork.

During the second phase of the study twenty-four psychologists, social workers, counsellors, teachers and child and youth care workers were included. Semi-structured individual interviews were conducted with each of them to identify critical aspects to support victims of male child sexual abuse. For the purpose of the second phase the interpretive descriptive design was used. The results suggest that the following critical aspects should be considered in the conceptualisation of a proposed support strategy: Relationships as basis for support; strengthening the male child sexual abuse victims to deal with behavioural and emotional challenges; facilitating the safety of the male child sexual abuse victims to avoid continued exposure to abuse; providing a structured environment and coordinated support efforts to ensure sustainability.

The third phase of this study consisted of the conceptualisation of a support strategy for male child sexual abuse victims. Two focus groups were conducted with fourteen psychologists, social workers, counsellors, teachers and child and youth care workers to conceptualise the support strategy. The proposed support strategy suggests the incorporation of different role players in a collaborative team approach for a multilevel support approach. The proposed support strategy involves three main facets, namely strengthening of the male child sexual abuse victim as an individual, sustaining a deep/trusting relationship, as well as the facilitation of a supportive context for the male child sexual abuse victim.

Key words: Male child sexual abuse; clinic schools; support; middle childhood; support strategy; collaborative team; phenomenology; interpretive descriptive design

OPSOMMING

Seuns in hulle middelkinderjare wat in 'n kliniekskool geplaas is, ervaar ernstige emosionele en gedragsprobleme. Die meeste van hierdie seuns is seksueel misbruik. Die trauma van die seksuele misbruik kan moontlik bydra tot hulle gedragsprobleme. Indien hierdie leerlinge effektief ondersteun word om die trauma van die seksuele misbruik te hanteer gedurende die tydperk wat hulle in die kliniekskool is, kan sommige van hulle emosionele en gedragsprobleme moontlik ook aangespreek word. Hulle kan dan moontlik ontwikkel sonder die hindernis van die seksuele misbruik wat kan lei tot die herintegrasie van die leerlinge in die hoofstroomskole voor die ouderdom van twaalf jaar.

Hierdie studie het uit drie fases bestaan. Gedurende die eerste fase is die ervarings van sewe seksueel misbruikte seuns wat in kliniekskole in Gauteng Provinsie in Suid-Afrika geplaas is geëksploreer, ten einde 'n beter begrip te ontwikkel van hulle ondersteuningsbehoefte. Dit is bereik deur drie indiepte onderhoude met elke seun te voer. Vir die doel van die eerste fase is die kwalitatiewe ontwerp gebruik, wat fenomenologies, beskrywend en verkennend van aard is, ten einde die fenomeen van die seksueel misbruikte seun te verken en beskryf. Uit die bevindinge blyk dit dat seksueel misbruikte seuns wat in 'n kliniekskool geplaas is intense emosionele reaksies toon, sowel as sekere probleme wat met die seksuele misbruik van seuns geassosieer kan word. Die intense emosionele reaksies sluit 'n intense gevoel van hartseer en hulpeloosheid, 'n gevoel van skuld en skaamte, 'n gevoel van dissosiasie en afstomping, vermyding van situasies wat met die seksuele misbruik geassosieer kan word, vrees vir herhalende insidente van misbruik en die herbelewing van die trauma in. Die probleme wat met die seksuele misbruik van seuns geassosieer word, sluit bekommernis rondom eie seksualiteit, probleme met interaksies met ander mense, hantering van woede en aggressie, self-destruktiewe gedrag en probleme met skoolwerk in.

Gedurende die tweede fase van die studie is vier-en-twintig sielkundiges, maatskaplike werkers, beraders, onderwysers en jeugwerkers betrek. Semi-gestruktureerde individuele onderhoude is met elkeen gevoer om die kritiese aspekte te bepaal hoe om 'n seun te ondersteun wat misbruik is. Vir die doel van die tweede fase is die interpreterende beskrywende ontwerp gebruik. Die bevindinge wys dat die volgende kritiese aspekte in aanmerking geneem moet word in die konseptualisering van die voorgestelde ondersteuningstrategie: Verhoudings as basis vir ondersteuning; versterk die seksueel misbruikte seun om die emosionele en gedragssuitdagings te hanteer; fasiliteer die veiligheid van die seksueel misbruikte seuns as slagoffers ten einde moontlike herhalende misbruik te voorkom; voorsien 'n gestruktureerde omgewing en koördineer ondersteuningspogings om volhoubaarheid te verseker.

Die derde fase van die studie het bestaan uit die konseptualisering van die voorgestelde ondersteuningstrategie vir seuns wat seksueel misbruik is. Twee fokusgroepe is gehou met veertien sielkundiges, maatskaplike werkers, beraders, onderwysers en jeugwerkers om die ondersteuningstrategie te konseptualiseer. Die voorgestelde ondersteuningstrategie stel die inkorporering van verskillende rolspelers voor in 'n gesamentlike spanbenadering vir ondersteuning op verskeie vlakke. Die voorgestelde ondersteuningstrategie sluit drie hoofasette in, naamlik die versterking van die seksueel misbruikte seun as 'n individu, handhawing van 'n diep verhouding wat gebaseer is op vertroue, sowel as die fasilitering van 'n ondersteuningskonteks vir die seksueel misbruikte seun.

Sleutelwoorde: Seksuele misbruik van seuns; kliniekskole; ondersteuning; middelkinderjare; ondersteuningstrategie; gesamentlike spanbenadering; fenomenologie; interpreterende beskrywende ontwerp

PREFACE

- For purposes of examination the thesis is presented as a single document consisting of four parts that include an introduction, three articles (as indicated in rule A.14.4.2 of the year book of the North-West University, Potchefstroom Campus), the conclusions and recommendations, as well as a single and combined reference list of all the sections. Where in-text references refer to three to five authors, the names of all the authors were used the first time the reference appears in each of the sections as each section is viewed as a separate unit. Thereafter only the name of the first author will be used when referring to all the authors.
- The American psychology Association (APA) guidelines (6th edition), were used in Part 1 and 3. In Part 2 the articles are written according to the guidelines of the journals, which are provided in Appendix G. Articles 1 and 3 used Harvard referencing and article 2 used APA referencing. However, Article 1 used the abbreviated Harvard style and Article 3 used the Harvard system for references. Therefore the styles of Article 1 and 3 differ.
- Article 1 is published, with the following reference:

 Steyn, H., Van Wyk, C. & Kitching, A. E. (2014). *Child Abuse Research in South Africa*, 15(1), 15-28.

 Article 2 will be submitted to the *Journal of Child Sexual Abuse*.

 Article 3 will be submitted to the *Social Work/Maatskaplike Werk* journal.
- Please note that the term "researcher" was used to refer to the first author who conducted the research for this study.
- A letter of permission from the co-authors to submit the articles for examination purposes is included.

LETTER OF PERMISSION

We, the promoter and co-promoter, declare that the input and effort of Helga Steyn in writing these articles, reflects the research done by her. We hereby grant permission that she may submit these articles for examination purposes in fulfilment of the degree Doctor Philosophiae in Psychology.



Carlien Van Wyk

Promoter



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Co-Promoter

DECLARATION OF LANGUAGE EDITOR

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I hereby certify that I have language edited the treatise prepared by Helga Steyn, entitled **A proposed support strategy for sexually abused boys in their middle childhood placed in a clinic school.**

ME Nelson

6 November 2014

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SECTION 1

INTRODUCTION TO STUDY

Section 1 will be divided into Part 1, Part 2 and Part 3. In Part 1 an orientation to the study will be discussed. In Part 2 the literature overview for this study will be discussed. Part 3 explains the theoretical framework used in this research.

SECTION 1: PART 1

ORIENTATION TO THE STUDY

1 Introduction and Statement of the Problem

Child sexual abuse (hereafter referred to as CSA) is a worldwide phenomenon. A meta-analysis done by Pereda, Guilera, Forns and Gómez-Benito (2009) on the prevalence of CSA revealed that South Africa appears to have the highest incidence of CSA globally. According to the South African Police Services' Annual Crime Report (2011) a total of 28 128 sexual offence cases against children under the age of eighteen years were reported between 1 April 2010 and 31 March 2011. In a study done by Dunn (2008a) it is stated that currently one in three children in South Africa will be sexually abused some time during their childhood.

The Criminal Law Sexual Offences and Related Matters Amendment Act 32 of 2007 (South Africa, 2007) defines CSA as the conduct of any person who engages a child under the age of eighteen years with or without the consent of the child, in a sexual act. The sexual act is an act of sexual penetration or an act of sexual violation. The Children's Act 38 of 2005 (South Africa, 2005) mentions the child as being a child in need of care and protection if the child is being maltreated, abused, deliberately neglected or degraded. According to this Act much more attention must be given to support these children to arrive at quality of life despite the trauma that they experienced.

Although most studies of CSA have focused on girls, the sexual abuse of both boys and girls is common (Alaggia & Millington, 2008; Bullock & Beckson, 2011; Dorahy & Clearwater, 2012; Thielmann, 2010). In a study undertaken in the residential areas of southern Johannesburg, Gauteng Province in South Africa, it was found that just as many boys as girls under the age of fifteen years are sexually abused (Brookes & Higson-Smith, 2004). The research on male child sexual abuse (hereafter referred to as MCSA) which is

available consistently shows that the sexual victimisation of males is noteworthy. According to research conducted at the international level by Schraufnagel, Davis, George and Norris (2010) roughly 14% of males are sexually abused during childhood. In a South African study conducted by Mathews, Abrahams and Jewkes (2013) in urban Gauteng Province, a prevalence rate of 20,4% for MCSA was found before the age of eighteen years. This percentage, however, may also be underestimated due to continued low disclosure rates (Kiselica & Novack, 2011; Maikovich-Fong & Jaffee, 2010; O’Leary & Gould, 2009; Schraufnagel et al., 2010; Thielmann, 2010) and boys’ way of suppressing emotions (Barker & Crenshaw, 2011; Haen, 2011; Kiselica & Englar-Carlson, 2011; Thielmann, 2010). A conspectus of the research that has been done on MCSA reveals that the long-term effects of CSA is equally damaging to girls and boys (Alaggia & Millington, 2008; Chen et al., 2010; Larsen, Sandberg, Harper & Bean, 2011; Maikovich-Fong & Jaffee, 2010; O’Leary & Gould, 2009; Thielmann, 2010).

The sexual abuse of boys in middle childhood has serious effects on these children who will often display extreme forms of emotional and behavioural difficulties (Alaggia & Mishna, 2014; Asgeirsdottira, Sigfusdottirb, Gudjonssona & Sigurdsson, 2011; Coohey, 2010; Diamanduros, Cosentino, Tysinger & Tysinger, 2012; Gospodarevskaya, 2013). Due to these problems they may not be able to cope in mainstream schooling and are then placed in clinic schools.

Clinic schools accommodate learners with special educational needs and are therefore referred to as *Learners with Special Educational Needs* (hereafter referred to as LSEN) schools (Department of Education South Africa, 2001). At an international level clinic schools are referred to as “residential care” (Casey et al., 2010; Quisenberry & Foltz, 2013), “institutional youth care” (De Swart et al., 2012) or “alternative schools” (Lehr, Soon Tan & Ysseldyke, 2009; Simonsen, Britton & Young, 2010; Simonsen & Sugai, 2013). For the

purpose of this research the term “clinic schools” was used. The specific focus of clinic schools is on learners with behavioural and emotional problems (Casey et al., 2010; De Swart et al., 2012; Lehr et al., 2009; Quisenberry & Foltz, 2013; Simonsen et al., 2010; Simonsen & Sugai, 2013). The main reason for referral to a clinic school remains the learners’ angry, ambivalent and externalising behaviour (Broecher, 2014; McNamara, 2010), which is often characterised by hostility, defiance, hyperactivity, noncompliance and aggression (Thomas, 2010). The main objective of a clinic school is to offer a short-term and interim alternative educational setting (Lee & Barth, 2011) in which learners can become rehabilitated with the intention of re-integrating them into the mainstream educational settings (Flick, 2011; Haid & Donnelly, 2013) or less restrictive environments (Ennis, Jolivet, Swoszowski & Johnson, 2012; Simonsen et al., 2010). These clinic schools can accommodate learners until they reach the age of twelve years (RE¹, personal communication, March 3, 2014).

The research literature indicates that a significant group of children who are placed in clinic school contexts experienced abuse (Lebel & Kelly, 2014; McNamara, 2010; Quisenberry & Foltz, 2013; Suk-ching Chong & Leung, 2012). Practitioners who work in the context of clinic schools confirmed that many of these boys have been sexually abused and that the trauma of the sexual abuse may contribute to their problem behaviour. JvH (personal communication, May 24, 2012), the social worker and RE (personal communication, May 24, 2012), the principal at one of these clinic schools in the area where the research was conducted confirmed, based on their practical experience, these learners have serious emotional and behavioural problems due to the fact that they have been sexually abused.

Currently the sexual abuse of learners in these clinic schools is not addressed properly, because there are not sufficient support strategies available for MCSA victims. This results in the continuation of the problem behaviour and the delay to integrate these learners into the

¹ In the case of personal communication, the initials of the persons were used to protect their identity.

mainstream educational setting again. No support strategies or programmes nationally or internationally that focus specifically on sexually abused boys placed in a clinic school through a collaborative team approach could be located. According to SS (personal communication, March 12, 2012), a counsellor at one of these clinic schools, she struggles to support these MCSA victims, because she lacks the knowledge to address the MCSA and does not have a support strategy to assist her in this process. Yet, social support can be seen as a protective factor among individuals at risk where supported individuals show better adaptation after a stressful life event than non-supported individuals (Arias & Johnson, 2013; Sperry & Widom, 2013). In the case of MCSA (Schönbucher, Maier, Mohler-Kuo, Schnyder & Landolt, 2014; Yancey & Hansen, 2010) social support can thus assist a MCSA victim to adapt better after the experience of the abuse. This emphasises the importance of support to MCSA victims.

The overarching focus of this study was to propose a support strategy for MCSA victims in the contexts of a clinic school. In order to understand the experiences of MCSA victims in clinic schools, these boys had to be incorporated in this research. This phenomenological method of inquiry implies that the participants were approached with genuine willingness to learn and an open mind to discover their personal experiences of the phenomenon of MCSA (Edmonds & Kennedy, 2013). Chan, Lam and Shae (2011) add that children in research should be considered as dynamic agents who can give us valuable perceptions of their experiences, knowledge and thoughts. Jackson, Newall and Backett-Milburn (2013) stressed that neglected and abused children are mostly an exposed group whose opinions have often been disregarded in the past. This motivated the involvement of children in research as they can have some say in the decisions that are made about them. Research of this issue is thus a necessity in order to support this vulnerable group of children optimally.

The theoretical framework of the Strengths Perspective was used to conceptualise the proposed support strategy. Within the Strengths Perspective all individuals have the potential and strengths that can be organised to improve the value of life as it builds on the individual's assets, possibilities, resiliencies and capabilities for change (Chapin, 2011; Gray, 2011; Saleebey, 2012; Teater, 2014), instead of just focusing on personal weaknesses, difficulties and failures (Lietz, 2011; Roose, Roets & Schiettecat, 2012). Other theoretical frameworks applied in this study are the Resilience Theory (Masten, 2011; Masten & Wright, 2012), Attachment Theory (Bowlby, 2013; Karakurt & Silver, 2014), Social Support Theory (House, 1981; Van Toledo & Seymour, 2013) and Developmental Perspective.

Based on the above-mentioned discussion, the following problem can be formulated for this study:

Boys in their middle childhood placed in clinic schools experience severe emotional and behavioural problems. Most of these boys have been sexually abused. The trauma of this sexual abuse may contribute to their problem behaviour. If the learners can be effectively supported in addressing the trauma of the MCSA during their time at the clinic school, some of their emotional and behavioural problems may also be addressed. Without these emotional and behavioural problems they may be able to develop without hindrance of the MCSA and be integrated into the mainstream educational setting before they reach the age of twelve years. The researcher could not find any research about MCSA in the context of a clinic school or a support strategy for MCSA victims. This causes this process to fail in assisting these boys in dealing with the MCSA and emphasises the importance of this study.

The main **research question** for this study is:

What will a proposed support strategy entail to support sexually abused boys in their middle childhood placed in a clinic school?

To answer this question, the following sub-questions need to be answered:

1. Based on their experiences of being MCSA victims, what are the support needs of these sexually abused boys placed in a clinic school?
2. What do professionals including social workers, psychologists, counsellors, teachers and child and youth care workers perceive as critical aspects of support for MCSA victims placed in a clinic school?
3. How do professionals including social workers, psychologists, counsellors, teachers and child and youth care workers conceptualise a support strategy for victims of MCSA in a clinic school?

2 Purpose, Aim and Objectives of the Study

The *purpose* of this study is to contribute to the provision of more advanced support for boys who were victims of MCSA and placed in a clinic school in order to uplift them in some of the emotional and behavioural difficulties they are experiencing due to the MCSA. This might subsequently enable them to become integrated into the mainstream educational setting again and return to a less restrictive environment.

The research *aim* of this study was to develop a proposed support strategy for sexually abused boys in their middle childhood placed in a clinic school, in order to uplift them in the emotional and behavioural difficulties they are experiencing due to the MCSA. This might subsequently enable them to become integrated into the mainstream educational setting again and return to a less restrictive environment.

In order to achieve the above-mentioned aim the following *objectives* were formulated:

- to explore and describe the experiences of sexually abused boys placed in a clinic school, in order to develop a better understanding of their support needs;

- to identify critical aspects for support, as perceived by social workers, psychologists, counsellors, teachers and child and youth care workers, for MCSA victims placed in a clinic school; and
- to conceptualise a proposed support strategy for sexually abused boys in their middle childhood placed in a clinic school.

3 Central Theoretical Argument

Boys in their middle childhood placed in a clinic school experience behavioural and emotional problems (Casey et al., 2010; De Swart et al., 2012; Quisenberry & Foltz, 2013; Simonsen & Sugai, 2013), like negativity, hostility, defiance, hyperactivity, noncompliance and aggression (Broecher, 2014; McNamara, 2010). Most of these boys have been sexually abused (Lebel & Kelly, 2014; Quisenberry & Foltz, 2013; Suk-ching Chong & Leung, 2012). Their problem behaviour may stem from the trauma caused by the MCSA and may have been aggravated by the placement in the clinic school. No support strategies for sexually abused boys placed in a clinic school could be found.

There are, however, different protective factors which can buffer the impact of MCSA. A secure attachment (Bowlby, 1980, 2013; Karakurt & Silver, 2014) can serve as an internal protective factor that can promote resilience (Masten, 2011; Masten & Wright, 2012; Wright, Masten & Narayan, 2013). A secure attachment between the MCSA victim and the psychologist, social worker, counsellor, teacher and child and youth care worker (hereafter referred to as role players) can also enhance the social support (House, 1981; Schönbucher et al, 2014; Van Toledo & Seymour, 2013) offered to these sexually abused boys. Social support to these MCSA victims can subsequently improve their resilience. Therefore enhancing the social support through a secure attachment will enhance the MCSA victim's resilience even further.

It is argued that if the trauma relating to the MCSA can be understood and these boys can be supported effectively in a more proactive and intensified manner, the behavioural and emotional problems that were the original cause of the boy being removed from the mainstream educational setting may also be addressed. Through the Strengths Perspective the focus will be on the MCSA victim's strengths, instead of just focusing on personal weaknesses, failures and difficulties (Lietz, 2011), like the MCSA and subsequently the emotional and behavioural difficulties these boys are experiencing. This will play a significant role in improving reintegration of these learners into the mainstream educational setting and addressing the trauma of the MCSA in the long term. Within the Strengths Perspective the focus is the identification and mobilisation of the resources, assets, wisdom and knowledge that every person has, as well as their potential for transforming their experiences (Saleebey, 2012).

4 Research Design and Methodology

4.1 Literature overview

For the purpose of this study the researcher conducted a literature review in order to understand MCSA, the effects of MCSA during the middle childhood, the context of a clinic school, the collaborative team, as well as the theoretical framework for this study. In a qualitative study it is also necessary to do a literature search, where the findings can be discussed within the context of what has already been written about MCSA and clinic schools. This literature study can help to validate and confirm the data from the interviews, identify unique aspects from the findings from the interviews that are not in the literature or state aspects in the literature that could not be found in the interviews (Streubert & Carpenter, 2010).

A variety of scientific literature like books, journals, research reports, articles and completed research were used and included in this study. Databases like Science Direct, SA EPublications, Google Scholar, Sabinet Online, Boloka IR, EBSCO Host, PsychLit and ProQuest was used to identify appropriate literature. The researcher used books and theses from the North-West University, University of Pretoria and UNISA.

The following table outlines the main concepts for the literature study, as well as a list of the references mainly studied for each concept.

Table 1

Main concepts and reference list

MAIN CONCEPTS	REFERENCES
Male child sexual abuse	Alaggia & Millington, 2008 Alaggia & Mishna, 2014 Barker & Crenshaw, 2011 Bullock & Beckson, 2011 Chan, Lam, & Shae, 2011 Chen et al., 2010 Diamanduros, Cosentino, Tysinger & Tysinger, 2012 Dorahy & Clearwater, 2012 Dorais & Meyer, 2009 Gartner, 2011 Haen, 2011 Kiselica & Englar-Carlson, 2011 Kiselica & Novack, 2011 Larsen, Sandberg, Harper & Bean, 2011 Lowenstein, 2011 Maikovich-Fong & Jaffee, 2010 Mathews, Abrahams & Jewkes, 2014 O’Leary, 2009

MAIN CONCEPTS	REFERENCES
	O’Leary & Gould, 2009 Schraufnagel, Davis, George & Norris, 2010
Clinic schools	Bastiaanssen et al., 2012 Bastiaanssen, Delsing, Kroes, Engels & Veerman, 2014 Casey et al., 2010 Conn, Calais, Szilagyi, Baldwin & Jee, 2014 Ennis, Jolivette, Swoszowski & Johnson, 2012 Flick, 2011 Jolivette et al., 2014 Nahgahgwon, Umbreit, Liaupsin & Turton, 2010 Suk-ching Chong & Leung, 2012
Middle childhood development	Berk, 2012 Bergin & Bergin, 2014 Bjorklund & Blasi, 2012 Charlesworth, 2013 Daniel, Wassell & Gilligan, 2010 Davies, 2010 Gordon & Browne, 2014 Levine & Munsch, 2013 Louw & Louw, 2014 McDevitt, 2013 Santrock, 2014
Collaborative team	Bruns et al., 2014 Dresser et al., 2009 Flåm, 2009 Fulcher, 2008 Kutash et al., 2014 Molteni, Guldberg & Logan, 2013 Suter & Bruns, 2009

MAIN CONCEPTS	REFERENCES
	Zabel, Kaff & Teagarden, 2013
Social Support Theory	Arias & Johnson, 2013 Bradshaw, Mitchell & Leaf, 2010 Curby, Rimm-Kaufman & Abry, 2013 Cyr, McDuff & Hébert, 2013 House, 1981 McLewin & Muller, 2006 Schönbucher, Maier, Mohler-Kuo, Schnyder & Landolt, 2014 Sperry & Widom, 2013 Van Toledo & Seymour, 2013 Wilson & Scarpa, 2013 Yancey & Hansen, 2010
Strengths Perspective	Bertolino, 2010 Chapin, 2011 Eloff, Ebersöhn & Viljoen, 2007 Fraser, Kirby & Smokwoski, 2004 Gray, 2011 Kelly & Gates, 2010 Kisthardt, 2012 Lietz, 2011 Roose, Roets & Schiettecat, 2012 Sabalaukas, Ortolani & McCall, 2014 Saleebey, 2012 Teater, 2014
Resilience Theory	Kelly & Gates, 2010 Marriot, Hamilton-Giachritsis & Harrop, 2014 Masten, 2011 Masten & Wright, 2012 Theron et al., 2011 Rutter, 2012

MAIN CONCEPTS	REFERENCES
	Theron & Theron, 2013 Van Hook, 2014 Van Rensburg, Theron, Rothmann & Kitching, 2013 Whitelock, Lamb & Rentfrow, 2013 Wright, Masten & Narayan, 2013
Attachment Theory	Bowlby, 1980, 2013 Karakurt & Silver, 2014 McLewin & Muller, 2006 Mikulincer & Shaver, 2007

4.2 Research paradigm

This research was approached from a social constructivist paradigm (Creswell, 2012, 2014; Gray, 2013; Higginbottom & Lauridsen, 2014; Lincoln, Lynham & Guba, 2011; Newman, 2012). Ontologically (Effingham, 2013; Killiam, 2013), the social constructivist paradigm views individuals as capable of developing subjective meanings of their experiences which are diverse and compound. Through these subjective meanings they construct their understanding of the world. This urges the researcher to look for the density of views as each participant gives multiple realities and perspectives to the same phenomenon being studied (Creswell, 2014; Higginbottom & Lauridsen, 2014). Epistemologically (Audi, 2011; Dew & Foreman, 2014; Gringeri, Barusch & Cambron, 2013a; Killiam, 2013; Lapan, Quartaroli & Riemer, 2011; Miller, 2013), within this paradigm the researcher relies mostly on the views and experiences of the participants to understand better the world the children and role players are functioning in. Therefore the means to collect data within this paradigm is to ask open-ended questions in order to construct the meaning the participants attach to a certain situation (Creswell, 2014). In the case of this research the emphasis was on a phenomenological approach where the researcher used in-depth interviews to understand

better the experiences of sexually abused boys placed in a clinic school to develop an idea of their support needs. Qualitative interpretive design was used during the semi-structured individual interviews and focus groups.

4.3 Research approach

The research approach of this study was qualitative (Drisko, 2013; Flick, 2014), in that it seeks to understand and describe phenomena (Fouché & Delport, 2011). The phenomenon in this study is MCSA. Creswell (2014) defines qualitative research as a means for exploring and understanding the meaning individuals or groups ascribe to a social or human problem. Qualitative research aims to discuss social phenomena. Within this qualitative approach the following research designs were used for the three phases of this research.

4.4 Research design

The study consisted of three phases. Each phase was designed separately and will therefore be discussed separately.

4.4.1 Phase 1.

During the first phase the researcher explored and described the experiences of sexually abused boys placed in a clinic school in order to develop an understanding of how to support them optimally. In order to understand the experiences of MCSA victims and their support needs, these boys had to be incorporated in the research as participants. For the purpose of the first phase the researcher undertook qualitative phenomenological research (Creswell, 2012; Edmonds & Kennedy, 2013; Joyce & Sills, 2014; Maltby, Williams, McGarry & Day, 2014; McWilliam, 2013), which was of a phenomenological, descriptive and exploratory nature in order to explore and describe the phenomenon of MCSA. This phenomenological method of

inquiry implies that the participants were approached with genuine willingness to learn and an open mind to discover their personal experiences of the phenomenon (Edmonds & Kennedy, 2013). Since this is an area where much needs to be done to improve support, the MCSA victims needed to be consulted. This was a research with children, not about them or on them. Chan et al. (2011) add that children in research should not be treated as objects or subjects to be counted or measured; rather, they should be regarded as active agents, as capable of enlightening us with their knowledge, thoughts and why they hold certain views in ways they like and feel comfortable.

4.4.2 Phase 2.

During the second phase the researcher obtained the opinions and inputs from role players on the critical aspects of how to support MCSA victims. For the purpose of the second phase interpretive descriptive design (Schwartz-Shea & Yanow, 2012; St. George, 2010; Stake, 2010; Thorne, 2008) was used, as the data from the semi-structured individual interviews were interpreted and then described in the second phase. According to Schwandt (2007) interpretive design is the act of clarifying or explaining the meaning of some phenomenon. According to Schwartz-Shea and Yanow (2012) practitioners know much, see much and are closest to the action. Therefore, practice is the perfect candidate for interpretive description. This kind of inquiry is about describing interpretively what the researcher learns and understands about the meanings of practice situations. These participants can thus provide valuable insight and understanding on critical aspects to support MCSA victims.

4.4.3 Phase 3.

During the third phase qualitative interpretive design (Schwartz-Shea & Yanow, 2012; St. George, 2010; Stake, 2010; Thorne, 2008) was used to conceptualise a proposed support

strategy. Focus groups were conducted with role players to assist in the conceptualisation of a proposed support strategy. The interpretive design was used, as these participants can assist in gaining knowledge about how the critical aspects to support MCSA victims can be applied in practice.

4.5 Sampling

4.5.1 Phase 1.

The population of Phase 1 consisted of sexually abused boys aged nine to twelve years who attended clinic schools in Gauteng. Non-probability sampling (Merriam, 2009; Punch, 2014; Yin, 2010) was used and specifically purposive sampling (Creswell, 2014; Flick, 2014; Lapan et al., 2011; Maltby et al., 2014; Maxwell, 2012; Monette, Sullivan & DeJong, 2011; Yin, 2010) to select seven participants with each of whom the researcher conducted three in-depth interviews. During this phase the criteria for the sampling size were determined by sufficiency and saturation of information (Creswell, 2014; Greeff, 2011). Therefore data were collected until saturation of information was achieved. Clear pre-selected criteria for the selection of participants were formulated. The criteria for inclusion in this purposive sampling were: (1) Boys who attend clinic schools in Gauteng; (2) boys in middle childhood (9-12 years); (3) boys who disclosed the MCSA and/or whose parents gave clear indications of such abuse; (5) boys had to be able to communicate in Afrikaans or English to accommodate the researcher who cannot understand any other languages; (6) boys had to be open and willing to share their experiences of MCSA; (7) boys and their parents had to give consent and be willing to be recorded digitally; and (8) boys must have had support from a registered professional to work through the trauma of MCSA prior to and after the research.

4.5.2 Phase 2.

Non-probability, purposive sampling (Creswell, 2014; Flick, 2014; Lapan et al., 2011; Maxwell, 2012; Merriam, 2009; Punch, 2014; Yin, 2010) was used to select twenty-four participants with whom the semi-structured individual interviews (Babbie, 2013; Flick, 2014; Maltby et al., 2014; May, 2011; Punch, 2014; Yin, 2010) were conducted.

The sample size of the second population was determined by sufficiency and saturation of information (Creswell, 2014; Greeff, 2011). Therefore data were collected until saturation of information was achieved. The criteria for inclusion in this population were: (1) Psychologists, social workers, counsellors, teachers and child and youth care workers in Gauteng; (2) having experience of MCSA and/or clinic schools; (3) working in a welfare organisation or private practice; and (4) having experience in the fields of MCSA and/or clinic schools of at least five years in order to make a contribution from their practical experience.

4.5.3 Phase 3.

During this phase non-probability, purposive sampling (Creswell, 2014; Flick, 2014; Lapan et al., 2011; Maxwell, 2012; Merriam, 2009; Punch, 2014; Yin, 2010) was used to select fourteen participants to include in two different focus groups. The criteria for inclusion in this population were: (1) Having professional qualifications in the fields of psychology, social work, education or youth work; (2) having experience of MCSA and/or clinic schools; (3) coming from a welfare organisation or private practice; and (4) having experience of at least five years in order to make a contribution from their practical experience.

4.6 Procedures and data collection

The following table outlines the procedures of data collection in the three phases of this study:

Table 2

Procedures of data collection

PHASE	OBJECTIVE	SAMPLE	DATA COLLECTION
1	To obtain the experiences on MCSA of sexually abused boys placed in a clinic school, in order to understand their support needs.	7 sexually abused boys (9 – 12 years old)	In-depth interviews
2	To identify critical aspects of support to sexually abused boys placed in a clinic school.	24 psychologist, social workers, counsellors, teachers and child and youth care workers	Semi-structured individual interviews
3	To conceptualise a proposed support strategy to support sexually abused boys	14 psychologist, social workers, counsellors, teachers and child and youth	Focus groups

PHASE	OBJECTIVE	SAMPLE	DATA COLLECTION
	placed in a clinic school.	care workers	

The table above gives a summary of the procedures of data collection which were followed in this research. In the following section these will be discussed in more depth.

4.6.1 Phase 1.

During the first phase permission from the ethical committee of the North-West University, Potchefstroom Campus, (Ethical number: NWU-00060-12-A1), the Gauteng Department of Education (see Appendix A), the two applicable district offices (see Appendix B), as well as the clinic schools (see Appendix C) was obtained to conduct this study. These schools indicated that they were willing to partake. The social workers of these clinic schools were requested to act as mediators to gain access to these learners and to identify potential participants. The researcher conducted an individual interview with each of the potential participants' parents to explain this research to them. During these interviews the parents signed consent forms (see Appendix D) for their children to partake in this study. The social workers then acted as mediators to discuss and explain this study to the learners who met the set criteria and asked these learners if they were willing to partake in this study. Their role also included bringing together the researcher and the prospective participants, establishing the initial rapport with them and providing all the potential participants' details to the researcher. The participants of the first population had not attained the legal age of consent and therefore the participants gave assent to partake in this study, but the parents or legal

guardians still gave the final permission and consent.

The three in-depth interviews (Johnson & Rowlands, 2012; Maltby et al., 2014; Monette et al., 2011; Nolas, 2011; Punch, 2014; Yin, 2010) with each of the participants were conducted at the two clinic schools in a private office during school hours. All of the learners placed in clinic schools receive counselling on a weekly basis. It is therefore not out of the ordinary for a learner to be called to go to an office for an interview. The researcher ensured that all telephones and cell phones were switched off during the interviews to minimise any interruptions. The place of the interview was familiar to the participants and made them feel comfortable, non-threatened and secure (Seidman, 2012). The interviews were recorded digitally (Greeff, 2011; Yin, 2010). This enabled the researcher to review the interviews afterwards to ensure that no information or non-verbal cues were missed. The recorders were checked beforehand for any problems and to ensure that the interviews were recorded properly.

Before the in-depth interviews were conducted the researcher ensured that she was equipped to conduct these interviews. The focus of the interviews was on the experiences and support needs of these learners and basic communication techniques (Greeff, 2011; Seidman, 2012) were applied to conduct the interviews. The researcher was prepared and supervised by a registered social worker through this process and she discussed the interviews with the social worker. The researcher had ethical clearance from the North-West University, permission from the parents, Gauteng Department of Education, the two applicable district offices and the principals of the schools to proceed with the research. All the participants gave assent to partake in these in-depth interviews. At the onset of these interviews participants were also reminded that participation was voluntary and they could stop the interview at any time if they felt uncomfortable or felt unwilling to talk about their experiences. The researcher ensured that the participants felt safe and comfortable to start

with the interviews. Some time was spent with the participants to get to know them better and in order to let them feel at ease (Postmus, 2013) at the beginning of each interview. The duration of this rapport-building process was at least 40 minutes with each participant prior to each in-depth interview. This was done by means of talking in general about the participants' interests and hobbies, playing a board game and building a puzzle together. Thereafter the interviews were conducted, which lasted about 20-30 minutes each.

Only after the participant was at ease the first in-depth interview started. The researcher undertook data collection during this phase by means of a single open-ended question. This question was: "Tell me about your experiences of MCSA." This open-ended question was checked and evaluated by a registered social worker and educational psychologist for its applicability. The researcher furthermore made sure that all the participants had been in counselling and would therefore be in a position to discuss their experiences without being traumatised. The researcher considered the first interview with a participant who also met the criteria. This enabled the researcher to make adjustments before the study was conducted with the remaining participants. This open-ended question was then used with the remainder of the participants. The first interview was an in-depth interview (Maltby et al., 2014; Punch, 2014; Yin, 2010) to explore the participant's experiences of MCSA, in order to develop an understanding of their support needs. The second interview was a creative session where a collage (Butler-Kisber, 2010; Martin & Hanington, 2012) as a visual method was used. This collage was used to reflect on their experiences, in order to develop an even better understanding of their support needs. Between the second and third interview member checking (Creswell, 2014) was used where the researcher clarified some of the data which were obtained during the first and second interviews. During the third interview some ways in which these participants felt they needed support were explored. During these in-depth interviews the researcher used some communication techniques to facilitate the interviews,

like minimal verbal response, paraphrasing, probing, reflecting, clarifying, summarising and the tolerance of silences (Greeff, 2011; Seidman, 2012).

The researcher observed the non-verbal behaviour of the participants (Monette et al., 2011; Schmidt, 2010) during the in-depth interviews. The researcher made field notes (Tracy, 2013; Yin, 2010) and recorded behaviours of the participants while gaining in-depth insight into the manifestations of the child's behaviour, body language, non-verbal cues and actions (DeWalt & DeWalt, 2010; Linder & Bixby, 2010; Monette et al., 2011; Schmidt, 2010) by means of anecdotal records. These records are short objective descriptions, by means of key phrases and words of the basic actions and behaviours of the participants. These field notes were included in the researcher's observations, but also gave an account of the circumstances prevailing during the interviews (Yin, 2010).

4.6.2 Phase 2.

During the second phase semi-structured individual interviews (Babbie, 2013; Flick, 2014; Maltby et al., 2014; May, 2011; Punch, 2014; Yin, 2010) were conducted with twenty-four participants who have knowledge in the field of MCSA and/or clinic schools. These participants' opinions and inputs on critical aspects to support sexually abused boys placed in a clinic school were obtained during these semi-structured individual interviews, which lasted about 45-60 minutes each. These interviews were also recorded digitally.

An interview schedule (Gray, 2013; Greeff, 2011) was designed based on the data obtained from the in-depth interviews during the first phase of the study, as well as a literature study and was used to guide the semi-structured individual interviews. The researcher gave the interview schedule to one social worker to check for recommendations and make changes if necessary.

Appointments were made with the different participants and they were met at a convenient time and place to conduct the semi-structured individual interviews. These participants completed an informed consent form (see Appendix E) (Gray, 2013; Marzano, 2012).

The interview schedule was then used as a pilot interview schedule (Greeff, 2011; Strydom & Delport, 2011) with two participants from this population to determine whether the relevant data would be obtained from the population from the semi-structured individual interviews. The nature of the questions for the interview schedule was tested and modified if necessary for the remaining participants. The data obtained from this pilot test with two participants were also analysed together with the other data that came from the semi-structured individual interviews.

4.6.3 Phase 3.

During the third phase fourteen participants were included in two focus groups (Barbour, 2014; Flick, 2014; Morgan, 2012; Postmus, 2013; Wayne, 2013). These group sessions were about 120 minutes each and were conducted in a convenient place for the participants. These participants also filled in an informed consent form (see Appendix F). During these focus groups the participants got the opportunity to give inputs on the conceptualisation of a proposed support strategy for sexually abused boys placed in a clinic school.

A support strategy was then proposed from the data obtained from all three phases, research literature and theoretical perspectives.

4.7 Data analysis

All the data from the in-depth interviews, semi-structured individual interviews and focus groups were analysed through thematic analysis (Clarke & Braun, 2013). The phases as

recommended by Clarke and Braun (2013) were used for the data-analysis of the qualitative data of all three phases of this research. The six phases of this data analysis process are presented in Table 3, whereafter it will be discussed in more detail.

Table 3

Data analysis

PHASE NUMBER	PHASE NAME	DETAIL
1	Familiarisation with the data	Digital data were labelled and stored. Familiarisation of data by listening and watching digital recordings. Transcriptions were made and read through several times.
2	Coding	Data were coded and categories generated.
3	Searching for themes	An analytical categorisation of data into themes. Data that supported the codes were collated.
4	Reviewing themes	Themes were reviewed, typologies were developed.
5	Defining and naming themes	A detailed analysis of each theme was written. Each theme was named.

PHASE NUMBER	PHASE NAME	DETAIL
6	Writing up	Data were written up to integrate the analytic narrative and data extracts.

- *Phase 1 - Familiarisation with the data*

All the digital data were labelled (dates, places and interviewee identifying information) and stored on a computer system to ease retrieval for analysis. Backup copies were made and one master copy was kept at a different location to prevent any loss of data. Computerised data were protected by a password and encryption. The researcher became familiar with all the data by listening and watching the digital recordings of the interviews and focus groups. These data were then transcribed (Kowal & O'Connel, 2014), after which it was read through several times (Bazeley, 2013) to become familiar with the content.

- *Phase 2 – Coding*

During this phase the initial research question for each phase of this research guided the coding process, in order to be able to answer the specific research question. During this phase, data were coded (Bazeley, 2013; Creswell, 2014; Flick, 2014; Harding, 2013) and categories were generated (Harding, 2013). The analytic process started and codes were used to capture both semantic and conceptual readings of the data. The data were coded and then all these codes and relevant data extracts were collated.

- *Phase 3 - Searching for themes*

During this phase of the data analysis process an analytical categorisation of data into themes was done (Harding, 2013), in order to identify and label relevant categories or topics of data. After this process possible themes were identified and the data that supported the codes were collated.

- *Phase 4 - Reviewing themes*

The themes were reviewed to ensure that they tell a compelling story about the data and to refine it. Typologies needed to be developed, in which phenomena were classified in terms of their common characteristics in relation to other phenomena. The typologies needed to be mutually exclusive and any overlap between categories needed to be eliminated. The relationship between the different themes was also observed.

- *Phase 5 - Defining and naming themes*

A detailed analysis of each theme was written. Each theme was named according to its most essential feature.

- *Phase 6 - Writing up*

All the data were written up to integrate the analytic narrative and the data extracts. This is a process to enable the reader to understand a coherent account of the data and put it into the context of existing literature. This final phase entailed the presentation of these data. This interpretation of data was presented in the journals considered for publication.

4.8 Ethical aspects

Ethical guidelines were followed to ensure that the research was both ethically and

scientifically correct (Hugman, 2014; Monette et al., 2011; Nolas, 2011; Yin, 2010).

- *Ethical accountability*

The Ethical committee of the North-West University, Potchefstroom Campus (Ethical number: NWU-00060-12-A1), Gauteng Department of Education, as well as the two applicable district offices gave ethical approval for this study to be conducted. The researcher ensured that she is competent, honest and skilled to undertake this research. The researcher had training in research methodology at Honours level at the University of Stellenbosch and at Masters level at the University of South Africa. This study was done under the supervision of a registered educational psychologist and registered social worker.

- *Informed consent*

Informed consent (Gray, 2013; Marzano, 2012; Reamer, 2013) implies that the participants were informed about the research before they decided to partake in the research. All the possible information on the goal of the research, the procedures which would be followed, possible advantages, risks and discomforts had to be explained to all potential participants (Creswell, 2014; Lapan et al., 2011). The participants were also informed about the use of a digital recorder (Greeff, 2011) which would be used during the interviews. Informed consent was done by signing a written document.

During Phase 1 the participants were children and could therefore not consent to partake in this research. The researcher met separately with all these potential participants' parents. During this interview the research process, as well as the consent form was explained to the parents. Possible questions were answered and misunderstandings were clarified. These parents then signed the consent form. These participants gave assent to partake in this research, after the social workers, who acted as

mediators in this process, had explained the whole research to them.

During Phase 2 and 3 the researcher made contact with possible participants who met the research criteria for inclusion. This was done telephonically or via email. The research was explained to the participants and the informed consent form was emailed to all these participants. These participants got a week's time to decide whether they would like to participate in this research. After a week the researcher contacted them again to finalise participation. The researcher finalised the list of participants who were willing to partake. Times, dates and convenient venues for the participants were scheduled to conduct the semi-structured individual interviews and focus groups. Before the semi-structured individual interviews (Phase 2) and focus groups (Phase 3) were conducted, the procedures, risks, discomforts and rights of participation were explained again to the participants. Time was allowed for questions. The participants then signed the informed consent form.

- *Voluntary participation*

All the possible risks and benefits involved were explained to the participants. Risks for participants in Phase 1 might include traumatic experiences and memories when talking about their experiences as MCSA victim. The researcher was aware that all the participants were already receiving counselling on a weekly basis from a psychologist, counsellor or social worker and could therefore be referred to these professionals if it happened that any secondary trauma occurred during the in-depth interviews. The participants were informed that participation was voluntary (Babbie, 2013) and anyone could withdraw from the study at any time without any negative consequences for them (Gray, 2013).

The benefits for the participants from Phase 1 were being able to voice their

experiences of MCSA, in order for the researcher to understand their support needs. These participants could therefore give valuable insights into this phenomenon of MCSA, as well as their support needs. In all three phases the participants gave valuable inputs and all the role players, as well as MCSA victims could benefit from the conceptualisation of a proposed support strategy. This proposed support strategy could enable the role players to support these MCSA victims more effectively and could subsequently lead to the integration of these learners into the mainstream educational setting again.

- *Anonymity and confidentiality*

Anonymity and confidentiality in this research were very important, as participants shared their personal experiences on the topic of MCSA. As this is such a sensitive topic, the researcher ensured that all the participants had the right to anonymity and confidentiality (Babbie, 2013; Kaiser, 2012; Reamer, 2013). Anonymity (Babbie, 2013; Creswell, 2014; Gray, 2013) was ensured by refraining from using the names of the participants and the sites. Each participant got an allocated number, which was only known to the researcher. Only these allocated numbers were used when referring to these participants in the research report. Confidentiality (Babbie, 2013; Creswell, 2014; Gray, 2013; Kaiser, 2012; Reamer, 2013) was ensured during the research process, as identifying information and data were kept safe locked away in a file cabinet with restricted access and computerised data were protected by a password and encryption. After the research was completed and submitted to the University of North-West, all data and transcriptions would be kept at the university's premises for safe keeping for five years.

The in-depth interviews with the participants from Phase 1 were conducted in a private office at the clinic schools. All the learners from the clinic schools were receiving counselling on a weekly basis and therefore it was not out of the ordinary for these

participants to be called to go the office. The social worker met with the particular participants at the school's office and escorted him to her private office where the procedures were explained to them. The social worker then took the participant to the private office where the in-depth interviews were conducted. No other learners or teachers in the school were therefore aware that the specific learner was busy with an in-depth interview on the topic of MCSA.

During Phase 2 the semi-structured individual interviews were conducted at a convenient time and venue for each particular participant. In most cases these interviews were conducted in the offices of the participants or in their private homes used as offices for their professional work. The two focus groups of Phase 3 were also conducted at convenient and private venues for the participants. For the first focus group a private boardroom was used. The second focus group was conducted in a private room, rented at a restaurant.

- *No harm to participants*

The procedures to be followed during the research were explained to all involved in this study, in order to avoid any deception of the participants (Creswell, 2014). The researcher did this study with caution, because of the sensitive nature of the topic of MCSA and the vulnerability of the children involved. She received regular supervision from a registered educational psychologist and registered social worker to ensure this research was done correctly. The researcher used communication techniques (Greeff, 2011; Seidman, 2012) to facilitate the in-depth interviews, semi-structured individual interviews and focus groups. The researcher ensured that no physical or emotional harm (Reamer, 2013) was done to the participants during the research. All the participants from Phase 1 were already receiving counselling from psychologists, social workers or counsellors at the

clinic school and therefore they could be referred to these professionals if any secondary trauma occurred during the interviews with them or if they needed any further support. These professionals met with these participants after the in-depth interviews were conducted to ensure that no secondary harm occurred during these interviews. The participants of Phase 2 and 3 also got the opportunity at the end of each semi-structured individual interview and the focus groups, to clarify any misconceptions. These participants could also be referred to a psychologist if it seemed that any secondary trauma occurred during the data collection phase. It seemed that no secondary harm occurred during the three phases of this study.

- *Release or publication of the findings*

The overall results of this study will be made available (Reamer, 2013; Webster, Lewis & Brown, 2013). The findings of this research which will be in article format will be published in article format.

4.9 Trustworthiness

The criteria for excellent qualitative research were used to ensure trustworthiness during this study (Tracy, 2010, 2013). The criterion of a *worthy topic* (Tracy, 2010) is ensured, as the phenomenon of MCSA is very relevant and significant, because the occurrence of MCSA is a reality and research regarding MCSA is limited.

Qualitative research needs to entail *rich rigor* with sufficient data and time in the field (Barusch, Gringeri & George, 2011; Gray, 2013; Tracy, 2010) to enable the collection of detailed and in-depth data. During Phase 1 data were obtained from seven participants with each of whom three in-depth interviews, as well as member checking were conducted. In Phase 2 semi-structured individual interviews were conducted with twenty-four participants

and during Phase 3 data were obtained from two focus groups which included fourteen participants. In all three phases this was a rich sample and data were collected rigorously until data saturation (Barusch et al., 2011; Creswell, 2014; Greeff, 2011) occurred.

Sincerity refers to self-reflexivity (Gringeri et al., 2013a; May & Perry, 2014; Watt, 2007) about subjective values, biases and inclinations of the researchers (Creswell, 2014; Tracy, 2010). This was, however, overcome by peer reviews (Gringeri, Barusch & Cambron, 2013b; Loh, 2013) where specific descriptions or themes were given to some of the participants to check for accuracy, comments and recommendations during follow-up interviews and this gave the participants the opportunity to comment on the findings and to assist with the interpretation of the data. Expert supervision was also provided by a registered educational psychologist and registered social worker throughout this research to prevent the researcher from becoming biased.

Credibility refers to a dense description (Creswell, 2014; Tracy, 2010, 2013), concrete detail, triangulation or crystallisation (Creswell, 2014; Kline, 2008; Loh, 2013; Tracy, 2010). Member checking (Creswell, 2014; Gringeri et al., 2013b; Stake, 2010) was used where possible themes were given to a registered social worker to review. In this research data were obtained from three different samples by means of in-depth interviews, semi-structured individual interviews and focus groups. This enabled a dense description (Creswell, 2014; Tracy, 2010, 2013) of the research. A dense description of research methodology and literature control was also done. The raw data and tentative interpretations of the data were discussed with three participants. The data were audited (Creswell, 2014; Gringeri et al., 2013b; Kline, 2008; Loh, 2013) by a co-coder. Expert supervision by a registered educational psychologist and registered social worker was provided during this data-analysis process.

The researchers aim to make a *significant contribution* (Tracy, 2010) through this research to the support of sexually abused boys placed in a clinic school is a field where there is

limited research available. The conceptualisation of a proposed support strategy for MCSA victims is very practical and could assist the role players to support these MCSA victims more effectively.

Ethical considerations were also taken into account throughout this research and have already been outlined in this section (Part 1 - 4.8).

The division of the thesis will be discussed.

5 Division of Thesis

This thesis is divided into four sections. Section 1 is divided into three parts. In Part 1 the introduction and statement of this research problem are outlined. The research methodology is also described. In Part 2 of this section a literature overview is given. In Part 3 the theoretical framework for this research is outlined.

In Section 2 the three articles are presented. The titles, as well as the journals in which these articles will be published are as follows:

Article 1: Boys in middle childhood placed in a clinic school: Experiences of sexual abuse

Reference: Steyn, H., Van Wyk, C., & Kitching, A. E. (2014). Boys in middle childhood placed in a clinic school: Experiences of sexual abuse. *Child Abuse Research in South Africa*, 15(1), 15-28.

Article 2: Identifying critical aspects of support for sexually abused boys in middle childhood

Article will be submitted for publication in *Journal of Child Sexual Abuse*.

Article 3: Conceptualising a proposed support strategy for sexually abused boys in middle childhood

Article will be submitted for publication in *Social work/Maatskaplike Werk*.

In Section 3 the conclusions, recommendations, limitations, as well as the contributions of this research will be outlined.

In Section 4 is a single and combined reference list of all the sections.

SECTION 1: PART 2

1 Literature Overview

The aim of this study is to conceptualise a proposed support strategy for sexually abused boys in their middle childhood placed in a clinic school. The main concepts of MCSA and clinic schools will be discussed in this section.

1.1 Male child sexual abuse

MCSA is the sexual abuse of a male child by a perpetrator. The Criminal Law Sexual Offences and Related Matters Amendment Act 32 of 2007 (South Africa, 2007) defines sexual abuse as follows:

Any person (“A”) who unlawfully and intentionally engages a child under the age of 18 years (“B”) with or without the consent of the child (“B”), in an act of sexual penetration, is guilty of the offence of rape.

In 2010 there were approximately 50,5 million people living in South Africa. More than 18,523,917 of these people are children under the age of eighteen years. South Africa’s youth population consists out of 6,197,021 children younger than five years, 6,018,608 children between six and eleven years and 6,308,289 children between twelve and seventeen years of age (Statistics South Africa, 2011). Children are particularly vulnerable to different kinds of victimisation, like poverty; alcohol and/or drug abuse of parents; mentally ill, depressed, or suicidal person in home; domestic violence; neglect, emotional, physical (Hertel & Johnson, 2013; Lebel & Kelly, 2014; Marriott, Hamilton-Giachritsis & Harrop, 2014), as well as CSA (Dunn, 2008b; Hertel & Johnson, 2013; Van Hook, 2014; Whitelock, Lamb & Rentfrow, 2013). For the purpose of this study the focus will be on MCSA.

The physical and emotional wounds young victims of MCSA have to deal with are

incomprehensible, leaving them with physical and emotional scars, a damaged sense of self and a stolen right to health and happiness (Dawes, Richter & Higson-Smith, 2005). Although the CSA of girls have been studied much in the past, young male victims have remained relatively unexamined (Alaggia & Mishna, 2014; Valente, 2005). The growing recognition of MCSA with its potentially debilitating effects for a boy has underscored the need to study this phenomenon further and to conceptualise a proposed support strategy to support this population.

1.1.1 Incidence and prevalence of MCSA.

Sexual abuse of both boys and girls is common (Bullock & Beckson, 2011; Diamanduros et al., 2012; Dorahy & Clearwater, 2012). Research on MCSA consistently shows that the sexual victimisation of males is noteworthy. At an international level Schraufnagel et al. (2010) mention a prevalence rate of 14% of MCSA during childhood. Alaggia and Mishna (2014) mentioned that the prevalence of MCSA is as high as 26% of men in community samples and up to 36% of men in clinical samples. In the South African context Mathews et al. (2013) mention a community-based survey done in 2013 in urban Gauteng Province which reported a MCSA prevalence of 20,4% before the age of eighteen. These percentages, however, may also be an underestimate due to continued low rates of disclosure (Kiselica & Novack, 2011; Maikovich-Fong & Jaffee, 2010; O’Leary, 2009; O’Leary & Gould, 2009; Schraufnagel et al., 2010) and boys’ reluctance to disclose MCSA (Barker & Crenshaw, 2011; Diamanduros et al., 2012; Haen, 2011; Kiselica & Englar-Carlson, 2011).

1.1.2 Possible consequences of MCSA reported in literature.

A conspectus of the research that has been done on MCSA reveals that the long-term effects of CSA is equally damaging to girls and boys (Chen et al., 2010; Larsen et al., 2011;

Maikovich-Fong & Jaffee, 2010; O'Leary, 2009; O'Leary & Gould, 2009). In studies which specifically focused on MCSA it became evident that the sexual abuse of boys in their middle childhood has serious effects (Alaggia & Mishna, 2014; Asgeirsdottira et al., 2011; Gospodarevskaya, 2013). MCSA victims can show signs of nightmares, major depression, post-traumatic stress disorder (Alaggia & Mishna, 2014; Asgeirsdottira et al., 2011; Diamanduros et al., 2012; Gospodarevskaya, 2013), antisocial personality disorder, hyperactivity, fear, anxiety and aggression (Alaggia & Millington, 2008; Alaggia & Mishna, 2014; Asgeirsdottira et al., 2011; Diamanduros et al., 2012; Kiselica & Novack, 2011). This hyperactivity is actually a form of busyness, which can help the child to avoid the feelings of sadness, shame, confusion and being scared (Ellsworth, 2007).

MCSA victims can also show extreme forms of emotional and behavioural problems, like suicidal behaviour (Asgeirsdottira et al., 2011; Coohy, 2010; Diamanduros et al., 2012) or they become involved in some form of addiction like drug and/or alcohol abuse to suppress the memories of the MCSA or to numb their feelings (Alaggia & Millington, 2008; Alaggia & Mishna, 2014; Asgeirsdottira et al., 2011; Diamanduros et al., 2012; Dorais & Meyer, 2009; Gospodarevskaya, 2013; Lowenstein, 2011; O'Leary, 2009). The coping mechanism of substance abuse is most common in MCSA victims. The substances make it easier for the MCSA victims to control the distress and discomfort, associated with the MCSA (O'Leary, 2009; Schraufnagel et al., 2010). In a study conducted by Ponton and Goldstein (2004) they found that the age of initial abuse appeared to be a major factor in the development of depression, substance abuse and suicidal attempts. Those who were sexually abused before the age of ten years, appear to have the highest possible level of depression. The number of abuse experiences however does not correlate significantly with depression, substance abuse and suicide attempts. These authors are of the opinion that a single abuse experience crosses a psychological threshold and that later abusive experiences simply repeat the same traumatic

experience without measurably deepening its scope or psychological impact. Valente (2005) found that during the sexual abuse, some boys may be given alcohol or other drugs as a way to increase their compliance with the sexual act. Later these boys learn that substances can help numb their emotional pain and distress. The victim of sexual abuse may then resort to selling sex and tolerating the abuse to support a substance abuse habit. Frequently MCSA victims develop anxiety that lead to self-destructive behaviour, such as self-mutilation or suicide attempts. They internalise the brutalisation and hatred they receive from the abuser and then act it out on themselves.

Many MCSA victims develop the problem of encopresis, bedwetting (Kiselica & Novack, 2011) or develop eating disorders (Carter, Bewell, Blackmore & Woodside, 2006; Diamanduros et al., 2012; Dworkin, Javdani, Verona & Campbell, 2014), like bulimia where the boy purges himself of food after bingeing (Dworkin et al., 2014). Some of them become a prey to violent vomiting, physical ailments and the misuse of laxatives (Dworkin et al., 2014; Kiselica & Novack, 2011). The sexually abused boy may develop obesity, anorexia or bulimia as a way to feel in control of his body, where he has a choice about what is done to his body. During the sexually abusive situations he had no control over his own body. The boy may experience the bingeing and purging as a way of taking control over what does or does not go in (food) or out (purging). The boy discovers that nobody else can control what, when and how much he eats (Ellsworth, 2007). According to Alaggia and Millington (2008) these outcomes can result in poor school performance, truancy, legal trouble and criminal transgressions.

There is also the risk for sexually abused boys to develop sexually related problems (Alaggia & Mishna, 2014; Diamanduros et al., 2012; Fanniff, Becker & Gambow, 2014; Valente, 2005), where the MCSA victim can avoid anything related to sexuality (Ponton & Goldstein, 2004), reject his genitals and exhibit sexual dysfunction, like seductiveness,

hypersexuality, not using a condom, becoming involved in a pregnancy and confused sexual identity (Kiselica & Novack, 2011; Schraufnagel et al., 2010). The sexually abused boy can confuse affection with sexual abuse and desire with tenderness. They may find it difficult to know the difference between sex, love, nurturance, affection and sexual abuse. It often happens that they think normal interpersonal relationships are seductive and manipulative, or that exploitative situations are the standard and acceptable (Gartner, 2011). A preoccupation with sex and excessive masturbation may occur in the victims of MCSA. They may use the masturbation as a coping mechanism to relieve stress when they experience stressful and disturbing emotions, like fear and anger (Ellsworth, 2007). These boys can also show sexually offending behaviour where they may try to victimise their peers, younger children and animals (Alaggia & Millington, 2008; Ellsworth, 2007; Valente, 2005). This victimisation can help the sexually abused child to shift his power roles from being in a powerless position to be in the power position. When the MCSA victim becomes the dominant abuser, this reinforces his sense of control, masculinity, dominance and power, thus rather than being the victim of MCSA, he re-experiences the trauma, but can even discover that being the abuser is sexually exciting (Ellsworth, 2007; Valente, 2005). It can also happen that the sexual abuse causes physical pleasure to the boy and can encourage him to attempt to re-create such sexual experiences with others (Ellsworth, 2007). Friedrich (2006) also notes that the sexual abusive situation, which was eroticising, can make the child continue to pursue sexual arousal.

MCSA victims can feel guilty and shameful about the MCSA. These boys have much difficulty with trust and intimacy, because of their feelings of betrayal by a trusted person (Kiselica & Novack, 2011; Ponton & Goldstein, 2004; Robinson, 2011; Stuart, 2013; Valente, 2005). The abuser wanted to satisfy his own needs and misused his age or authority to abuse a boy, resulting in the MCSA victim considering all people as dishonest, malevolent and undependable (Gartner, 2011). Valente (2005) is of the opinion that sexually abused boys

have lost their belief in fairness, safety, privacy and trust. LP (personal communication, May 24, 2012), a social worker with twenty-two years' experience of working with MCSA cases, also mentioned the mistrust these boys often show towards the non-offending parent for not protecting them against the MCSA. This mistrust often manifest in extreme aggression.

A specific context in which MCSA is prevalent is clinic schools. In the following sections LSEN schools and specifically clinic schools will be discussed more thoroughly.

1.2 Clinic schools

In South Africa human rights were more specifically promoted since democracy was established. This includes the right to education, free of discrimination and prejudice. The new Constitution of 1996 and a Bill of Rights focus on the right to quality education, where the South African Schools Act of 1996, outlines the right of all learners to be able to learn and receive quality education to meet their specific needs (Pillay & Di Terlizzi, 2009; Strydom, Nortjè, Beukes, Esterhuyse & Van der Westhuizen, 2012). The placement of learners with specific educational, emotional and behavioural needs within a LSEN school can be to the benefit of these learners. This can be as a result of being placed in a school which provides the necessary resources to meet the needs of these learners, which may be lacking in the mainstream educational setting (Pillay & Di Terlizzi, 2009; RE, personal communication March 1, 2012).

According to Strydom et al. (2012) special education requires an educational programme, class or school which can accommodates the needs of special learners, like those with emotional, behavioural, social, neurological or physical problems. For the purpose of this study the focus will fall specifically on clinic schools which focus on learners with emotional and behavioural difficulties.

Clinic schools are specialised schools focusing on the upliftment of the emotional and behavioural problems of learners (Casey et al., 2010; De Swart et al., 2012; Lehr et al., 2009; Simonsen et al., 2010; Simonsen & Sugai, 2013). The objective of a clinic school is to be a short-term and interim substitute educational setting for these learners (Lee & Barth, 2011; Lehr et al., 2009). These learners need to change their problem behaviour and be integrated again into the mainstream educational setting (Flick, 2011; Haid & Donnelly, 2013) and to be equipped to return to a less restrictive environment as quickly as possible (Ennis et al., 2012; Simonsen et al., 2010). Clinic schools can only accommodate these learners until they turn twelve years old (RE, personal communication March 3, 2014).

In the following section a profile of a learner placed in a clinic school will be discussed. The different role players in a clinic school setting will also be dealt with.

1.2.1 Profile of a learner placed in a clinic school.

The learners who are placed in clinic schools usually show a variety of behavioural and emotional difficulties (Casey et al., 2010; De Swart et al., 2012; Ennis et al., 2012; Jolivet et al., 2014; Lehr et al., 2009; McNamara, 2010; Quisenberry & Foltz, 2013; Simonsen et al., 2010; Simonsen & Sugai, 2013). PM (personal communication, June 20, 2012), who is employed at Gauteng-West District office, confirmed that these learners cannot cope in a mainstream school, due to the severity of their emotional instability. Quisenberry and Foltz (2013) are of the opinion that these learners are severely traumatised, due to their homely environment, physical, emotional and sexual abuse, as well as neglect. Several authors (Lebel & Kelly, 2014; McNamara, 2010; Quisenberry & Foltz, 2013; Suk-ching Chong & Leung, 2012) concur that many children who are placed in residential care formerly experienced abuse. Therefore MCSA may also play a role in the behavioural and emotional difficulties

these boys experience.

Learners who are placed in clinic schools show a lot of aggression (Broecher, 2014; McNamara, 2010; Simonsen et al., 2010; Thomas, 2010). This aggression often results in fighting, disrespect and truancy (Jolivet et al., 2014; McNamara, 2010). MvW (personal communication August 14, 2012), who is the Head of Department of a clinic school, RB (personal communication August 14, 2012), principal of a clinic school, as well as Broecher (2014) mentioned that this aggression can turn into vandalism towards school and residential facilities and fighting with each other.

The emotional problems include anxiety, possible depression, as well as suicidal attempts (JvH, personal communication, August 15, 2012; Quisenberry & Foltz, 2013). Some of these learners also experience rejection and a lack of support, especially at home.

The learners placed in a clinic school did not cope in a mainstream school. Their emotional and behavioural outbursts often resulted into being expelled from the classroom and school (RE, personal communication March 1, 2012). This can be a possible reason for their low cognitive performances and academically poor results in school (Ennis et al., 2012; Jolivet et al., 2014; Minahan & Rappaport, 2014; Nelson, Benner & Bohaty, 2014; Nicholson, 2014; Quisenberry & Foltz, 2013). HvdM (personal communication, August 21, 2012), a teacher with ten years' experience in a clinic school, is of the opinion that these learners struggle to handle any stress associated with schoolwork and will immediately start to act out and misbehave when they feel the work is too much or difficult for them to complete. ES (personal communication, November 27, 2012) is of the opinion that these learners' poor self-image results in poor academic performance, as some of them do not believe they are capable of doing the schoolwork. Their poor academically performance (Jolivet et al., 2014; Minahan & Rappaport, 2014; Nelson et al., 2014; Nicholson, 2014) also influences their self-image, so that it become even worse (LE, personal communication,

October 5, 2014).

Most MCSA victims in a clinic school also show sexual behaviour problems (Quisenberry & Foltz, 2013). This can range from obsessive and compulsive masturbation, child-on-child sexual abuse which can range from fondling, oral sexual activities to penetration and sexual talks (ES, personal communication, November 27, 2012; KK, personal communication, November 27, 2012). The complexity of challenges in a clinic school certainly necessitates collaboration between the role players in the school.

1.2.2 Collaboration of role players in a clinic school.

There are different role players who support learners placed in a clinic school. They can form part of a collaborative team, including psychologists, social workers, counsellors, teachers, child and youth care workers and parents. According to JvH (personal communication, August 14, 2012) this collaborative approach can enable the different role players to apply a support strategy in the different settings in which these boys are functioning, like at school, residential facility, home and counselling sessions and thus optimise the level of support given to these sexually abused boys. These learners are living in a residential facility during the week with child and youth care workers. Their role can be described as professional parenting (Bastiaanssen et al., 2012; Bastiaanssen, Delsing, Kroes, Engels & Veerman, 2014). The child and youth care workers can help these children through difficult events and processes (Bastiaanssen et al., 2014). These learners attend the clinic school, which is on the same premises as the residential facility. The teachers are responsible for attending to the academic needs of these learners. There are also psychologists, social workers and counsellors who are responsible for the support and daily counselling to these learners (RE, personal communication, April 11, 2014).

The use of a collaborative team could be very effective, as this enable the use of special skills and knowledge of various role players (Dresser et al., 2009; Flåm, 2009; Kutash et al., 2014; Roberge & Van Dick, 2010; Zabel, Kaff & Teagarden, 2013) to support children with serious emotional and behavioural problems in their home, school and community (Suter & Bruns, 2009). Roberge and Van Dick (2009) are of the opinion that diversity can improve creativity and innovation through the team members' greater variety of perspectives. Bruns et al. (2014) add, that if systems work separately it could be less effective in the support of the individual, as each system may maintain a separate plan for the child's care and may prescribe multiple supports that are duplicative and uncoordinated. This fragmentation can undermine support strategies.

Research shows the higher adjustment levels of abused children who are supported compared to those abused individuals with low levels of support (Arias & Johnson, 2013; Sperry & Widom, 2013; Van Toledo & Seymor, 2013). Van Toledo and Seymor (2013) mention the lack of caregiver support in the aftermath of abuse has been linked to increased stress and trauma symptomatology in the child. Several authors (Mathews et al., 2013; Sperry & Widom, 2013) add that social support has been associated with less immediate psychological distress and hypothesised that it is one of the protective factors that buffer children against the impact of MCSA.

In Part 3 the theoretical perspectives used in this research will be discussed.

SECTION 1: PART 3

1.1 Theoretical perspectives for the study

The theoretical perspectives applied in this study are the Strengths Perspective, Resilience Theory, Attachment Theory, Social Support Theory and Developmental Perspective. The following table gives a summary of the aim of each perspective, whereafter it will be discussed in more detail.

Table 1

Procedures and data collection

THEORETICAL PERSPECTIVE	AIM
Strengths Perspective	All individuals possess potential and strengths, which can build on resources, possibilities, resiliencies and capacities for change and transformation (Chapin, 2011; Gray, 2011; Teater, 2014). The focus is thus not on personal weaknesses, difficulties and failures (Lietz, 2011).
Resilience Theory	Resilience is the capacity to forge adaptive trajectories and coping well in the context of significant difficulty (Kelly & Gates, 2010; Rutter, 2012).
Attachment Theory	Attachment is the emotional bond with a specific person, especially under stressful circumstances (Bowlby, 2013).
Social Support Theory	The exchange of helping behaviours in social relationships, which creates a process of social networks of potential supporters (Schönbucher et al., 2014).
Developmental Perspective	Developmental Perspective defines the developmental stages an individual progress through life.

1.1.1 Strengths Perspective as a basis for support.

Instead of focusing on personal weaknesses, difficulties and failures (Jones-Smith, 2011; Lietz, 2011; Roose et al., 2012) seen from the Strengths Perspective all individuals possess the potential and strengths that can be marshalled to improve quality of life as it builds on the individual's resources, possibilities, resiliencies and capacities for change and transformation (Chapin, 2011; Gray, 2011; Kelly & Gates, 2010; Teater, 2014). The Strengths Perspective focuses on the identification and mobilisation of resources, assets, wisdom and knowledge that every person, family, group or community has, as well as their potential for transforming their experiences and lives. The Strengths Perspective focuses on these resources and the potential they may have for reversing misfortune, the lessening of pain and the ability to reach certain goals (Saleebey, 2012). According to Kelly and Gates (2010) nearly every "deficit" can be viewed from a perspective of resources and possibilities. Several authors (Lietz, 2011; Roose et al., 2012) are of the opinion that individuals will do better when they are supported to recognise and use the strengths and resources available in themselves and in their specific situation.

Although negative experiences, such as MCSA, can bring opportunities and capabilities to an individual, family or community, it does not indicate that the emotional pain associated and caused by the negative experience is not acknowledged. These negative experiences can cause the MCSA victim to learn new skills and develop personal attributes. The Strengths Perspective assumes that people who are facing negative and traumatic experiences are often very resilient and resourceful and professionals should explore and learn from their strategies to overcome this adversity (Saleebey, 2012). The Strengths Perspective offers an opportunity to reframe the experiences (Kelly & Gates, 2010) of sexually abused boys. In this study the

MCSA victims' opinions will be highly valued. They are viewed as inherently strong and resilient rather than flawed (Sabalauskas, Ortolani & McCall, 2014).

Within the Strengths Perspective and in the context of a clinic school the role players will discuss coping strategies and cognitive restructuring of the MCSA victim, rather than just focusing on consequences and correction (Sabalauskas et al., 2014) of problem behaviour.

Through the Strengths Perspective, the MCSA victims' voices are heard and valued at all levels of support. It is important for people from the helping professions to listen carefully to their narratives, their hopes and fears and their resources rather than attempt to place them in the narrow confines of a diagnosis (Saleebey, 2012). During the first phase of this study the in-depth interviews with MCSA victims allowed the researcher to hear properly the stories and narratives from them, what their experiences and beliefs are of MCSA in order to develop an understanding of their support needs. This enables the conceptualisation of a proposed support strategy that really focuses on the concerns, fears and hopes of these MCSA victims, rather than pre-conceived ideas about what MCSA victims must be experiencing.

The Strengths Perspective is relational as it occurs in the context of partnerships formed between clients and professional people (Bertolino, 2010; Lietz, 2011). It also takes into consideration naturally occurring networks within social networks in families and communities, for the support needed to help clients accomplish their goals (Kisthardt, 2012; Lietz, 2011). In the context of this study the connection between the MCSA victim and the different role players needs to be explored and all these relationships involved in the MCSA victim's life should be included in the support process.

Research (Fraser, Kirby & Smokowski, 2004; Kelly & Gates, 2010; Lietz, 2011) showed that theories of resilience inform an understanding of the Strengths Perspective. In the following section Resilience Theory will be discussed in more depth.

1.1.2 Resilience Theory.

Resilience is the capacity to forge adaptive trajectories and coping well in the context of significant difficulty (Kelly & Gates, 2010; Masten, 2011; Rutter, 2012; Theron et al., 2011; Van Hook, 2014; Wright et al., 2013), such as parental stress, poverty, daily instability and serious parental mental health problems (Marriott et al., 2014). CSA can also be considered as a significant difficulty for children (Dunn, 2008b; Van Hook, 2014; Whitelock et al., 2013). In the case of this study MCSA will be the significant difficulty. Several authors (Chen et al., 2010; Maikovich-Fong & Jaffee, 2010; O’Leary, 2009; O’Leary & Gould, 2009) mention the negative impact of MCSA. Research (Kelly & Gates, 2010) however showed that rather than assume that all children exposed to CSA or other traumatic events will develop behavioural or emotional difficulties, Resilience Theory suggests that some may not. Marriott et al. (2014), as well as Whitelock et al. (2013) mention that a considerable number of people exposed to a variety of risks demonstrate resilience and positive outcomes or show few long-term negative outcomes as a result of early adverse experiences.

Positive adaptation to difficult life circumstances requires supportive systematic initiatives and/or responses (Van Rensburg, Theron, Rothmann & Kitching, 2013). Similarly, Wright and Masten (2005) argue that a protective factor is a quality of a person, context, or the interaction of the two that predicts better outcomes in situations of risk or adversity. Theron and Theron (2013) report that South African youths draw on protective factors, such as supportive resources of families, schools and communities to adjust well to difficult life circumstances. In the context of this study the MCSA victim, placed in a clinic school will rely on the support of the collaborative team to support him in the different settings in which he is functioning. According to Theron et al. (2011) individual traits and assets like intelligence, temperament, a sense of humour and optimism can also serve as protective factors and can add to resilience. Van Rensburg et al. (2013) confirm that studies of resilience

among South African youths underscore the protective value of schools and how they offer resilience-supporting resources, opportunities and skills. Masten and Wright (2012) also mention the importance of positive attachments, or being able to form and benefit from constructive relationships to enhance resilience. In this study it will therefore be important for the collaborative team to build strong relationships with the MCSA victims, in order to develop positive attachments with these boys. In the following section Attachment Theory will be discussed.

1.1.3 Attachment Theory.

Attachment can be defined as an emotional bond with a specific person, especially under stressful circumstances (Bowlby, 1980, 2013), like MCSA in the case of this research. Through interactions with primary caregivers, children develop internal working models of themselves, others and relationships (Bowlby, 1980). In the context of this research the MCSA victims are placed in the clinic school with residential facilities. Therefore the primary caregivers will be the child and youth care workers and teachers. The interactions between the MCSA victim and these caregivers in the clinic school will thus form the basis of attachment that the sexually abused boy will experience.

According to Attachment Theory, the early bond between caregiver and child is crucial for healthy development (Bowlby, 2013). Mikulincer and Shaver (2007) define a secure base as a caregiver to whom the child turns whenever protection is needed. According to Bowlby (1980, 2013), individuals' experiences with their caregivers are internalised through internal working models, leading to whether the self is seen as worthy of love and support and whether others are seen as trustworthy and available in later life. Several authors (Karakurt & Silver, 2014; McLewin & Muller, 2006) confirm that a securely attached child, who has generally experienced consistent and sensitive care, is likely to develop a model of the other

person as responsive, themselves as worthy of love and competent in eliciting attention and the relationship as rewarding. An insecurely attached child, who has generally not experienced consistent or sensitive care, will likely develop a model of other people as unpredictable, themselves as unworthy of love and unable to gain positive attention and the relationship as unsatisfactory. In the case of MCSA the abuser satisfied his own needs and misuse his age or authority to abuse a boy, resulting in the MCSA victim considering all people as dishonest, malevolent and undependable (Gartner, 2011). This can result in an insecure attachment. According to McLewin and Muller (2006) attachment can thus serve as a protective factor, which acts as an “inner resource” that promotes resilience.

1.1.4 Social Support Theory.

Social support can be defined as the exchange of helping behaviours in social relationships, which creates a process of social networks of potential supporters (Schönbucher et al., 2014). Wilson and Scarpa (2013) define social support as being loved by, cared for or appreciated by another and functioning as part of an interpersonal network. Social support can be seen as a protective factor among individuals at risk (McLewin & Muller, 2006; Schumm, Vranceanu & Hobfoll, 2004), like MCSA. Research (Arias & Johnson, 2013; Mathews et al., 2013; Sperry & Widom, 2013; Van Toledo & Seymor, 2013) suggests that social support may buffer an individual against life stress. In the case of this research social support can serve as a protective factor against the negative impact of MCSA, which is also confirmed by research literature (Schönbucher et al., 2014; Yancey & Hansen, 2010).

According to Schönbucher et al. (2014) social support has different functional components including emotional (provision of care and empathy), informational (provision of information or advice) and instrumental support (provision of material support). With regard to MCSA, social support is often described as believing what the victim is telling about the abuse

experience, taking protective actions and providing emotional support.

Research (McLewin & Muller, 2006; Wilson & Scarpa, 2013) confirms the significance of social support for resilience. Longitudinal research with high risk individuals has indicated that a socially supportive relationship and a secure attachment with at least one figure are protective against maladaptation later in life.

1.1.5 Developmental Perspective.

This research focuses on MCSA in the middle childhood years and therefore it is important to define middle childhood more thoroughly. For the purpose of this research an overview of the following areas of development of the child will be discussed: Cognitive, psychosocial, moral and sexual development, the implications of MCSA in each of these developmental areas, as well as how it will be used to support these boys.

1.1.5.1 Cognitive development.

According to the theory of Piaget (Bergin & Bergin, 2014; Gordon & Browne, 2014; Levine & Munsch, 2013; McDevitt, 2013; Mooney, 2013; Santrock, 2014) children are actively constructing knowledge as they manipulate and explore their world (Berk, 2012). The child progresses through a series of four stages of cognitive development, namely the sensorimotor (ages 0-2 years), preoperational (ages 2-7 years), concrete operational (ages 7-11 years) and the formal operational stages (7 years on), each characterised by qualitatively distinct ways of thinking. These stages were studied by several authors (Berk, 2012; Bjorklund & Blasi, 2012; Daniel, Wassell & Gilligan, 2010; Gordon & Browne, 2014; Louw & Louw, 2014).

During the middle childhood years the child goes through the transition period and goes into the concrete operations period, where he is able to handle more complex cognitive

problems (Charlesworth, 2013; Louw & Louw, 2014; Santrock, 2014). During this stage cognition becomes logical, although restricted to concrete objects. The child's reasoning becomes logical and better organised, but thinking falls short of adult intelligence. It is not yet abstract (Berk, 2012; Bjorklund & Blasi, 2012). Important processes and tasks achieved during the concrete operational stage are classification, decentration, conservation, seriation, decline in egocentrism and an understanding of space (Louw & Louw, 2014; Santrock, 2014).

1.1.5.1.1 Cognitive development and the child's interpretation of sexual abuse.

According to research literature (Calitz, De Jongh, Horn, Nel & Joubert, 2014) a traumatic event, like CSA, can have a major impact on a child's cognitive development. The following table gives an understanding how the cognitive developmental stage can be used as a guideline to understand better how the sexually abused child in his middle childhood has experienced the abuse.

Table 2

Cognitive developmental stage and interpretation of MCSA

AGE RANGE	EXPERIENCE OF SEXUAL ABUSE
8-12 years	• Less egocentric – begins to understand own sexual behaviour and that the behaviour of the abuser is wrong. • Takes everything personally and thinks he is “bad” simply by virtue of being engaged in “bad” behaviour. • May understand wrongfulness of CSA, but conforms to instruction of adults to please them or to avoid punishment. This can result in more guilt, to be part of a sexually abusive situation, but unable to stop it.

(Adapted from Fouché & Yssel, 2006)

In a study conducted by Van der Merwe (2009) the nine traumagenic dynamics were mentioned, namely self-blame, powerlessness, loss and betrayal, fragmentation of bodily experience, stigmatisation, eroticisation, destructiveness, dissociation and attachment disorder. It is clear that the MCSA victim experiences self-blame and stigmatisation. There is a tendency of victims of CSA to blame themselves for the abuse (Cantón-Cortés, Cortés & Cantón, 2012; Van der Merwe, 2009). Thoughts such as “I deserved it” or “I could have stopped it” are evident. This may lead to unhelpful patterns of impulsive negative thoughts which may transform into behaviour patterns such as over-control or destructive behaviours. There are internal and external factors that set off the self-blame dynamic. From an egocentric position children can believe that they did something wrong and therefore deserved the abuse. Self-blame is a moral emotion and also a cognitive distortion which may function to keep the image of the perpetrator clean, especially with ambivalence in the victim versus the perpetrator prevailing. Self-blame is often embedded in the unresponsiveness of the victim during the abuse experience when he did not actively resist the perpetrator. Self-blame can also be the consequence if victims accepting bribes from the perpetrator (Van der Merwe, 2009).

The dynamics of stigmatisation refers to the negative messages that the MCSA victim receives about CSA (Finkelhor & Browne, 1985). The child incorporates feelings of badness, worthlessness, shame, guilt and responsibility for the MCSA. These negative meanings and messages can come directly from the abuser, who may make blaming and shaming comments to the child. When the abuser or others pressure the boy to keep the abuse a secret, this can also convey powerful messages of shame and guilt to the boy. Stigmatisation can also be reinforced by attitudes that the boy hears from family members, the community or labels heard in the media. Stigmatisation distorts and destroys the MCSA victim’s self-esteem and can result in feelings of disgust, isolation, drug and/or alcohol abuse, delinquency, criminal

activities, self-mutilation or suicide (Fouché & Yssel, 2006; Scheepers, 2006). This self-mutilation is a coping mechanism for the emotional pain experienced by the sexually abused boy. It can include cutting himself with knives or razor blades, picking sores, pulling hair out or intentionally burning himself (Ellsworth, 2007). In the support to these sexually abused boys, it will thus be very important for the MCSA victim to be able to build a relationship with a trustworthy person. In this deep trusting relationship the MCSA victim will be able to develop some self-worth.

1.1.5.2 Psychosocial development.

According to psychosocial development the child has certain emotional developmental tasks which need to be addressed for optimal growth and functioning. Erik Erikson outlined eight stages in psychosocial development of which each one is characterised by a crisis (Gordon & Browne, 2014; Levine & Munsch, 2013; McDevitt, 2013; Santrock, 2014). The solution of each crisis is in a synthesis of the two poles and each stage builds on the successful completion of the earlier stage (Berk, 2012; Bjorklund & Blasi, 2012; Charlesworth, 2013; Daniel et al., 2010; Huston & Ripke, 2010). If the crisis of one stage has not been solved successfully, it remains present and must still be completed before moving on to the next stage. For the purpose of this study the stage of industry versus inferiority (Louw & Louw, 2014; Santrock, 2014) will be discussed in more detail, as well as the effects of MCSA on this psychosocial developmental stage of the MCSA victim.

During the stage of industry versus inferiority the existential question is: *Can the child make it in the world of people and things?* This stage starts at the age of six and lasts through the primary school years. During this stage the child is eager to learn and accomplish complex skills. The achievement of success, mastery of certain skills and experiences of

competence are very important (Charlesworth, 2013; Davies, 2010; Flick, 2011; Kestly, 2010; Schaefer & Drewes, 2010; Thomas, 2010; Woolf, 2010). Most children in their middle childhood lack a fully developed capacity for abstract thought, which is a prerequisite to meaningful verbal expression and understanding of complex issues, motives and feelings (Blundon Nash & Schaefer, 2011; Kaduson, 2011). Thomas (2010) mentions that if the child in this developmental phase experiences failure in tasks of competence and mastery, it can result in problems in terms of competence and self-esteem, leading to feelings of terror, despair, frustration, rage and resignation. The balance between industry and inferiority leads to the psychosocial strength of competence. In support to sexually abused boys it will be necessary for them to experience success and mastery. This can subsequently enhance their self-esteem.

1.1.5.2.1 Psychosocial development and the effects of MCSA.

MCSA has a severe impact on the child's impulse control and on his abilities to achieve success. During the MCSA experience these boys were disempowered. This resulted in feelings of helplessness and inferiority. The boy internalises messages such as "I am damaged" and "I am powerless", which can finally lead to behaviour reflecting helplessness and aggression (Dunn, 2008b). The sexually abused boy can experience a feeling of defeat and failure, because he was unable to stop the MCSA (LE, personal communication, August 19, 2014). In the support process it will thus be important to empower the MCSA victim, in order to give back control to him. When taking the Strengths Perspective into account, it can be an empowering process to these boys when they realise their own personal strengths and resources. When the MCSA victim is supported in such a manner, he will no longer view himself as helpless and only as a victim of his circumstances.

According to the traumagenic dynamics (Cantón-Cortés et al., 2012; Van der Merwe, 2009) powerlessness happens when the boy's body territory and personal space is repeatedly invaded against his wishes. This is exacerbated by the abuser's use of force, threat of injury or trickery to involve the boy in the abuse process. Powerlessness is then reinforced when the boy feels unable to protect himself, make others believe about the abuse and with no ability to stop the abuse himself (Finkelhor & Browne, 1985). Several authors (Dunn, 2008a; Fouché & Yssel, 2006; Scheepers, 2006) report that this powerlessness results into feelings of anxiety, lowered sense of efficacy and a need to control. This boy may experience nightmares, phobias, somatic complaints, eating and sleeping disorders, depression, dissociation, truancy, delinquency and aggressive behaviour, like bullying.

1.1.5.3 Moral development.

According to Louw and Louw (2014) moral development refers to the process in which children learn the principles to evaluate certain behaviours as good or bad and to change their own behaviour according to these principles. Kohlberg's theory of moral development states that the child must go through different stages of moral development (Dunn, 2008b; Louw & Louw, 2014). The following table illustrates the first three stages of Kohlberg's stages of moral development.

Table 3

Kohlberg's theory of moral development

AGE	LEVEL/STAGE	KIND OF BEHAVIOUR
5-9 years	Level 1: Pre-conventional Level	
	Stage 1: Punishment-avoidance and obedience orientation.	Child obeys rules to avoid punishment and gets rewards. The child will not evaluate behaviour as wrong if it is not noted by somebody.
	Stage 2: Self-interest orientation	Children obey rules to obtain rewards or favours.
Most adolescents and adults	Level 2: Conventional Level	
	Stage 3: Social conformity orientation	Children obey rules in order to be accepted and win people's acceptance and to avoid rejection. The emphasis is on living up to social expectations and norms because of how they impact day-to-day relationships.

(Adapted from Berk, 2012; Bjorklund & Blasi, 2012; Louw & Louw, 2014)

1.1.5.3.1 *Impact of sexual abuse on a child's moral development.*

The following table illustrates the relationship between Kohlberg's stages of moral development and the child's interpretation of sexual abuse.

Table 4

Impact of MCSA on child's moral development

STAGE	CHILD'S INTERPRETATION OF SEXUAL ABUSE
Stage 1 (4-8 years)	• Child conforms without understanding it is wrong. • Child can be tricked to believe that it is normal, special or fun. • Child may not disclose due to obedience to authority. • Child's vulnerability to do what he is told influences him to lie that sexual abuse did or did not happen.
Stage 2 (8-10 years)	• Child may understand wrongfulness, but conforms to instructions to please or to avoid punishment. • If the relationship with abuser is the strongest relationship, child will most likely not disclose. • Child is vulnerable to do what he is told, including lying about the absence or presence of involvement in sexual abuse.
Stage 3 (10-12 years)	• Child understands wrongfulness and may disclose the abuse. • If supportive relationship exists apart from the abuser and these relationships become more significant than the relationship with the abuser, the child may disclose. • Child whose emotional needs are not met by caregivers could make a false allegation in order to gain nurture from others.

(Fouché, 2007)

1.1.5.4 Sexual development.

The child's sexual behaviour develops and certain sexual behaviour is normal for a boy at certain ages and developmental stages. There are however certain sexual behaviours which are abnormal. Normal sexual development and problematic sexual development will be discussed.

1.1.5.4.1 Normal sexual development.

It is important to have a clear understanding about normal sexual development in middle childhood. Normal sexual development is a natural sexual exploration and an information-gathering process during childhood (Bjorklund & Blasi, 2012; Charlesworth, 2013). There is a definite balance between sexual curiosity and other interests, hobbies or aspects of the boy's life. The sexual curiosity is just one aspect out of a whole range of other activities (Charlesworth, 2013; LA, personal communication, June 1, 2010). The normal sexual exploration may lead to embarrassment or shame, but does not generate feelings of guilt, anger, anxiety or fear (Fouchè, 2007; LA, personal communication, June 1, 2010).

According to Fouchè (2007) normal sexual play has the purpose to explore and is spontaneous and unplanned where participation is voluntarily with mutual agreement and no force between the involved. This kind of play happens between children of the same age, size or developmental stages and is easily diverted when parents or adults tell the children to stop. In some cases the sexual behaviours of children are, however, not normal and can be seen as problematic. In the following section this problematic sexual development will be discussed.

1.1.5.4.2 Problematic sexual development.

According to the traumagenic dynamics (Cantón-Cortés et al., 2012; Van der Merwe, 2009) traumatic sexualisation includes where the child's sexuality, including both sexual feelings and sexual attitudes is shaped and changed in an inappropriate and dysfunctional manner by the CSA (Finkelhor & Browne, 1985). In some further studies (Dunn, 2008a; Fouché & Yssel, 2006; Scheepers, 2006; Van der Merwe, 2009) it was confirmed that traumatic sexualisation happens when a boy is repeatedly rewarded by means of affection, attention, gifts and privileges by an abuser for sexual behaviour that is inappropriate to his level of development. Through this the boy gets the idea that sexual behaviour, appropriate or inappropriate, can be a means to manipulate others to gain gratification.

The boy gets confused about sexual behaviour and sexual morality when certain parts of his body are fetishised and given distorted importance. This has an effect on future sexual behaviour and can result in sexual acting out, promiscuity, sexually abusive behaviours, sexual fears or addictions and a negative attitude towards the boy's own body. It can also happen that his sexuality becomes traumatised when negative memories become associated with any sexual activity (Fouché & Yssel, 2006; Scheepers, 2006; Van der Merwe, 2009).

Sexual behaviour problems involve the boy's sexual body parts, like genitals, breasts or buttocks. This kind of behaviour is age-inappropriate or can be potentially harmful to the self or others. It can be entirely self-focused as in the case of excessive masturbation or the behaviours can include and involve others. The latter can range from the exposing or looking at private parts, to fondling and penetration (Silovsky, Swisher, Widdifield & Burris, 2011). Sexual behaviour becomes problematic when the boy starts to masturbate obsessively and compulsively and it intervenes with his play behaviour and daily activities (Fouché, 2007; LA, personal communication, June 1, 2010). Masturbation becomes problematic when the

child uses an object to masturbate with (JvH, personal communication, August 14, 2012). It raises concern when the child attempts to penetrate his own or somebody else's anus or vagina, digitally or with an object, during masturbation. Mutual masturbation between the child and somebody else is abnormal sexual development. Any oral-genital or oral-anal contact is abnormal sexual development. It is problematic when there is a difference in age, size and developmental stages between the children involved in sexual activities (JvH, personal communication, August 14, 2012; LA, personal communication, June 1, 2010).

Problematic sexual behaviour is frequent, repeated and compulsive. This kind of behaviour is aggressive, forced and coerced and does not decrease after the child is asked to stop and given consequences. Sexual behaviour problems provoke strong emotional reactions in the boy, such as anger or anxiety and could cause harm to the boy and/or others (Fouchè, 2007).

1.2 Summary

The theoretical framework for this study was discussed. This included the Strengths Perspective, Resilience Theory, Attachment Theory, Social Support Theory, as well as the Developmental Perspective. In the following section the three articles for this study are presented. Article 1 explores the experiences of sexually abused boys placed in a clinic school in order to understand their support needs. Article 2 aims to identify critical aspects to support sexually abused boys placed in a clinic school and Article 3 outlines the conceptualisation of a proposed support strategy for MCSA victims.

SECTION 2

Section 2 includes the following three articles:

Article 1: Boys in middle childhood placed in a clinic school: Experiences of sexual abuse

Reference for Article 1:

Steyn, H., Van Wyk, C., & Kitching, A. E. (2014). Boys in middle childhood placed in a clinic school: Experiences of sexual abuse. *Child Abuse Research in South Africa*, 15(1), 15-28.

Article 2: Identifying critical aspects of support for sexually abused boys in middle childhood

Article 2 will be submitted to the *Journal of Child Sexual Abuse*.

Article 3: Conceptualising a proposed support strategy for sexually abused boys in middle childhood

Article 3 will be submitted to the *Social Work/Maatskaplike Werk* journal.

SECTION 2: ARTICLE 1

Boys in Middle Childhood Placed in a Clinic School: Experiences of Sexual Abuse.

Reference for article 1:

Steyn, H., Van Wyk, C., & Kitching, A. E. (2014). Boys in middle childhood placed in a clinic school: Experiences of sexual abuse. *Child Abuse Research in South Africa*, 15(1), 15-28.

**BOYS IN MIDDLE CHILDHOOD PLACED IN A CLINIC SCHOOL:
EXPERIENCES OF SEXUAL ABUSE**

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ABSTRACT

This study formed part of a larger research, which aimed to conceptualise a proposed support strategy for sexually abused boys in their middle childhood placed in a clinic school. The experiences of these boys were explored in this study, in order to understand their support needs. For the purpose of this study seven sexually abused boys in their middle childhood (9-12 years) placed in two clinic schools in Gauteng Province in South Africa fitted the criteria for inclusion in the study and were selected through purposive sampling. Data were obtained through three in-depth interviews with each participant. The results showed that sexually abused boys placed in clinic schools exhibit intensified emotional reactions, as well as certain problems associated with male child sexual abuse. The intensified emotional reactions included a deep sense of sadness and helplessness, a sense of guilt and shame, a sense of dissociation and numbness, avoidance of situations associated with male child sexual abuse, fear of recurring incidents and the re-experiencing of the trauma. The problems associated with male child sexual abuse included concerns regarding their own sexuality, difficulties in interacting with other people, dealing with anger and aggression, displaying self-destructive behaviour and difficulties to cope with schoolwork.

Keywords: male child sexual abuse, clinic schools, experiences, support, boys, middle childhood

INTRODUCTION

Clinic schools form part of *Learner with Special Educational Needs* schools (Department of Education South Africa 2001). At an international level clinic schools are referred to as “residential care” (Casey, Reid, Trout, Duppong Hurley, Chmelka & Thompson 2010:323; Quisenberry & Foltz 2013:280), “institutional youth care” (De Swart, Van den Broek, Stams, Asscher, Van der Laan, Holsbrink-Engels & Van der Helm 2012:1818) or “alternative schools” (Lehr, Soon Tan & Ysseldyke 2009:19; Simonsen, Britton & Young 2010:180; Simonsen & Sugai 2013:3). In South Africa these schools are referred to as clinic schools (Department of Education South Africa 2001). For the purpose of this research the term “clinic schools” was used. The main objective of a clinic school is to be a short-term alternative educational setting for learners with emotional and behavioural difficulties (Lee & Barth 2011:253; Simonsen *et al.*, 2010:180; Simonsen & Sugai 2013:3) to become rehabilitated, change their problem behaviour and be integrated again into the mainstream educational setting as quickly as possible (Flick 2011:44) or by the time the learner reaches the age of twelve years (RE 2012). The main reason for referral to a clinic school is the learners’ angry and externalising behaviour, which is often characterised by defiance, hyperactivity and aggression (Broecher 2014:22; McNamara 2010:215; Thomas 2010:413). Research (Casey *et al.*, 2010:324; Lebel & Kelly 2014:78-95; McNamara 2010:214; Quisenberry & Foltz 2013:280; Suk-ching Chong & Leung 2012:30) confirms that many children placed in clinic schools experienced abuse. According to JvH² (2012), a social worker at a clinic school, a possible reason for this delay in integration into the mainstream

² In the case of personal communication, the initials of the persons were used to protect their identity.

school may be the failure to resolve the learners' trauma effectively while they are placed in the clinic school. She is of the opinion that male child sexual abuse (hereafter referred to as MCSA) may add to the trauma of these learners, resulting in even more emotional and behavioural problems. MvW (2013) mentions the absence of support strategies for MCSA victims placed in clinic schools.

LITERATURE REVIEW

Due to the limited attention given to MCSA in clinic schools the problem behaviour displayed by these learners often continues after their return to mainstream education and therefore contributes to the delayed integration of some learners into mainstream educational settings. Research (Cyr, Mcduff & Hébert 2013:210; Phasha 2008:312) indicates that sexually abused children who are effectively supported show higher adjustment levels compared to those abused individuals with low levels of support. Support for these children to address the trauma of MCSA while at the clinic school, might alleviate the emotional and behavioural problems to such an extent that they will be enabled to function in a mainstream educational setting. The need to support MCSA victims placed in a clinic school, urged the researchers to study MCSA as a phenomenon with the aim to conceptualise a proposed support strategy for MCSA victims.

For the purpose of this study the focus was on sexually abused boys aged nine to twelve years placed in the only two clinic schools with residential facilities in Gauteng Province, South Africa. JvH (2012), the social worker and RE (2012), the principal of a clinic school confirm that many of these learners have been sexually abused and the trauma of the MCSA may contribute to their problem behaviour. The reality of MCSA is further illustrated by the following findings.

Pereda, Guilera, Forns and Gómez-Benito (2009) find that South Africa appears to have the highest incidence of child sexual abuse (hereafter referred to as CSA) globally. In a study done by Dunn (2008a:37) it is stated that one in three children in South Africa will be sexually abused some time during their childhood.

The sexual abuse of both boys and girls are common (Bullock & Beckson 2011:197; Parent & Bannon 2012:354). In a study undertaken in the residential areas of southern Johannesburg it was found that just as many boys as girls under the age of fifteen years are sexually abused (Brookes & Higson-Smith 2004:111). According to international estimates roughly 14% of males experienced MCSA (Schraufnagel, Davis, George & Norris 2010:369). In the South African context Mathews, Abrahams and Jewkes (2013:640) mention a survey done in urban Gauteng Province, which stated a prevalence rate of 20,4% of MCSA before the age of eighteen years. These percentages, however, may not be a true reflection of the reality either, due to low disclosure rates of MCSA (Alaggia & Mishna 2014:41; Dorahy & Clearwater 2012:156; Easton, Saltzman & Willis 2013:1; Maikovich-Fong & Jaffee 2010:435) and boys' way of suppressing emotions (Barker & Crenshaw 2011:location 1375; Haen 2011:7). Research on MCSA reveals that the long-term effects of CSA are equally damaging to girls and boys (Alaggia & Millington 2008:266; Larsen, Sandberg, Harper & Bean 2011:436; Maikovich-Fong & Jaffee 2010:429; O'Leary & Gould 2009:951).

In studies which specifically focused on MCSA it became evident that the sexual abuse of boys in their middle childhood has serious effects. The victims of MCSA are at an increased risk of developing various mental illnesses and disorders (Maikovich-Fong & Jaffee 2010:435; Schraufnagel *et al.*, 2010:369). MCSA victims may present with nightmares, major depression, post-traumatic stress disorder, antisocial personality disorder, hyperactivity, fear, anxiety disorders and aggression (Alaggia & Mishna 2014:41; Diamanduros, Cosentino, Tysinger & Tysinger 2012:134; Gospodarevskaya 2013:278;

Kiselica & Novack 2011:location 2810). MCSA victims can also show extreme forms of emotional and behavioural problems, like suicidal behaviour or becoming involved with some form of addiction like drug and/or alcohol abuse to suppress the memories of the MCSA or to numb their feelings (Diamanduros *et al.*, 2012:134; Lowenstein 2011:296). O'Leary (2009:477) is of the opinion that the substances make it easier to control the distress associated with the MCSA.

MCSA victims also run the risk of developing sexually related problems (Alaggia & Mishna 2014:41; Diamanduros *et al.*, 2012:134; Fanniff, Becker & Gambow 2014:168-180), which could range from the avoidance of anything related to sexuality by the MCSA victim (Ponton & Goldstein 2004:210), to the rejection of his genitals and the exhibition of sexual dysfunction, like hyper sexuality and confusion about sexual identity (Kiselica & Novack 2011:location 2810; Schraufnagel *et al.*, 2010:370). A preoccupation with sex and excessive masturbation may occur in the victims of MCSA (LA 2012; LP 2012). The feeling of guilt and shame is often present in MCSA victims. Often they struggle to trust and be in a close relationship with someone, because of their feelings of betrayal by a trusted person (Alaggia & Mishna 2014:41; Kiselica & Novack 2011:location 2810). The MCSA victim often starts to think that all people are dishonest, malevolent and undependable (JvH 2012).

The research to date highlights the need to develop support for MCSA victims. This study as part of a larger research, aimed at conceptualising a proposed support strategy for MCSA victims in their middle childhood placed in a clinic school. As a prerequisite for the conceptualisation of this proposed support strategy, a thorough understanding of their experiences of MCSA was required. However, no research that focused specifically on the experiences of sexual abuse of MCSA victims placed in a clinic school could be located at national or at international level. Understanding their experiences became paramount to the conceptualisation of the proposed support strategy.

In order to understand the experiences of MCSA victims in clinic schools, these boys had to be incorporated in the research as participants. For this purpose qualitative phenomenological research was used (Edmonds & Kennedy 2013:136; Joyce & Sills 2014:16-29; McWilliam 2013:229-248) in order to explore and describe the phenomenon of MCSA and to develop an understanding of their support needs. This phenomenological method of inquiry implies that the participants were approached with genuine willingness to learn and an open mind to discover their personal experiences of the phenomenon (Delpont, Fouchè & Schurink 2011:305; Edmonds & Kennedy 2013:138). Since this is an area where much needs to be done to improve support, the MCSA victims needed be consulted. This was a research with children, not about them or on them. Chan, Lam and Shae (2011:164) add that children in research should not be treated as objects or subjects to be counted or measured; rather, they should be regarded as active agents, as capable of enlightening us with their knowledge, thoughts and why they hold certain views in ways they like and feel comfortable. Cashmore (2002:838) states that this involvement could give them some sense of being active agents in relation to their own care. Jackson, Newall and Backett-Milburn (2013:1, 10) urge that neglected and abused children are a particularly vulnerable group whose voices have so often been ignored in the past. These children should therefore be involved and have some say in the decisions that are made about them. These authors (Cashmore 2002:838; Jackson *et al.*, 2013:1, 10) urge that research of this matter is thus a necessity.

Considering the above-mentioned the research question addressed in this article is:

Based on their experiences of being MCSA victims, what are the support needs of these sexually abused boys placed in a clinic school?

The research aim for this part of the project was to explore and describe qualitatively, by means of a phenomenological strategy the experiences of sexually abused boys placed in a

clinic school in Gauteng to understand their support needs. Through studying the experiences of MCSA, the people involved in the MCSA victim's life may have a better understanding of the phenomenon of MCSA and support MCSA victims more effectively. The research is also intended to contribute to the conceptualisation of a proposed support strategy for sexually abused boys.

METHOD

As already outlined, this article presents the first phase of a research project aimed at conceptualisation a proposed support strategy for MCSA victims in middle childhood placed in a clinic school. The project consisted of three phases. During the first phase the experiences of sexually abused boys placed in a clinic school were explored and described. During the second phase the inputs from social workers, psychologists, counsellors, teachers and child and youth care workers (hereafter referred to as role players) were obtained to identify critical aspects of support to MCSA victims. The third phase consisted of the conceptualisation of this proposed support strategy for MCSA victims placed in a clinic school.

Research Design

The experiences of MCSA of boys placed in a clinic school were explored and described. For this purpose qualitative research was undertaken (Postmus 2013:241-263). According to Joyce and Sills (2014:16) the phenomenological method of inquiry implies that researchers approach participants with a genuine willingness to learn and an open mind to discover their personal experiences of the phenomenon.

Participants

To select the participants for the population with whom the in-depth interviews were conducted, non-probability sampling (Punch 2014:160) was used and specifically purposive sampling (Creswell 2014:189; Lapan, Quartaroli & Riemer 2011:84; Yin 2010:88). The criteria for inclusion in this purposive sampling were the following: (1) Boys who attend clinic schools in Gauteng; (2) boys in middle childhood (9-12 years); (3) boys who disclosed the MCSA and/or whose parents gave clear indications of such abuse; (5) boys had to be able to communicate in Afrikaans or English to accommodate the researcher who cannot understand any other languages; (6) boys had to be open and willing to share their experiences of MCSA; (7) boys and their parents had to give consent and be willing to be recorded digitally; and (8) boys must have had support from a registered professional to work through the trauma of MCSA prior to and after the research. Nine participants met the above set of criteria for inclusion in this study. Seven participants were willing to partake in the in-depth interviews.

Approval for this study to be conducted was obtained from the Ethical committee of the North-West University, Potchefstroom Campus (Ethical number: NWU-00060-12-A1), Gauteng Department of Education, the two applicable district offices, as well as the two clinic schools. Informed consent and assent (Marzano 2012:443-456; Reamer 2013:41) from the participants and their parents were obtained before participation. The procedures to be followed during the investigation were explained to all involved in this study, in order to avoid any deception of the participants. Participation was voluntary (Babbie 2013:66) and any person could withdraw from the study at any time. The participants were informed about the use of a digital recorder during the interviews (Greeff 2011:359). Anonymity and confidentiality of all participants were ensured (Babbie 2013:68; Kaiser 2012:457-464; Reamer 2013:46). All the participants from this population were already receiving

counselling from a psychologist, social worker or counsellor at the clinic schools and therefore the participants were referred to them if any secondary trauma or emotional harm occurred during the interviews or if the participants needed any further support. The participants got the opportunity at the end of each interview to talk about their experiences and any misperceptions were rectified.

Procedure

After the ethical approval for this research was obtained, the two clinic schools were approached and the social workers at the two schools identified all the potential learners who fit the above-mentioned criteria. Each of the potential participants' parents were met privately to explain the aim of this study, what were expected of them and their children, answer questions about the participation in this study and obtain their written consent for their children to partake in this study. The social workers acted as mediators to discuss and explain this study to these participants. The mediators' role also included bringing together the researcher and the prospective participants, establishing the initial rapport with them, as well as providing all the potential participants' details. Assent from the learners to participate were obtained and it was explained to them that their participation was voluntary and that they could withdraw from the study at any time for whatever reason without any negative consequences.

Data collection

In-depth interviews were conducted (Greeff 2011:341-374; Johnson & Rowlands 2012:99-114; Nolas 2011:23) with seven participants to gain knowledge and a better understanding of the experiences of MCSA and the meaning the participants make of that experience, in order to develop an understanding of their support needs. Before the in-depth interviews were conducted some time was spent with the participants to get to know them better and in order

to let them feel at ease. This was done by means of talking in general about the participants' interests and hobbies, playing a board game and building a puzzle together. This rapport-building process was before each interview and lasted about 40 minutes each. After the participant was at ease the first in-depth interview started. These interviews were about 20-30 minutes each. Data collection was done during this phase by means of a single open-ended question. This question was: "Tell me about your experiences of MCSA." This open-ended question was checked and evaluated by a social worker for its applicability. A pilot study of this open-ended question was conducted with one participant who also met the sampling criteria to make adjustments before the study was conducted with the remaining participants. Three interviews with each participant were conducted. The first interview was an in-depth interview to explore the participant's experiences of MCSA in order to better understand their support needs. The second interview was a creative session where a collage (Butler-Kisber 2010:102-120; Martin & Hanington 2012:34) as visual method was used. The participants got the opportunity to explain and discuss their collage. This collage was used to reflect on their experiences, in order to develop an even better understanding of their support needs. Between the second and third interview member checking (Creswell 2014:201) was used where the researcher clarify some of the data which was obtained during the first and second interviews. During the third interview the participants' perception of what support they needed were explored.

Observations were also conducted during the in-depth interviews. Field notes were made and the participants' actions were recorded while gaining in-depth insight into the manifestations of their body language, non-verbal cues and actions (DeWalt & DeWalt 2010; Yin 2010:161). Field notes were written immediately after each interview to ensure that all observations and additional information were recorded. These observations were included in

the field notes and also gave an account of the prevailing circumstances during the interviews (Nieuwenhuis 2007:84).

Data analysis

The qualitative narrative information that came from the three in-depth interviews with each participant was read (Bazeley 2013:101), notes about observations were made during the interviews to be able to analyse the data. Themes and sub-themes were identified through thematic analysis. The phases as recommended by Clarke and Braun (2013:120-123) were used to analyse the qualitative data.

The researcher became familiar with all the raw data, transcribed all the data (Kowal & O'Connell 2014:64-78) while reading through the data (Bazeley 2013:101) and assigning possible codes (Creswell 2014:197; Flick 2014:305; Harding 2013:81, 129) to the data. After this process possible themes were identified and the data that supported the codes were collated (Harding 2013:107). The themes were reviewed, whereafter the themes were defined and named (Bazeley 2013:223). Then it was all written up to integrate the analytic narrative and the data extracts.

Trustworthiness

The following key criteria of trustworthiness of Lincoln and Guba were included (Lincoln 1995:275-289; Nieuwenhuis 2007:80). These authors refer to four constructs to ensure trustworthiness, namely credibility, transferability, dependability and confirmability. The following table gives an explanation of the constructs mentioned and how they were implemented in this study.

Table 1

Key criteria of trustworthiness of Phase 1

STRATEGY	CRITERIA	APPLICATION
Credibility	Reflexibility	Field notes were written immediately after the interviews and were also analysed.
	Triangulation	Different data sources were used, like literature study, in-depth interviews, field notes and participant observations.
	Member checking	Between the second and third interview participants got the opportunity to comment on the findings and to assist with the interpretation of the data.
Transferability	Saturation	Data were collected until data saturation occurred.
	Dense description	Description of research methodology and checking of literature were done.
Dependability	Audit	Done by co-coder.
	Peer examination	Expert supervision was provided during this study by a registered educational psychologist and a registered social worker.
Confirmability	Triangulation	Different data sources were used, like literature study, in-depth interviews, field notes and participant observations.
	Reflexibility	Field notes were written immediately after interviews and were analysed. These field notes gave more information about the participants' non-verbal cues.

FINDINGS

Table 2

Themes and sub-themes identified in Phase 1

MAIN THEMES	SUB-THEMES
Theme 1 Intensified emotional reactions associated with MCSA	Subtheme 1.1 A deep sense of sadness and helplessness Subtheme 1.2 A sense of guilt and shame Subtheme 1.3 A sense of dissociation and numbness Subtheme 1.4 Avoidance of situations associated with MCSA Subtheme 1.5 Fear of recurring incidents Subtheme 1.6 Re-experiencing of the trauma
Theme 2 Problems associated with MCSA in boys	Subtheme 2.1 Concerns regarding their own sexuality Subtheme 2.2 Difficulties in interacting with other people Subtheme 2.3 Dealing with anger and aggression Subtheme 2.4 Displaying self-destructive behaviour Subtheme 2.5 Difficulties to cope with schoolwork

Theme 1: Intensified emotional reactions associated with MCSA

Intensified emotional reactions in this study refer to the emotional responses that the participants relate to the incidents of MCSA. The participants in this study reported a deep sense of sadness and helplessness, on-going struggle with guilt and shame, a sense of dissociation and numbness, avoidance of situations associated with MCSA, fear of recurring incidents and re-experiencing of the trauma.

Subtheme 1.1: A deep sense of sadness and helplessness

The participants when talking about their experiences of MCSA emphasised how sad and helpless they felt during the incidents. The intensity of these feelings of sadness is evident in the statements made below by participants:

When that rape happened to me, it felt like my heart was breaking apart and I did not know what to do. (Participant 3)

When I think and talk about the sexual abuse that happened to me, I am sad. (Participant 1)

I was crying while he raped me. (Participant 4)

Research supports this overwhelming feeling of sadness over sexual victimisation (Asgeirsdottira, Sigfusdottirb, Gudjonssona & Sigurdsson 2011:215; Olafson 2011:14). LE (2013) mentions that most MCSA victims feel an intense feeling of sadness over the MCSA. She is however of the opinion that often MCSA victims will not show these feelings, because of the gender role expectation that boys are supposed to be tough and do not show emotions. This suppression of emotions by boys is also confirmed by research (Barker & Crenshaw 2011:location 1375; Kiselica & Englar-Carlson 2011:location 1626). The prevalence of helplessness is illustrated in these narratives:

He closed my mouth. I could not shout for help. (Participant 1)

*I tried to get away from him (perpetrator), but I could not. I cried for my mother.
(Participant 4)*

*I could not stop him from touching my private parts. He was stronger than me.
(Participant 5)*

This feeling of helplessness in MCSA victims is supported by Walker, Archer and Davies (2005:78), who reported that the majority of victims said that they reacted with frozen fear and helplessness. In addition, Diamanduros *et al.* (2012:143) and Gospodarevskaya (2013:278) report that the individual's response to the event most often is one of helplessness.

Participants furthermore reported that those close to them who had to witness these incidents were also deeply saddened and became helpless on-lookers. One participant recalled the following:

There was a time when my dad did sexual stuff to me, even in front of my mom. He did not even care if she called the police. He was not scared anymore. My mom would go sit in front of the TV and start to cry. (Participant 2)

My dad always told my mom, whenever he wanted to do it (sexual abuse), he wants to have a dad-son talk with me, alone in the room and she must go out of the room. Then he would do all the wrong things with me, non-stop. He did this every day. Then he did the same thing, every day, every day, every day... I could not stop it. (Participant 2)

The prevalence of intense sadness and helplessness in boys, who have been exposed to MCSA, can be considered signs of childhood depression, as indicated by research (Alaggia &

Mishna 2014:41). The results therefore seem to confirm the findings of research (Alaggia & Millington 2008:266; Kiselica & Novack 2011:location 2810) which indicates that MCSA victims can show signs of major depression. In a study done by Trask, Walsh and DiLillo (2011:7) it is reported that sexually abused children display higher rates of depression than non-abused children with between 43% and 67% of children meeting diagnostic criteria for depression following CSA. This is confirmed by De Witt (2009:333) who states that depression is common amongst CSA victims, where the victim can manifest very low levels of self-esteem, social withdrawal and little or no displays of emotion. During this depressive state the sexually abused child can show suicidal tendencies, poor eating patterns and disturbed sleep patterns as symptoms of depression.

Subtheme 1.2: A sense of guilt and shame

It was evident from the data that MCSA victims experienced guilt and shame about the incidents of MCSA as stated by these participants:

He asked me to have sex with him and then I said “no” and then he forced me and raped me. Maybe I should have done something else. (Participant 3)

I am the wrong one. I should have stopped him. (Participant 5)

Participants showed a sense of guilt and partial responsibility for the MCSA, as illustrated by this narrative:

My mom always told me I must not go far and play in the yard. When my mom asked me if I was raped, I said “no”, because I knew I did wrong by going out of the yard. (Participant 1)

The guilt and shame goes hand in hand with anger directed at the self:

I am angry with myself for watching those sex movies with my dad. I feel guilty and ashamed for watching that movies. (Participant 6)

The guilt and shame are furthermore related to the way in which the participants engaged with the perpetrators during the incidents of MCSA. Evidence indicate that participants in some instances allowed fondling to happen and therefore also tend to accept partial responsibility for what happened. The feeling of guilt and shame was also stated by the participant who recalled his frustration to be unable to stop the sexual abuse. He narrated the following:

I am a boy. I am supposed to be strong and fought the boy who touched me. (Participant 5)

A participant mentioned the intense shame he felt for allowing the fondling to happen. This is illustrated in the following:

My mom taught me not to allow anyone to touch my private parts and now this happened. I feel ashamed about the touching, because I should have stopped it. (Participant 7)

Research findings by Kiselica and Novack (2011:location 2810) indicate that MCSA victims show feelings of being “dirty”, “ugly” and “no good”. These findings are confirmed in this study. Dorahy and Clearwater (2012:156) furthermore report that due to this extreme guilt and shame MCSA victims are often incapable of stopping the MCSA and to protect them from the abuse, as also indicated in this study.

The experience of MCSA challenges boys’ sense of masculinity and thus their sense of identity, which causes shame and guilt in the MCSA victim (Dorahy & Clearwater 2012:156; LE 2013; Valente 2005:12). Many MCSA victims feel powerless because they were unable to

stop the abuse and are embarrassed that they were unable to protect themselves and live up to their gender role by not doing enough to stop the MCSA (Dorahy & Clearwater 2012:156). To admit their victimisation is to indicate that they are weak, vulnerable and emasculated (Diamanduros *et al.*, 2012:133; Dorahy & Clearwater 2012:156).

Subtheme 1.3: A sense of dissociation and numbness

The participants reported that due to the intense nature of the emotional reactions associated with the MCSA incidents, they tended to feel numb and dissociated from the situation. Participants explained as follows:

While the sexual abuse happened to me, it felt like I was in jail. I couldn't break free. It felt like it was not really me the abuse is happening to, but then I went out of my own thoughts and it was as if I looked down at what was happening and saw that it was really me the sexual abuse is happening to. I felt so dead inside of myself.
(Participant 4)

After the sexual abuse, I had to keep these feelings inside of myself. It was as if I was not feeling anything anymore. I had to do this, in order for no one to find out about the sexual abuse. (Participant 5)

Valente (2005:13) is of the opinion that dissociation can serve as a survival mechanism for the MCSA victim to distance himself from the abuse experience, in order to create psychic numbing as a way to repulse pain and humiliation. Research (Diamanduros *et al.*, 2012:146; Dorahy & Clearwater 2012:156) supports this phenomenon of dissociation in MCSA victims.

Sub-theme 1.4: Avoiding situations associated with MCSA

Some of the participants narrated their experiences of avoidance of any stimuli associated with the sexual abuse. These avoidances ranged from hiding away from the perpetrator to

refusal to visit the place where the MCSA happened. This was illustrated by the following narratives:

Whenever my parents wanted to go to town, I used to hide under the car seats when we drove past the place where the sexual abuse happened. (Participant 4)

I used to go to the toilet a lot during night time, because I didn't want to be alone with him (perpetrator) in the same room. (Participant 5)

MCSA has been associated with traumatic reactions that may include attempting to avoid situations or stimuli that remind the victims of the abuse (Diamanduros *et al.*, 2012:143; Gospodarevskaya 2013:278; Trask *et al.*, 2011:7). Dissociation and alterations in consciousness can be seen as an automated strategy for either regulating feelings or becoming deeply absorbed in internal stimuli, including painful feelings and memories (Dorahy & Clearwater 2012:167). This way of coping with the MCSA was also supported by the MCSA victim who liked to avoid anything related to the MCSA. The participant narrated:

After the sexual abuse happened to me, I liked to sleep as a way not to think about the sexual abuse. (Participant 4)

Sub-theme 1.5: Fear of recurring incidents

It became clear that anxiety and fears form part of the experiences of MCSA victims in this study. This is evident in the following narrative:

He raped me. I felt scared. (Participant started to cry.) (Participant 3)

I am afraid that he (perpetrator) might hear me talking about the sexual abuse. (Participant talks softly.) (Participant 5)

Some of the participants showed concerns for their own safety and a fear of the possibility that the MCSA could re-occur. A participant commented:

As a boy to be sexually abused, he forced you to do sexual stuff to him. Then whenever I see him, I am always scared and my heart is beating fast and I am always afraid. (Participant started to cry.) (Participant 3)

I am always scared and afraid that the rape can happen again. (Participant 4)

According to research (Alaggia & Mishna 2014:41; Diamanduros *et al.*, 2012:134; Gospodarevskaya 2013:278; Kiselica & Novack 2011:location 2810) MCSA victims often show signs of fear and anxiety. In a study done by Trask *et al.* (2011:7) it is reported that the prevalence of anxiety disorders is significantly higher in CSA victims than in non-abused children (12% versus 3%).

Subtheme 1.6: Re-experiencing of the trauma

MCSA victims often re-experience the trauma of MCSA. Some of them responded during the in-depth interviews that especially during the night they have a lot of nightmares, think a lot about the MCSA and sex and therefore can't sleep properly. This was illustrated in the following narratives:

Sometimes when you want to sleep at night, you can't sleep, because you always think about the sexual abuse that happened. (Participant 4)

I dreamt yesterday night that boy came into this school. That thing... the rape... it happened again. (Participant started to cry.) (Participant 3)

After the rape I could not sleep. I dreamt about the rape every night. (Participant 1)

Several authors (Gospodarevskaya 2013:278; Trask *et al.*, 2011:7) confirm that MCSA victims often re-experience the trauma of MCSA in the form of nightmares.

Theme 2: Problems associated with experiences of MCSA

The participants reported problems on the intrapersonal, interpersonal and behavioural levels of their lives that they associate with the experiences of MCSA. The problems specifically reported in this study relate to concerns regarding their own sexuality, difficulties in interacting with other people, dealing with anger and aggression, displaying self-destructive behaviour and difficulties to cope with schoolwork.

Subtheme 2.1: Concerns regarding their own sexuality

It became evident that MCSA victims experience concerns regarding their own sexuality. Participants mentioned:

He called me a gay-boy, because of what happened between us. (Participant looked very angry.) (Participant 2)

Some children are teasing me and call me gay. (Participant 5)

The confusion about their own sexuality seems to be more serious if they ejaculated during the MCSA. Evidently participants question their own sexuality, especially when the perpetrator was male. The one participant recalled the incident:

My dad licked and sucked my private part. He did this licking and sucking of my private part until this white stuff (ejaculation) came from my private part. (Participant 2)

There is the risk for sexually abused boys to develop sexually related problems (Alaggia & Mishna 2014:41; Diamanduros *et al.*, 2012:134; Fanniff *et al.*, 2014:168-180; Parent &

Bannon 2012:357), where the MCSA victim can avoid anything related to sexuality (Ponton & Goldstein 2004:210), reject his genitals and exhibit sexual dysfunction, like hyper sexuality and confused sexual identity (Kiselica & Novack 2011:location 2810). LA (2012) supported this feeling of vulnerability and questioning about the boy's own sexuality, sexual orientation and masculinity, if he experienced sexual arousal, an erection and equalling physical pleasure during the sexual abusive experience by a male.

Some participants indicated their fear of homosexuality because of the physical pleasure they experienced during the MCSA. This was stated by a participant:

He (perpetrator) told me, because I did not stop him while he played with my thing (penis), I actually enjoyed it. (Participant 5)

Research literature (Diamanduros *et al.*, 2012:133; Gartner 2011) confirms if the MCSA victim was sexually stimulated by aspects of this sexual experience, he may feel he participated in or even invited the MCSA. This creates great confusion inside the boy, who knows he was also repelled by the experience at the same time. Gartner (2011) finds that these feeling of guilt about the sexual pleasure he felt during the MCSA, may cause the MCSA victim to become ambivalent about any sexual pleasure.

MCSA victims often show sexualised behaviour, such as compulsive masturbation, especially when they think about the MCSA or experience an extreme emotional feeling, such as fear or anger (JvH 2012; LA 2012). A participant stated:

I felt so bad when I woke up and realised that I dreamt about the sexual abuse. (Participant 4)

In a study done by Trask *et al.* (2011:7) it is reported that approximately 28% of CSA victims show highly sexualised behaviour which is one of the most widespread and troublesome

problems reported following CSA. LP (2012) and JvH (2012) mention that a preoccupation with sex and excessive masturbation may occur in MCSA victims.

Subtheme 2.2: Difficulties in interaction with other people

As far as their interaction with other people is concerned the participants reported that they experience feelings of mistrust in any adult or trusted person. Some of the participants reported mistrust in adults, as illustrated by this participant:

I trusted my dad to take care of me while my mom was at work. I was wrong to trust him. (Participant 6)

I told my child and youth care worker about the sexual abuse, but she didn't do anything about it. (Participant 5)

MCSA victims have much difficulty with trust and intimacy, because of their feelings of betrayal by a trusted person (Alaggia & Mishna 2014:42; Kiselica & Novack 2011:location 2810). The abuser wants to satisfy his own needs and misuses his age or authority to abuse a boy, resulting in the MCSA victim considering all people as dishonest, malevolent and undependable (Gartner 2011). Valente (2005:10) is of the opinion that sexually abused boys have lost their belief in fairness, safety, privacy and trust.

This feeling of mistrust in the non-offending parent was also found in this study and one participant recalled:

My mom was not doing anything about the sexual abuse. (Participant 2)

LP (2012) also mentions the mistrust these boys often show against the non-offending parent for not protecting the child against the MCSA.

The feeling of social withdrawal was present in most of the participants, as illustrated:

I just want to be alone... in the classroom and during break time. (Participant 4)

*I don't want to play during break time. I just want to be alone and walk by myself.
(Participant 7)*

After the rape I didn't want to play with my friends. (Participant 3)

Thielmann (2010:location 42) supports this findings and reported that the shame resulting from the MCSA can limit the victim's social adjustment. According to RE (2012) and Gartner (2011) MCSA victims can confuse affection and friendship with sexual abuse and tenderness with desire. They may find it difficult to know the difference between sex, love, nurturance, affection, friendship and sexual abuse. It often happens that they will think normal interpersonal relationships are seductive and manipulative or that exploitative situations are normal and acceptable.

Sub-theme 2.3: Dealing with anger and aggression

Aggressive behaviour such as fighting and bullying was evident in the experiences of all the participants and was illustrated in the following extracts:

Whenever I hit someone, I think of my father who abused me. Then I just want to kill these children that I fight with. (Participant 2)

I always bully the children and give them an excuse to hit me. (Participant 3)

To be sexually abused makes me angry and upset. Now when I grow up and I realised what my dad has done to me, it makes me even angrier. (Participant 2)

Research (Gospodarevskaya 2013:278; Trask *et al.*, 2011:7) supports these findings and mentions that externalising problems, like aggression are commonly reported among children with a history of CSA. Valente (2005:12) reports that MCSA victims have a two to four times

higher risk than their normal counterparts of aggressive behaviour. MCSA victims often like to bully other children. The participants reported that the ability to bully somebody else, gave them the feeling of being in control of a situation, something they did not experience during the abusive situation. Parent and Bannon (2012:359) support this finding of aggressiveness with MCSA victims. They are of the opinion that this aggressive behaviour actually constitute coping and survival strategies used to show that the victim conforms to masculine stereotypes.

Sub-theme 2.4: Displaying self-destructive behaviour

Participants reported self-destructive behaviour that includes suicide attempts, destructive thoughts, addictive behaviour and truancy. Suicidal attempts and self-destructive thoughts and behaviours were evident as an effect of the MCSA. Participants narrated their experiences:

I wanted to end my life. I took a chain and tried to hang myself in my room.
(Participant 6)

I think about killing myself a lot. I was so angry with my mom for not letting me die. I wanted to die. (Participant 6)

After the rape I didn't want to live any more. (Participant showed no facial expression while talking about his suicidal ideation.) (Participant 3)

According to Valente (2005:14) these feelings of hopelessness, helplessness, futility, worthlessness and depression can be seen as warning signs for suicidal behaviours. MCSA victims show 1,4 to 1,5 times higher rates of attempting suicide than non-abused ones. Coohey (2010:857) supported the finding that MCSA victims are more likely to think about killing themselves or try to kill themselves than sexually abused girls. This suicidal behaviour

of MCSA victims was also supported by several authors (Alaggia & Millington 2008:266; Parent & Bannon 2012:357).

Another form of self-destructive behaviour is the involvement with some form of addiction. This was further illustrated in the following narratives of participants:

I remember the time when my dad took me to the bar with him. My dad's friends gave me alcohol to drink and forced me to lick and suck their private parts. The alcohol helped me not to think about what was really happening to me. (Participant 2)

When my dad gave me that alcohol to drink, it felt so funny. Actually while he was doing the sexual stuff with me, I was not feeling anything or thinking about anything at all. (Participant 2)

Valente (2005:14) is of the opinion that during the sexual abuse, some boys may be given alcohol or other drugs as a way to increase their compliance with the sexual act. Later these boys learn that substances can help to dull feelings, numb their emotional pain and distress. Gospodarevskaya (2013:278), as well as Alaggia and Mishna (2014:41) confirm the possibility of MCSA victims to become involved with drug and/or alcohol abuse.

Running away from home or school is common in MCSA victims. This was illustrated in the following statements:

Every day when I saw him (perpetrator) at school, I wanted to run away. (Participant 5)

My dad thinks I am homosexual, because of what happened to me. Now I just want to run away from home. (Participant 5)

I wanted to run away from home, whenever I saw them (perpetrators). (Participant 4)

MCSA victims are two to four times more likely to run away from home than non-abused boys (Valente, 2005:12). They so desperately want to remove themselves from their abusive situation that they do not mind the implications of their actions (Alaggia & Millington 2008:266; Barker & Hodes 2007: 39).

Subtheme 2.5: Difficulties to cope with schoolwork

Scholastic problems form part of the aftermath of MCSA. A participant stated:

I used to destruct the classrooms. (Participant 6)

I could never sit still and do my schoolwork. (Participant 4)

*I refused to do any homework and I struggled to concentrate in the classroom.
(Participant 1)*

Children who have been abused show significant difficulties in dealing with all aspects of the school environment, including cognitive tasks, serious behaviour problems and are at extremely high risk of failure at school (Frederick & Goddard 2010:23). has found a correlation between poor school performance and MCSA (Alaggia & Millington 2008:266; Parent & Bannon 2012:357). The child is sometimes unable to give adequate attention in class (De Witt 2009:328; Gospodarevskaya 2013:278). This hyperactivity is actually a form of busyness, which can help the child to avoid the feelings of sadness, shame, confusion and being scared (Ellsworth 2007:26). Aside from the diagnosis of Attention Deficit Hyperactivity Disorder per se, studies have shown that sexually abused children are significantly more hyperactive than are non-maltreated children (Trask *et al.*, 2011:7).

DISCUSSION AND RECOMMENDATIONS

The research question addressed in this article was:

Based on their experiences of being a MCSA victim, what are the support needs of these sexually abused boys placed in a clinic school?

To answer the above-mentioned research question qualitative phenomenological research were used (Edmonds & Kennedy 2013:136; Gray 2009:28; McWilliam 2013:229-248), in order to hear the voices of MCSA victims placed in a clinic school regarding their experiences of MCSA. Seven participants from the two clinic schools in Gauteng were involved by means of three consecutive in-depth interviews with each participant.

In common with the findings of other research it was found that MCSA is a serious stressor. There were also commonalities with existing research regarding the increasing evidence of its adverse and potentially numerous debilitating and multifaceted consequences for the child's psycho-social growth and development (LP 2012; JvH 2012). Research consistently indicated the intensified emotional reactions associated with MCSA, which also correlated with this study. In common with the findings of previous research it was found that sadness (Asgeirsdottira *et al.*, 2011:215; Olafson 2011:14) and helplessness (Bullock & Beckson 2011:201; Diamanduros *et al.*, 2012:143) form part of the intensified emotional reactions of MCSA victims. What differentiates this study from other research is that the in-depth interviews with the participants were done with South African boys, still in their middle childhood about their experiences of MCSA. Most other research was done with adult participants relating their retrospective accounts of MCSA in their childhood years. This is supported by Jackson *et al.* (2013:1).

Research indicated that MCSA victims tend to suppress emotions and are reluctant to disclose emotions regarding the MCSA (Barker & Crenshaw 2011:location 1375; Haen 2011:7). In contrast to these findings the participants in this study openly discussed their emotions and reactions. This could be due to the fact that these boys placed in a clinic school

were already receiving counselling on a weekly basis and were therefore used to discuss their experiences and emotions with professional people.

Previous research illustrated the feelings of guilt and shame which is most often present in MCSA victims. MCSA challenges boys' sense of masculinity and their sense of identity, which causes shame and guilt in the MCSA victim (Dorahy & Clearwater 2012:156). This correlates with the narratives in this study where MCSA victims narrated intense feelings of powerlessness because they were unable to stop the abuse and embarrassment that they were unable to protect themselves and live up to their gender role by not doing enough to stop the MCSA.

In common with other research this study correlates a sense of dissociation and numbness as part of the experiences of sexually abused boys (Diamanduros *et al.*, 2012:146; Dorahy & Clearwater 2012:156). Research indicates that MCSA victims often avoid situations associated with MCSA (Diamanduros *et al.*, 2012:143; Trask *et al.*, 2011:7). This avoidance of situations associated with MCSA was supported in this study. In previous research it is reported that MCSA victims often experience fears and anxiety (Diamanduros *et al.*, 2012:134; Kiselica & Novack 2011:location 2810). This correlates with this study where the MCSA victims showed an intense feeling of fear for recurring incidents, where they show concerns for their own safety and a fear that the MCSA can re-occur. Research indicates that MCSA victims can re-experience the trauma of the MCSA (Alaggia & Millington 2008:266; Trask *et al.*, 2011:7). In this study the MCSA victims often re-experience the trauma of the MCSA in the form of nightmares.

Research has shown the correlation between MCSA and concerns regarding their own sexuality (Diamanduros *et al.*, 2012:134; Parent & Bannon 2012:357). This correlates with the findings of this study. In this study this concern regarding own sexuality was particularly

the case where the MCSA victim experienced physical pleasure during the MCSA. Previous research done by Trask *et al.* (2011:7) reported that approximately 28% of CSA victims show highly sexualised behaviour, like a preoccupation with sex and excessive masturbation or masturbation in public. In this study however the MCSA victims did not mention masturbation. This could be due to the sensitive nature of the topic and the feeling of boys that masturbation is wrong and will be punished if known to an adult.

Commonalities exist between previous research and this study regarding social interaction and mistrust of MCSA victims. Research indicates that MCSA victims tend to mistrust (Kiselica & Novack 2011:location 2810) and tend to be socially isolated from others (Thielman 2010:location 42). This study correlates with research which indicated that MCSA victims have problems dealing with anger and aggression (Trask *et al.*, 2011:7). In this study it was found that the ability to hurt somebody else gives the MCSA victim the feeling of control of a situation and power over somebody else, which they did not experience during the abusive situation. Research mentions self-destructive behaviour, which includes suicidal tendencies, addictive behaviour and truancy (Coohey 2010:857; Parent & Bannon 2012:357). In this study self-destructive behaviour was evident in the form of suicidal tendencies and truancy. The prevalence of addictive behaviour was however low. The researchers are of the opinion that this could be due to the relative young age of the MCSA victims in this study. Research regarding the correlation between school functioning and CSA was supported in this study. MCSA victims have much difficulty coping with schoolwork, like concentration and destructiveness in the classroom.

The purpose of this study was to gain better understanding of the experiences of MCSA of sexually abused boys in their middle childhood placed in a clinic school in order to support these MCSA victims better.

Learners placed in clinic schools exhibit a wide range of emotional and behavioural problems. According to MvW (2013) and RE (2012) both clinic schools have trained counsellors, but no support strategies are in place to support MCSA victims with the intensified emotional reactions and the problems associated with MCSA. The conceptualisation of such a support strategy could support MCSA victims to deal better with the MCSA. If MCSA victims can be supported effectively, it may reduce the intensified emotional reactions and problems associated with MCSA. Subsequently this could assist in the re-integration of these learners into the mainstream educational setting.

Research on the phenomenon of MCSA is limited compared to research on CSA in general and no research about MCSA in the context of a clinic school could be found. No support strategies to support MCSA victims, even outside the context of a clinic school could be located. It is therefore recommended that the results in this article be used to conceptualise a proposed support strategy to support sexually abused boys in their middle childhood placed in a clinic school.

LIMITATIONS

In the interpretation of the results presented in this article, some limitations should be taken into consideration. The article focused on the experiences of MCSA victims placed in a clinic school. The first limitation is that the findings are limited to a small sample of participants. Therefore the findings from this study cannot be generalised for the population of MCSA victims living in other residential settings. These findings are therefore not necessarily applicable beyond the scope of the project. A second limitation was the inclusion criteria which stated that the boys had to disclose the MCSA at a previous stage or their parents had to give a clear indication of such abuse. Because of low disclosure rates among MCSA victims it is possible that some potential participants were left out in this study.

FINAL CONCLUSIONS

MCSA is a reality. Understanding the experiences of MCSA victims in their middle childhood placed in a clinic school will contribute to the conceptualisation of a proposed support strategy for the larger research project. This support strategy could possibly enable the people involved with these MCSA victims to support them more effectively. This support can help to relieve some of their emotional and behavioural problems and subsequently enhance the process to integrate them into the mainstream educational system again as soon as possible.

SECTION 2: ARTICLE 2

Identifying Critical Aspects of Support for Sexually Abused Boys in Middle Childhood

Article will be submitted to the *Journal of Child Sexual Abuse*.

IDENTIFYING CRITICAL ASPECTS OF SUPPORT FOR SEXUALLY ABUSED BOYS IN MIDDLE CHILDHOOD

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Male child sexual abuse is a worldwide phenomenon. Limited research literature is available on support to these boys. The research aim was to identify critical aspects how to support sexually abused boys in their middle childhood placed in a clinic school, using qualitative interpretive design. Inputs from twenty-four participants were obtained through semi-structured individual interviews.

The results suggested that the following critical aspects should be considered in the conceptualisation of a proposed support strategy: Relationships as a basis for support; strengthening the MCSA victims to deal with behavioural and emotional challenges; facilitate safety of the MCSA victims to avoid continued exposure; provide a structured environment and coordinate support efforts to ensure sustainability.

KEYWORDS: male child sexual abuse, clinic schools, middle childhood, support, critical aspects

Until recently, accurate prevalence rates of male child sexual abuse (hereafter referred to as MCSA) have remained elusive. Rates of MCSA may also be underestimated due to continued low disclosure rates (Easton, 2014; Kiselica & Novack, 2011; Schraufnagel, Davis, George & Norris, 2010). Current research on MCSA is still limited to a few studies that focus on adult participants' retrospective accounts of MCSA in their childhood years (Easton, Saltzman & Willis, 2013; Fergusson, McLeod & Horwood, 2013; Jackson, Newall & Backett-Milburn, 2013). Yet, it is estimated worldwide that approximately 14% of males experienced MCSA (Schraufnagel et al., 2010). Easton (2014) mentions that at an international level the prevalence rate is between 5% and 10%. In a South African study Mathews, Abrahams and Jewkes (2013) conducted a community-based survey in urban Gauteng Province in South Africa which found a 20,4% prevalence rate for MCSA before the age of eighteen. Traditionally sexual abuse of girls get more attention, yet the long-term effects of child sexual abuse (hereafter referred to as CSA) are equally damaging for girls and boys (Larsen, Sandberg, Harper & Bean, 2011; Maikovich-Fong & Jaffee, 2010).

A particular context in which MSCA is present is clinic schools. A clinic school forms part of *Learner with Special Educational Needs* schools (Department of Education South Africa, 2001). At an international level clinic schools are referred to as “residential care” (Casey et al., 2010; Quisenberry & Foltz, 2013), “institutional youth care” (De Swart et al., 2012) or “alternative schools” (Lehr, Soon Tan & Ysseldyke, 2009; Simonsen, Britton & Young, 2010; Simonsen & Sugai, 2013). For the purpose of this research the term “clinic schools” was used. Clinic schools are short-term substitute educational settings (Lee & Barth, 2011) for learners with behavioural and emotional difficulties (Casey et al., 2010; De Swart et al., 2012; Simonsen et al., 2010; Simonsen & Sugai, 2013). The objective of a clinic school is to support these learners in their problem behaviour in order to re-integrate them into the mainstream educational setting (Flick, 2011; Haid & Donnelly, 2013) and to reroute them to

a less restrictive environment as quickly as possible (Ennis, Jolivette, Swoszowski & Johnson, 2012; Simonsen et al., 2010). These learners can only attend a clinic school until they reach the age of twelve years (RE¹, personal communication, August 21, 2012). Many children placed in clinic schools experienced abuse (Lebel & Kelly, 2014; Quisenberry & Foltz, 2013; Soenen, D'Oosterlinck & Broekaert, 2014; Suk-ching Chong & Leung, 2012). According to JvH (personal communication, August 23, 2012), a social worker at a clinic school, some of these MCSA victims are placed in clinic schools, because of their emotional and behavioural difficulties. In this article the focus is on the identification of critical aspects of support for sexually abused boys in clinic schools in the Gauteng Province, South Africa.

MCSA victims are at an increased risk of developing of various mental illnesses and disorders (Easton, 2014; Maikovich-Fong & Jaffee, 2010; Schraufnagel et al., 2010). Some MCSA victims might present with nightmares, major depression, post-traumatic stress disorder, antisocial personality disorder, hyperactivity, fear, anxiety disorders and aggression (Diamanduros, Cosentino, Tysinger & Tysinger, 2012; Kiselica & Novack, 2011). MCSA victims can also exhibit extreme forms of emotional and behavioural problems (Gospodarevskaya, 2013; Lowenstein, 2011), like suicidal tendencies or they become involved in some form of addiction (Diamanduros et al., 2012; Mathews et al., 2013). Some develop sexually related problems (Fanniff, Becker & Gambow, 2014), like the rejection of genitals and the exhibition of sexual dysfunction, confusion about sexual identity and a preoccupation with sex and excessive masturbation (Kiselica & Novack, 2011; Schraufnagel et al., 2010). The feeling of guilt and shame about the MCSA is often present in MCSA victims. MCSA victims may struggle to trust and be in a close relationship with someone as they view most relationships as potentially threatening (Cohen, Mannarino, Kliethermes &

¹ In the case of personal communication, the initials of the persons were used to protect their identity.

Murray, 2012). Kiselica and Novack (2011) found that the victims of MCSA perceive most people to be dishonest and undependable.

In view of the challenges associated with MSCA one would expect that support systems would be in place in contexts such as clinic schools where the prevalence of MCSA is much higher. However, it became evident that no coordinated efforts to support these MCSA victims are in place. These limitations regarding support were confirmed in personal communication with some of the staff members (MvW, personal communication, April 24, 2013). Apparently this lack of support of these MCSA victims, result in the continuation of the problem behaviour and delay the integration process of these boys into the mainstream educational setting. No national or international research on guidelines for the support to MCSA victims placed in a clinic school could be located.

As this study is based on support, the Social Support Theory (House, 1981) is used as a theoretical framework for this study. Several authors (Arias & Johnson, 2013; Mathews et al., 2013; Sperry & Widom, 2013; Van Toledo & Seymor, 2013) are of the opinion that social support serves as a 'protective' factor against people's vulnerability on the effects of stress on health and that is associated with networking, which provides social support and aims to reduce stress. McLewin and Muller (2006) mention that research with adult survivors of physical and sexual abuse also attests to the importance of social support for resilience. Longitudinal research with high-risk individuals has indicated that a socially supportive relationship and a secure attachment with at least one figure are protective against maladaptation later in life. In the case of this study research indicate that sexually abused children who are effectively supported show higher adjustment levels compared to those with low levels of support (Arias & Johnson, 2013; Cyr, McDuff & Hébert, 2013; Mathews et al., 2013; Van Toledo & Seymor, 2013). If MCSA victims can be successfully supported during their period at the clinic school, some of their emotional and behavioural difficulties may also

be addressed and this may subsequently lead to their integration into the mainstream educational setting.

Research was therefore undertaken to obtain a thorough understanding of what social workers, psychologists, counsellors, teachers and child and youth care workers (hereafter referred to as role players) consider as critical aspects of support for MCSA victims in clinic schools in South Africa. In view of this gap in the knowledge and the challenges that these MCSA victims and their carers face it seemed imperative to identify critical aspects of support. The assumption has been made that through knowledge and understanding of these aspects, the role players involved in the MCSA victims' lives may be able to support these MCSA victims more effectively.

The investigation involved role players who are familiar with MCSA and/or clinic schools. The research question was:

What do professionals including social workers, psychologists, counsellors, teachers and child and youth care workers perceive as critical aspects of support for MCSA victims placed in a clinic school?

METHOD

The research involved three phases. During the first phase the experiences of MCSA of boys placed in a clinic school were explored and described in order to understand their support needs (Steyn, Van Wyk & Kitching, 2014). During the second phase, reported in this article, the inputs from role players were obtained to identify critical aspects to support MCSA victims placed in a clinic school. In the third phase of this study a proposed support strategy for MCSA victims placed in a clinic school was conceptualised.

Research Design

During the second phase of the research the qualitative interpretive design (Schwartz-Shea & Yanow, 2012; St. George, 2010; Stake, 2010; Thorne, 2008) was used, as the data from the semi-structured individual interviews were interpreted and then described in the second phase. According to Schwandt (2007) interpretive design is the act of clarifying or explaining the meaning of some phenomenon. According to Schwartz-Shea and Yanow (2012) practitioners know much, see much and are closest to the action. Therefore, practice is the perfect candidate for interpretive description. This kind of inquiry is about describing interpretively what the researcher learns and understands about the meanings of practice situations. These participants can thus provide valuable insight into and understanding of critical aspects to support MCSA victims.

Participants

The population for this study consisted of role players in Gauteng with at least five years' experience in MCSA and/or clinic schools. The sample size was determined by sufficiency and saturation of information (Creswell, 2014; Greeff, 2011). Purposive sampling (Creswell, 2014; Flick, 2014; Maxwell, 2012; Punch, 2014) was used in this qualitative interpretive design (Schwartz-Shea & Yanow, 2012; St. George, 2010; Stake, 2010; Thorne, 2008) to select twenty-four participants. The criteria for inclusion in this population were: (1) Social workers, psychologists, counsellors, teachers and child and youth care workers in Gauteng; (2) with experience of MCSA and/or clinic schools; (3) working in a welfare organisation or private practice; and (4) having experience in the fields of MCSA and/or clinic schools of at least five years in order to make a contribution from their practical experience. The sample included nine social workers, two psychologists, two counsellors, seven teachers and four child and youth care workers.

Ethical guidelines were followed to ensure that the research was both ethically and scientifically correct (Nolas, 2011). The Ethical committee of the North-West University, Potchefstroom Campus (Ethical number: NWU-00060-12-A1), Gauteng Department of Education and the two applicable district offices gave ethical approval for this study to be conducted. Informed consent (Gray, 2013; Marzano, 2012; Reamer, 2013) was obtained from the participants and they were informed about the use of a digital recorder (Greeff, 2011) during the interviews. The participants were informed that participation was voluntary (Babbie, 2013) and anyone could withdraw from the study at any time (Gray, 2013). The participants also got the opportunity at the end of each interview, to clarify any misconceptions. Anonymity (Babbie, 2013; Creswell, 2014; Gray, 2013) was ensured by refraining from using the names of the participants and the sites. Confidentiality (Babbie, 2013; Creswell, 2014; Gray, 2013; Reamer, 2013) was ensured as identifying information and data were kept safe locked away in a file cabinet with restricted access and computerised data were protected by a password and encryption.

Data Collection

Semi-structured individual interviews were conducted (Babbie, 2013; Flick, 2014; Maltby, Williams, McGarry & Day, 2014) with the selected participants who have knowledge and experience in the field of MCSA and/or clinic schools. The intention was to obtain input on critical aspects of support that could guide role players to support MCSA victims in the context of clinic schools. An interview schedule (Gray, 2013; May, 2011) was designed based on literature, as well as the data obtained from the in-depth interviews conducted in the first phase of the study. The interview schedule was presented to a social worker who recommended changes to ensure that the interview schedule is effective in answering the research question of this study. The interview schedule was then piloted (Strydom & Delpont,

2011) with two participants to determine whether the relevant data could have been obtained for the study. The necessary changes were made after the pilot interviews. The interviews with the other twenty-two participants were then conducted.

Data Analysis

Thematic analysis was applied to analyse the data. The phases as recommended by Clarke and Braun (2013) were used to analyse the qualitative data. The researcher became familiar with all the raw data, transcribed all the data (Kowal & O'Connel, 2014) while reading through the data (Bazeley, 2013) and assigning possible codes (Creswell, 2014; Flick, 2014; Harding, 2013) to the data. After this process possible themes were identified and the data that supported the codes were collated (Harding, 2013). The themes were reviewed, whereafter the themes were defined and named. Then it was all written up to integrate the analytic narrative and the data extracts.

Trustworthiness

Criteria set by Tracy (2010, 2013) for excellent qualitative research were used to ensure trustworthiness during this study. The phenomenon of MCSA is a very relevant, significant and *worthy topic*, as the occurrence of MCSA is very high and research regarding MCSA is limited. Qualitative research needs to entail *rich rigor* (Barusch, Gringeri & George, 2011; Gray, 2013) with sufficient data and time in the field. During this phase of the study data were obtained from twenty-four participants. This was a rich sample and data were collected rigorously until data saturation occurred. *Sincerity* was ensured by making use of supervision with a registered educational psychologist and registered social worker and reflecting on the researcher's own experiences of clinic schools.

Member checking (Creswell, 2014; Stake, 2010) were used where possible themes were

given to one participant to review. There was also correspondence via email and personal discussions with five participants to validate some findings after analysis of the data. During follow-up correspondence these participants had the opportunity to comment on the findings and to assist with the interpretation of the data. *Credibility* was reached as a dense description (Creswell, 2014; Tracy, 2013) of research methodology and literature control was done. The raw data and tentative interpretations of the data were discussed with three participants. The data were audited (Creswell, 2014) by a co-coder and expert supervision by a registered educational psychologist and registered social worker was provided during this process of data-analysis. *Ethical guidelines* were followed to ensure that no harm was done to any participant during this study.

RESULTS

The following aspects were identified through the semi-structured individual interviews as critical for the provision of ongoing support for the MSCA victims in clinic schools.

Relationships as a basis for support

The participants, in concurrence with Kiselica and Novack (2011) indicated that a sustainable relationship, characterised by a deep-rooted connection provides a basis for support to MCSA victims, *who struggle to trust people (P5)*. Participants confirm that *the relationship between the boys and those who care for them is perceived as the basis for support (P6, 8, 9, 13, 15, 18, 22, 23)* and should *involve a commitment to invest time in these relationships (P13, 21)*.

The development of such a relationship needs commitment. In the research literature the relationship is viewed as a form of intervention that is immediate and grounded in the present. The immediacy of the relationship could allow these boys to experiment with new

ways of acting and experiencing as they are living their lives (Garfat & Fulcher, 2011; Ranahan, 2013).

The cornerstone of this relationship is the development of trust with the MCSA victims. A participant (P20) suggested that *opportunities should be created for positive experiences; in which he can express himself freely*. Participants (P5, 6, 7, 8, 17, 18, 20) supported the *importance of confidentiality*.

The relationship between the MCSA victims and the different role players provides the boy with the experience of trusting another, which he can extrapolate into other relationships. This experience of trust creates a positive internal working model of himself and his abilities within relationships, which means that he will go on to anticipate positive experiences of future relationships (Cohen et al., 2012; Stuart, 2013). MCSA victims need to be assured that *everything he tells will be treated as confidential* (P5, 17, 18, 20). The role players should therefore be good listeners who ensure confidentiality and be trustworthy persons (Kiselica & Englar-Carlson, 2011; Kiselica & Novack, 2011; Landreth, 2012; Soenen, D'Oosterlinck & Broekaert, 2013).

Various ways of strengthening the trusting relationships with these boys were suggested by the participants. The first way is the enhancement of self-esteem. *If the role players build on the self-worth of the child, by praising him and allowing him to experience positive experiences of achievements, it will help to build the relationship. This will uplift the boy's self-esteem* (P1, 6, 19, 21). Armstrong (2012) supports the use of frequently specific and immediate praise. Crosson-Tower (2003) add that negative self-concepts can be offset by positive experiences that MCSA victims might have in the relationship with the role players. The use of verbal praise and positive feedback to build the relationship are supported in

research literature (Akin-Little, Little & Laniti, 2007; Armstrong, 2012; Suk-ching Chong & Leung, 2012).

Secondly, a caring attitude towards the boy: *The role players should be friendly, warm, sympathetic, sensitive and patient (P7, 15, 21). The role players should be caring and be truly interested in the boy's life (P21, 22), which can be done by spending time with the boy, by means of playing games or talking about hobbies or sport (P13, 21).* The value of a caring, friendly and sympathetic attitude towards MCSA victims is confirmed (Jones-Smith, 2011; Landreth, 2012; Sahay, 2013; Soenen et al., 2013; Suk-ching Chong & Leung, 2012; Swanzen, 2011).

Thirdly, a relaxed way of interacting: *The role players must be relaxed with the boys and use a sense of humour (P1, 15).* This is confirmed by research (Barton, Gonzalez & Tomlinson, 2011; Suk-ching Chong & Leung, 2012). This feeling of relaxation could be accomplished when the role players play a game or engage in some activity with MCSA victims, during which they will talk about their interests and experiences (Kiselica & Englar-Carlson, 2011; Kiselica & Novack, 2011). These activities can include eating something together, playing of board and electronic games, tossing a ball, talking about sports and music or playing with puppets.

Strengthening MCSA Victims to Deal with Behavioural and Emotional Challenges

Due to the experiences of MCSA victims (Steyn et al., 2014) they show behavioural and emotional challenges (Gospodarevskaya, 2013; Lowenstein, 2011). Participants (P5, 7, 9, 10) indicated that MCSA victims might *show tendencies to assert their power to hurt other people or animals.* Based on these experiences participants suggest that *there should be definite boundaries regarding MCSA victims' behaviour (P2, 9, 11). Sometimes MCSA*

victims want to abuse or hurt somebody else the way they were hurt. This can give them the feeling of being in control, something they did not experience in the abusive situation (P5). The participants therefore suggest as indicated by Kiselica and Novack (2011) that MCSA victims should learn that exerting power and control over one's own behaviour is something positive, while exerting power and control over another person is not. They suggested the following: *When MCSA victims show acting out behaviour, the role players need to be strict (P11). Role players need to provide the necessary boundaries (P2, 6, 7, 8, 9, 11).* Several participants (P3, 8, 11, 14, 17, 18, 19, 23) mentioned the importance of *referral to a social worker or psychologist if the behaviour of MCSA victims does not change for the better.*

In view of the problems experienced by MCSA victims to contain their behaviour, the participants indicated that *the boys should be guided to take responsibility for their disruptive behaviour (P2, 11).* They suggest that in order to teach these boys responsibility, *there should be consistent and immediate consequences for destructiveness (P11, 14).* This is in agreement with research literature (Armstrong, 2012; Rauktis, Fusco, Cahalane, Kierston Bennett & Reinhart, 2011). Kiselica and Novack (2011) agree that the boys who show any destructive behaviour need to take responsibility for their actions. The preferred way to teach these boys to take responsibility according to the participants is that the *teacher should send him out for time-out to calm down (P9, 16, 17).*

According to several authors (Lewis, Romi & Roache, 2012; Soenen et al., 2013) the exclusion of a learner from of the classroom can serve the class, the learner and the teacher. It may provide the teacher with the support of more senior staff or simply give the teacher some immediate relief. Exclusion provides the opportunity for a conversation between the learner and the teacher, which could create reflection of the learner upon his behaviour and commit to more responsible ways of behaving. However research (Davis, Culotta, Levine & Rice, 2011) indicate the negative effects of removing a learner from the classroom. Exclusion may

also become the first step in a process of recurrent and continued seclusion, suspension and removal from the institution or of the learner actively dropping out and should therefore be dealt with in a sensitive manner (Lewis et al., 2012; Soenen et al., 2013).

Research literature (Armstrong, 2012; Baker & Ryan, 2014; Lewis, Mitchell, Johnson & Richter, 2014; McLaughlin & Ruedel, 2012; Mitchell & Bradshaw, 2013; Sprague, Jolivette & Nelson, 2014; Vargas, 2013) indicate the use of positive behaviour support to promote a positive environment, where positive and desired behaviour is reinforced, rather than exclusionary discipline strategies. According to Armstrong (2012), as well as Meyer and Evans (2012) this positive learning environment will provide the learner with clear expectations for behaviour, fairly implemented consequences for both appropriate and inappropriate behaviour.

Consistency in dealing with unacceptable behaviour should be maintained by *ensuring that the same boundaries are set at home, school, the residential facilities and the counselling sessions (P5)*.

The participants clearly indicated in accordance with research (Jackson et al., 2013; Steyn et al., 2014) that MCSA victims often experience intensified emotional reactions and find it difficult to deal with the deep emotions associated with the MCSA and insisted that *the role players need to listen to the boy and acknowledge and validate his emotions (P1, 6, 14, 16)*. Concurrently, participants suggested that opportunities to express emotions in a non-threatening environment should be provided, as confirmed in research (Archer & Gordon, 2013; Bloomquist, 2013; Cohen et al., 2012; Greene, Grasso & Ford, 2014; Hertel & Johnson, 2013; Suk-ching Chong & Leung, 2012; Swanzen, 2011). Participants suggested that practical tools such as emotion charts are provided to assist those who work with the boys to express their emotions: *When the role players notice that the boy starts to show*

emotions, he can be given an emotion chart to identify the specific emotion he experiences at that particular moment, which can help him to come in contact with his emotions and can be empowering to him (P1, 20).

Verbal emotional regulation in the form of giving the boy verbal empathic responses, which show recognition of the boy's emotions, are very important. Verbally reflecting the boy's emotions back to him helps him to gain insight so that he is able to accept his own emotions (Hertel & Johnson, 2013). Cohen et al. (2012), as well as Bloomquist (2013) support appropriate emotional expression. According to these authors feeling identification need to start on a very basic level, where the different role players may need to mirror the boy's facial expressions (e.g., smiling when the boy smiles) and labelling the emotion the boy appears to be experiencing at the moment (e.g., "You feel happy!").

Facilitate the Safety of MCSA Victims to Avoid Continued Exposure to Abuse

According to the participants it should be a priority to facilitate the safety of MCSA victims to avoid continued exposure to MCSA: *The boy's safety should be seen as a priority (P1, 6, 7, 15, 17).* This process should accordingly involve supervision during school hours, as well as in the residential facilities where these boys might be the victims of continued abuse (Caldwell & Rejino, 2014), as also suggested by the participants: *There should be adequate supervision during school hours and at the residential facilities to avoid any further possible abuse (P1, 2, 5, 7, 8, 9, 17, 18).* MCSA victims rely on the support and protection of different role players to keep them safe from further sexual abuse (Cohen et al., 2012; Fulcher, 2008; Sahay, 2013).

Participants (P2, 8, 18) furthermore suggested the monitoring of contact between MCSA victims and other potential abusive persons or family members. MCSA victims should be

removed from the abusive situation. Research (Haid & Donnelly, 2013; Kiselica & Novack, 2011; Ristuccia, 2013) concurs that everything needs to be in place to ensure that MCSA victims are never left alone with potential perpetrators. Research indicates that most disruptive behaviour takes place at times and places where there is little if any supervision (Kenney, 2013; Soenen et al., 2013). Riffel and Mitchiner (2015) mention the importance of active supervision.

A participant (P1) suggested that the development of a personal safety plan would enable these boys to safeguard themselves against further MCSA and equip their caregivers with the skills to support them. According to Cohen et al. (2012) a safety plan includes building the boy's personal safety skills, as well as helping him to access available external resources. This personal safety plan conveys to the boy that he has the ability to make positive choices and to obtain appropriate support, rather than continuing to view himself as helpless and at the mercy of others. The value of a safety plan for MCSA victims is further illustrated: *When MCSA victims have a safety plan in place, they will no longer view themselves as victims only (P1)*. Kiselica and Novack (2011) mention that a safety plan can reassure MCSA victims by teaching them to tell others when they feel afraid or to learn how to avoid potential abusers and dangerous situations. This is particularly important for MCSA victims who may never have experienced what it is to be safe from the sexual attention of others. Cohen, Mannarino & Murray (2011) mention, that the safety plan should be a concrete behavioural plan with in-session role play, practice at home, rewards for following the plan and clear consequences for non-compliance.

Provide a Structured Environment

The participants indicated that a structured environment is necessary to give these MCSA victims security, consistency and predictability. To create such an environment *definite rules*

and consequences for behaviour should be set to give a sense of predictability and thus security to MCSA victims (P5, 16). In this way MCSA victims will know what to expect in their daily routine. *This sense of consistency and predictability will make them feel emotionally safe and thus provide them with a feeling of security (P2, 3, 6, 11, 20).* The significance of having a highly structured environment with definite rules and regulations is supported by research literature (Armstrong, 2012; Riffel & Mitchiner, 2015; Soenen et al., 2013; Souverein, Van der Helm & Stams, 2013; Suk-ching Chong & Leung, 2012). This structured environment can give a sense of security to the MCSA victims. The staff should have a daily routine, instituting values and habits.

The importance of providing a predictable working area, one that does not change, along with rules that provide limitations and boundaries is supported in research (Armstrong, 2012; Cohen et al., 2012). MCSA victims need to know what to expect in their interactions with the role players. Any ambiguous situations in the aftermath of MCSA can be frightening to them.

Coordinate Support Efforts to Ensure Sustainability

Participants indicated that *all the possible support structures should be identified and coordinated as this can empower the MCSA victims to know that they are not alone (P1, 5).* Research literature (Cohen et al., 2011, 2012; Hernandez et al., 2009) supports coordinated efforts. The use of collaborative teams are supported in research literature (Kutash et al., 2014; Zabel, Kaff & Teagarden, 2013), as this enable the use of the special skills and knowledge of various people so that specific needs are met (Dresser et al., 2009; Flåm, 2009; Kutash et al., 2014; Roberge & Van Dick, 2010; Zabel et al., 2013). The researchers are of the opinion that a support strategy for MCSA victims placed in a clinic school through a collaborative approach could be effective. According to Roberge and Van Dick (2010) such a collaborative approach can improve creativity and innovation through the role players'

greater variety of perspectives. Such a support strategy will enable all the different role players to know each other's roles and this can optimise the level of support given to MCSA victims. Flåm (2009) mentions, that the extensive teamwork across services and professions is favourable to the professionals and the clients in this area of clinical practice.

Participants are of the opinion *that in the counselling process the MCSA victims will learn certain techniques. It is the role player's role to apply these learned techniques at home, in school and in the residential facilities (P2, 6, 7, 8).* The role players should meet regularly in parallel sessions with the professional who is supporting the boy on a therapeutic level to help them learn these skills. This enables the role players to support skills implementation at home, school and in the residential facilities. According to Cohen et al. (2012) this will assist the boy both when he is exposed to trauma reminders and when he otherwise experiences deregulation. The role players need to identify the connection between trauma reminders and regulation problems; understand how the boy is supposed to implement coping skills (learn relaxation, affect modulation and cognitive coping skills as they have been individualised for the boy) and effectively intervene when regulation difficulties begin.

DISCUSSION

The critical aspects identified in this study indicate the importance of consistency in the support that is provided for these MCSA victims. The consistency of the support is based in the relationships (Kiselica & Novack, 2011) between the role players and these boys. Participants in Phase 1 mentioned the importance of a trusting relationship with the role players (Steyn et al., 2014). The relationship therefore needs to be trustworthy (Cohen et al., 2012; Soenen et al., 2014; Stuart, 2013). According to Attachment Theory (Bowlby, 2013) children develop internal working models of themselves, others and relationships through interactions with primary caregivers. Mikulincer and Shaver (2007) define a secure base as a

caregiver to whom the child turns whenever protection is needed. Several authors (Karakurt & Silver, 2014; McLewin & Muller, 2006) confirm that a securely attached child, who has generally experienced consistent and sensitive care, is likely to develop a model of the other person as responsive, themselves as worthy of love and competent in eliciting attention and the relationship as rewarding. An insecurely attached child, who has generally not experienced consistent or sensitive care, will likely develop a model of other people as unpredictable, himself as unworthy of love and unable to gain positive attention and the relationship as unsatisfactory. According to Masten and Wright (2012) attachment can thus serve as a protective factor, which proposes that attachment acts as an “inner resource” that promotes adaptive coping.

In addition these boys need consistent guidance to deal with the challenges relating to their behaviour and their emotional state of mind (Jackson et al., 2013). The behavioural challenges are seemingly underpinned by power issues (Kiselica & Novack, 2011) that these boys experience due to the fact that their rights have been violated by others. In dealing with these issues it is therefore critically important to approach them from a position of care (Sahay, 2013; Soenen et al., 2013) and not from a position of power. Although exclusion (Lewis et al., 2012; Soenen et al., 2013) is proposed it is imperative that exclusion should be used with care and not to punish (Mitchell & Bradshaw, 2013). The data from Phase 2 also correlate with the data from Phase 1 where the participants mentioned their need to calm down when they experience extreme emotions, like anger. Participants mentioned the value of time-out. Not necessarily as a punishment, but as a time to calm down before returning to the rest of the learners. According to the Strengths Perspective (Saleebey, 2012) this is a proactive manner of dealing with the boy, where the role players approach the boy in a positive manner and the focus is not just on his weaknesses and failures, like the behaviour difficulties.

The provision of consistency also involves the creation of a safe (Armstrong, 2012; Cohen et al., 2012; Sahay, 2013) and structured environment (Riffel & Mitchiner, 2015; Soenen et al., 2013; Souverein et al., 2013; Suk-ching Chong & Leung, 2012). This can be obtained by providing regular supervision (Kenney, 2013; Riffel & Mitchiner, 2015; Soenen et al., 2013) to these boys to avoid continued exposure to MCSA. This correlates with data from Phase 1 where the participants mentioned their need to be protected from further abuse. These participants also supported the value of structured activities, like gym, playing soccer or playing with toys.

To obtain collaboration between the role players it seems essential that all the role players have the knowledge and training to deal with MCSA victims and to apply these critical aspects of support to these boys. Therefore this collaboration should include meetings with all the different role players for the people with diverse backgrounds to share knowledge and skills on how to implement these critical aspects. This can be extended with practical and experiential workshops where all the role players are present. During these workshops the less experienced role players will have the opportunity to observe how these critical aspects are applied by the more experienced role players. These collaboration meetings and workshops may assist in developing a shared ownership for supporting the MCSA victims. All the role players need to be willing to share their knowledge and skills and also be willing to learn from others who might have more experience than they themselves.

Limitations

This study was of a sensitive nature. This limitation was however overcome by the experience of the researcher who conducted the interviews. Expert supervision was also received from a registered social worker and registered educational psychologist throughout this study to ensure that no emotional or psychological harm was done to any participant. A

limitation in this study was the limited scope of study due to the inclusion criteria which stated that the participants need to have at least five years' experience of working with MCSA victims and/or clinic schools. Quite a few teachers and child and youth care workers working at the two clinic schools did not meet these criteria and therefore could not be included in this population. However, the participants who were included, have a lot of experience in the field of MCSA and/or clinic schools and could therefore make valuable inputs in this study.

Conclusion

MCSA is a reality and support to these MCSA victims is very important. Exploring and applying these critical aspects of support, mentioned in this article, may help to uplift some of the MCSA victims' emotional and behavioural problems and subsequently enhance the process to integrate them into the mainstream educational system again as soon as possible. Using a collaborative approach may optimise the level of support given to MCSA victims. When these MCSA victims are supported effectively it can be a means to empower them to take control back of their own lives. This empowerment is something they did not experience during the abuse experience, as all their rights had been violated by others.

SECTION 2: ARTICLE 3

**Conceptualising a Proposed Support Strategy for Sexually Abused Boys in Middle
Childhood**

Article will be submitted to the *Social Work/Maatskaplike Werk* journal.

**CONCEPTUALISING A PROPOSED SUPPORT STRATEGY FOR SEXUALLY
ABUSED BOYS IN MIDDLE CHILDHOOD**

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Male child sexual abuse in middle childhood has serious effects with the increased risk of development of various mental illnesses and disorders, as well as extreme forms of emotional and behavioural problems. In this study a proposed support strategy for sexually abused boys in their middle childhood placed in a clinic school is conceptualised. The proposed support strategy involves three main facets, namely the strengthening of the sexually abused boy as an individual; a sustainable deep, trusting relationship; as well as the facilitation of a sustainable supportive context for these boys.

KEYWORDS: support strategy, male child sexual abuse, clinic schools, support, middle childhood, collaborative team

The research on male child sexual abuse (hereafter referred to as MCSA) shows that the incidence of sexual victimisation of males is significant. In an international context it is estimated roughly 14% of males are sexually abused during childhood (Schraufnagel, Davis, George & Norris, 2010:369). Alaggia and Mishna (2014:42) mention a prevalence as high as 26% of men in community samples and up to 36% of men in clinical samples. In the South

African context Mathews, Abrahams and Jewkes (2013:640) mention a community-based survey done in 2013 in urban Gauteng Province in South Africa which reported a prevalence of 20,4% of MCSA before the age of eighteen. The true extent of MCSA, however, remains unknown due to continued low rates of disclosure (Easton, Saltzman & Willis, 2013:2; Schraufnagel *et al.*, 2010:369). Current research is still limited to studies that focus on adult participants relating their retrospective accounts of child sexual abuse (hereafter referred to as CSA) in their childhood years (Easton *et al.*, 2013:2; Fergusson, McLeod & Horwood, 2013:665; Jackson, Newall & Backett-Milburn, 2013:1).

The focus of this study is on MCSA victims in their middle childhood. It seems that MCSA in this developmental phase has serious effects with extreme forms of emotional and behavioural problems (Diamanduros, Cosentino, Tysinger & Tysinger, 2012:134; Gospodarevskaya, 2013:278; Mathews *et al.*, 2013:640). It seems there is limited support available to MCSA victims amidst all the challenges. No support strategies at an international or national level could be located that focus specifically on the support of MCSA victims.

In Gauteng there are two clinic schools with residential facilities (Department of Education South Africa, 2001). At an international level clinic schools are referred to as “residential care” (Quisenberry & Foltz, 2013:280), “institutional youth care” (De Swart, Van den Broek, Stams, Asscher, Van der Laan, Holsbrink-Engels & Van der Helm 2012:1818) or “alternative schools” (Simonsen, Britton & Young, 2010:180; Simonsen & Sugai, 2013:3). For the purpose of this research the term “clinic schools” was used. Clinic schools form part of *Learners with Special Educational Needs* schools (Department of Education South Africa, 2001) and seek to educate learners requiring high intensity support in terms of behavioural and emotional difficulties (Casey, Reid, Trout, Duppong Hurley, Chmelka & Thompson, 2010:324; De Swart *et al.*, 2012:1818; Simonsen & Sugai, 2013:3). Therefore the behaviour of learners referred to these clinic schools, is mainly characterised by rebelliousness,

hyperactivity, disobedience and aggression (Thomas, 2010:413). The objective of a clinic school is to be a short-term and interim substitute educational setting for these learners (Lee & Barth, 2011:253; Lehr, Soon Tan & Ysseldyke, 2009:30). Their problem behaviour needs to be addressed in order for them to be integrated into the mainstream educational setting (Flick, 2011:44) and to equip them to return to a less restrictive environment as soon as possible (Ennis, Jolivette, Swoszowski & Johnson, 2012:80; Simonsen *et al.*, 2010:180). Clinic schools can accommodate learners until they turn twelve years (RE¹, 2012). These learners with emotional and behavioural problems have difficulty in becoming integrated into the mainstream educational setting again (Casey *et al.*, 2010:324; Flick, 2011:4).

According to RE (2014), the principal of one of these schools there are also sexually abused boys placed in clinic schools. He believes that MCSA may add to the trauma of these learners, which may result in even more emotional and behavioural difficulties. Several authors (Quisenberry & Foltz, 2013:282; Soenen, D'Oosterlinck & Broekaert, 2014:155) confirm that many children placed in clinic schools have experienced abuse. For the purpose of this study the focus is specifically on MCSA victims placed in a clinic school.

According to Social Support Theory abused children who are effectively supported show higher adjustment levels compared to those abused individuals with low levels of support (Cyr, McDuff & Hébert, 2013:209; Sperry & Widom, 2013:416; Van Toledo & Seymor, 2013:772). Social support can give an individual the feeling of being loved and cared for. The individual can function as part of an interpersonal network (Wilson & Scarpa, 2013:1). Social support can be seen as a protective factor among individuals at risk (Arias & Johnson, 2013:823; Sperry & Widom, 2013:416), like MCSA victims (Schönbucher, Maier, Mohler-Kuo, Schnyder & Landolt, 2014:571). Yet no research at national or at international level about support strategies for MCSA victims placed in a clinic school could be located. In view

¹ In the case of personal communication, the initials of the persons were used to protect their identity.

of the above-stated findings it seemed imperative to conceptualise a proposed support strategy for these MCSA victims. According to personal communication with some staff members of a clinic school (MvW, 2013; SS, 2012) the people involved with the MCSA victims lack the knowledge to support these MCSA victims effectively without such a support strategy. This lack of support in the specific context of a clinic school necessitated the conceptualisation of such a proposed support strategy. The clinic school is unique in the sense that social workers, psychologists, counsellors, teachers and child and youth care workers (hereafter referred to as role players) are involved with these sexually abused boys on a daily basis. It could be of great value if these role players can work together in a coordinated effort as a collaborative team to support these MCSA victims. Phasha (2008:304) mentions that in South Africa, an average Grade four learner spends 1,400 hours at school per annum while learners in a residential facility spend 6,700 hours at school in a year. Therefore these role players can make a high impact on these learners, because of the close and constant interaction between them. These role players can function as a collaborative team and sustain a supportive context for these boys.

This lack of a proposed support strategy for MCSA victims, results in the continuation of the problem behaviour and the delay to integrate them into the mainstream educational setting again. If MCSA victims can be successfully supported during their period at the clinic school, some of their emotional and behavioural difficulties may also be addressed and this may subsequently lead to their integration into the mainstream educational setting.

The proposed support strategy was conceptualised from a Strengths Perspective (Jones-Smith, 2011; Saleebey, 2012). The Strengths Perspective focuses on the MCSA victims' resources, possibilities, resiliencies and capacities to address the MCSA. In this study it will be important to use the strengths and resources of the MCSA victim, as well as the context in which these boys are functioning. The weaknesses of the MCSA boy, like the emotional and

behavioural impact of the MCSA will also be taken into account. Seen from the Strengths Perspective all individuals possess the potential and strengths that can be marshalled to improve quality of life as it builds on the individual's resources, possibilities, resiliencies and capacities for change and transformation (Jones-Smith, 2011:21; Sabalauskas, Ortolani & McCall, 2014:122; Saleebey, 2012). The research aim was to conceptualise qualitatively, by means of qualitative interpretive design, a possible support strategy for sexually abused boys in their middle childhood placed in a clinic school in Gauteng.

Considering the above-mentioned the research question addressed in this article is:

How do professionals including social workers, psychologists, counsellors, teachers and child and youth care workers conceptualise a support strategy for victims of MCSA in a clinic school?

METHOD

The research project consisted of three phases. During the first phase the experiences of MCSA of boys placed in a clinic school were explored and described, in order to understand their support needs (Steyn, Van Wyk & Kitching, 2014:15-28). For this purpose seven participants were identified through purposive sampling in the two clinic schools in Gauteng and three in-depth interviews were conducted with each of these participants. These in-depth interviews were conducted at the two clinic schools and the duration of each interview was about 20-30 minutes. The following table gives a summary of the themes and sub-themes of the first phase that emerged from these in-depth interviews.

Table 1

Main themes and sub-themes identified in Phase 1

MAIN THEMES	SUB-THEMES
Theme 1 Intensified emotional reactions associated with MCSA	A deep sense of sadness and helplessness A sense of guilt and shame A sense of dissociation and numbness Avoidance of situations associated with MCSA Fear of recurring incidents Re-experiencing of the trauma
Theme 2 Problems associated with MCSA in boys	Concerns regarding their own sexuality Difficulties in interacting with other people Dealing with anger and aggression Displaying self-destructive behaviour Difficulties to cope with schoolwork

During the second phase the aim was to identify critical aspects to support sexually abused boys placed in a clinic school. Twenty-four participants were identified through purposive sampling, who included social workers, psychologists, counsellors, teachers and child and youth care workers. Semi-structured individual interviews were conducted with each of these participants to identify the five critical aspects to support MCSA victims placed in a clinic

school. These interviews lasted approximately 45-60 minutes each. The following table shows the five critical aspects of support, identified during these interviews.

Table 2

Critical aspects identified in Phase 2

CRITICAL ASPECTS OF SUPPORT
Relationships as basis for support
Strengthening MCSA victims to deal with behavioural and emotional challenges
Facilitating the safety of MCSA victims to avoid continued exposure to abuse
Providing a structured environment
Coordinating support efforts to ensure sustainability

The aim of the third phase was to conceptualise a proposed support strategy for MCSA victims placed in a clinic school. The qualitative interpretive design (Schwartz-Shea & Yanow, 2012:54; St. George, 2010:1624) was used where two focus groups (Barbour, 2014:313; Flick, 2014:242; Wayne, 2013:264) were conducted with fourteen participants to assist with the conceptualising of a proposed support strategy for MCSA victims placed in a clinic school. The participants could give valuable insight from their own practical experience. These focus groups lasted about 120 minutes each. The findings, as developed from the second phase of the study, were presented to these participants. Time was allowed to discuss the critical aspects in depth and how to transform these critical aspects into guidelines. The participants reached consensus and the data were analysed in order to conceptualise the guidelines for the proposed support strategy.

All the results obtained throughout the three phases were used to conceptualise a proposed support strategy. The conceptualising of a proposed support strategy for MCSA victims placed in a clinic school is described in this article.

Ethical considerations

The ethical aspects for Phases 1 and 2 were in place. The Ethical committee of the North-West University, Potchefstroom Campus (Ethical number: NWU-00060-12-A1), Gauteng Department of Education and the two applicable district offices gave ethical approval for this study to be conducted. During Phase 3 it was ensured that no physical or emotional harm was done to the participants. This study was done with caution, because of the sensitive nature of the topic of MCSA. The researcher ensured that she was competent, honest and skilled to undertake this research. Communication techniques were used (Greeff, 2011:345; Seidman, 2012:81, 88) to facilitate the focus groups. Informed consent was obtained (Marzano, 2012:443-456; Reamer, 2013:41) from the participants. The procedures to be followed during the investigation were explained to all involved in this study, in order to avoid any deception of the participants. All the participants were aware that participation was voluntary (Babbie, 2013:66) and anyone could withdraw from the study at any time. The participants were informed about the use of a digital recorder (Greeff, 2011:359) during the focus groups. Anonymity and confidentiality (Babbie, 2013:68; Reamer, 2013:46) of all participants were ensured. Identifying information was locked away in a file cabinet with restricted access and computerised data were protected by a password and encryption.

Data Analysis

Thematic analysis was applied to analyse the data. The phases as recommended by Clarke and Braun (2013:120-123) were used to analyse the qualitative data. The researcher became familiar with all the raw data, transcribed all the data (Kowal & O'Connel, 2014:64-78) while reading through the data (Bazeley, 2013:101) and assigning possible codes (Creswell,

2014:197; Flick, 2014:305; Harding, 2013:81, 129) to the data. After this process possible themes were identified and the data that supported the codes were collated (Harding, 2013:107). The themes were reviewed, whereafter the themes were defined and named (Bazeley, 2013:223). Then it was all written up to integrate the analytic narrative and the data extracts.

Trustworthiness

The criteria for excellent qualitative research were used to ensure trustworthiness during this study (Tracy, 2010:840). The criterion of a *worthy topic* (Tracy, 2010:840) is ensured, as the phenomenon of MCSA is very relevant and significant, because the occurrence of MCSA is a reality and research regarding MCSA is limited. Qualitative research needs to entail *rich rigor* with sufficient data and time in the field (Barusch, Gringeri & George, 2011:12; Tracy, 2010:840). During Phase 3 data were obtained from two focus groups who included fourteen participants in total. This was a rich sample and data were collected rigorously until data saturation (Barusch *et al.*, 2011:14; Creswell, 2014:189) occurred. Peer reviews (Gringeri, Barusch & Cambron, 2013b:762; Loh, 2013:6) were used where specific descriptions or themes were given to four participants to check for accuracy, comments and recommendations during follow-up interviews and gave the participants the opportunity to comment on the findings and to assist with the interpretation of the data. Member checking (Creswell, 2014:201) was used where possible themes were given to one participant to review. *Credibility* refers to a dense description (Creswell, 2014:202; Tracy, 2010:843), concrete detail, triangulation or crystallisation (Creswell, 2014:201; Loh, 2013:5; Tracy, 2010:840) and member reflections (Creswell, 2014:201; Gringeri *et al.*, 2013b:762). A dense description (Creswell, 2014:202) of research methodology and literature control was done. The raw data and tentative interpretations of the data were discussed with four participants. The data were audited (Creswell, 2014:202; Gringeri *et al.*, 2013b:764) by a co-coder and

expert supervision by a registered social worker and registered educational psychologist were provided during the data-analysis process.

RESULTS

The proposed support strategy is based on the data retrieved from all three phases throughout this study and the literature overview. The proposed support strategy involves three main facets, namely to strengthen the MCSA victim as an individual, to sustain a deep/trusting relationship with the MCSA victim, as well as the facilitation of a sustainable supportive context for these sexually abused boys. The guidelines will be presented with reference to ways to strengthen the individual, the relationship and context of the MCSA victim.

Strengthening the MCSA Victim as an Individual

According to the Strengths Perspective all individuals possess the potential and strengths that can be marshalled to improve quality of life as it builds on the individual's resources, possibilities, resiliencies and capacities for change and transformation (Gray, 2011:5-11; Jones-Smith, 2011:21; Saleebey, 2012). According to Eloff, Ebersöhn and Viljoen (2007) there needs to be knowledge about assets, resources and capacities around and within vulnerable children. These authors are of the opinion that such information can assist in the construction of a more rounded, comprehensive and accurate understanding of these children and that such an understanding will enable devising interventions that will maximise well-being by taking the totality of each child's existence into account. This can subsequently enhance resilience.

Resilience Theory emphasises the phenomenon of maintaining well-being and coping well in the context of significant difficulty (Theron, Cameron, Didkowsky, Lau, Liebenberg & Ungar, 2011:800; Van Rensburg, Theron, Rothmann & Kitching, 2013:286). Several authors (Van Rensburg *et al.*, 2013:289) reported that South African youths draw on protective

factors, such as supportive resources of families, schools and communities to adjust well to difficult life circumstances. According to Theron *et al.* (2011:800) individual traits and assets like intelligence, temperament, a sense of humour and optimism can also serve as protective factors and can add to resilience. The next facet of support, namely the strengthening of the MCSA victim as an individual will be discussed next.

The MCSA victim as an individual experience intensified emotional reactions (Jackson *et al.*, 2013:10; Steyn *et al.*, 2014:15-28) associated with MCSA, as well as problems associated with the MCSA (Steyn *et al.*, 2014:15-28). It is therefore important that the conceptualising of a proposed support strategy for MCSA victims take into account that this is an extremely vulnerable group of children. During the first phase of the study (Steyn *et al.*, 2014:15-28) it became clear that MCSA victims experience a deep sense of sadness and helplessness (Alaggia & Mishna, 2014:41; Diamanduros *et al.*, 2012:143; Gospodarevskaya, 2013:278), a sense of guilt and shame (Diamanduros *et al.*, 2012:133; Dorahy & Clearwater, 2012:156), a sense of dissociation and numbness (Diamanduros *et al.*, 2012:146; Dorahy & Clearwater, 2012:156), avoidance of situations associated with MCSA (Gospodarevskaya, 2013:278; Trask, Walsh & DiLillo, 2011:7), fear of recurring incidents (Alaggia & Mishna, 2014:41; Diamanduros *et al.*, 2012:134) and re-experiencing of the trauma (Gospodarevskaya, 2013:278; Trask *et al.*, 2011:7). The problems associated with the MCSA can range from concerns regarding the boy's own sexuality (Alaggia & Mishna, 2014:41; Parent & Bannon, 2012:357), difficulties in interacting with other people (Alaggia & Mishna, 2014:42; Kiselica & Novack, 2011:location 2810), dealing with anger and aggression (Gospodarevskaya, 2013:278; Parent & Bannon, 2012:359), displaying self-destructive behaviour (Alaggia & Millington, 2008:266; Parent & Bannon, 2012:357) to difficulties to cope with schoolwork (Frederick & Goddard, 2010:23; Parent & Bannon, 2012:357).

Provide emotional support

During Phase 2 participants mentioned the importance of role players, who deal with this vulnerable group of boys, to provide emotional support to MCSA victims. This can be done by not triggering guilt feelings while working with these boys. There should also be a strategy in place to deal with these boys' anger and aggression.

In the second and third phase the importance of validating emotions and facilitating healthy expressions as a way to strengthen the MCSA victim as an individual was supported. Research literature (Alaggia & Mishna, 2014:45; Bloomquist, 2013:147; Greene, Grasso & Ford, 2014:19-40; Koren-Karie, Oppenheim, Yuval-Adler & Mor, 2013:177) supports the use of validation of emotions. This can be done by means of an emotion chart where the sexually abused boy can physically show on a chart how he is feeling at a particular moment. It is important first to focus on only four basic emotions, namely happy, angry, sad and scared. Otherwise the MCSA victim can feel overwhelmed by all the different emotions. Lierheimer and Stichter (2011:21) however mention seven basic emotions, namely happy, sad, anger, fear, calm, disgust and surprise on which the focus should fall. Another way to allow the expression of emotions is when the role players validate and reflect the boy's emotions, like "You look scared." According to several authors (Hertel & Johnson, 2013:31; Robinson, 2011:214) this way of validation of emotions helps the MCSA victim to gain insight into his own emotions and can assist him to accept his emotions. Participants mentioned such an emotion chart should be used in the classroom, counselling room, residential facilities and at home. This will empower the MCSA victim to be able to express his emotions wherever he is at a particular moment. According to Kiselica and Englar-Carlson (2011:location 1930) the boy's emotional world can be explored by using artistic expressions, like music, art or drama. Research literature (Cohen, Mannarino, Kliethermes & Murray, 2012:534; Reese, Horne,

Bell & Wingfield, 2011:location 5173) support the importance of allowing the sexually abused child to express his emotions in a non-threatening environment.

Empower the MCSA victim

It is also important to give as many choices as often as possible to the MCSA victim, as this will empower the boy to take back control of his life. Bastiaanssen, Delsing, Kroes, Engels and Veerman (2014:49) confirm these children need the knowledge and skills to make their own decisions. Phasha (2008:323) mentions sexually abused children can develop a sense of personal identity when role players pinpoint the child's strengths. It is important that all the role players are aware of and agree upon the strengths of a particular boy to enhance the empowering effort based on the boy's strengths. Role players should exhibit high expectations of these boys. Reasonable goals could be set and the MCSA victim could be supported to make him confident about his own abilities. By fostering an environment that honours each boy's uniqueness these MCSA victims are taught that they are valued, accepted and capable.

Another way to empower the MCSA victim is to make use of a safety plan. In the first and third phases the value of a safety plan for the MCSA victim as individual was mentioned. Such a safety plan can build the MCSA victim's personal safety skills, as well as helping him to access available external resources (Barron & Topping, 2013:932, 935; Cohen *et al.*, 2012:531; Zeuthen & Hagelskjær, 2013:746). According to the data a safety plan can reassure the sexually abused boy by teaching him to tell others when he feels afraid or to learn how to avoid potential abusers and dangerous situations (Kiselica & Novack, 2011:location 3043, 3090). This is particularly important for the MCSA victim who may never have experienced what it is to be safe from the sexual attention of others.

Develop the self-worth of the MCSA victim

During Phase 3 it became evident that a way to strengthen these MCSA victims is to develop their self-worth in order to develop effectively the self-worth of the MCSA victim. The focus needs to be on the positive aspects in the boy's life and his strengths to counteract the stigmatisation of these boys. According to Sabalauskas *et al.* (2014:122) through the Strengths Perspective the child is inherently strong and resilient rather than flawed and in need of help. This can also build the self-worth of the MCSA victim as individual. CL (2013) added that negative self-concepts can be offset by positive experiences which the MCSA victims may experience in the relationship with the role players. Armstrong (2012:122) mentions the use of frequently specific and immediate praise to develop the self-worth of the child.

Sustain a Deep/Trusting Relationship

Participants in all three phases of this study mentioned the importance of sustaining a deep/trusting relationship between the role players and the sexually abused boy. Research literature (Armstrong, 2012:122; Otten & Tuttle, 2011:73) supports the importance of the relationship between the role player and the child. The role players will not be able to support the MCSA child effectively unless this relationship is deep (Handwerk, Huefner, Ringle, Howard, Soper, Almquist & Chmelka, 2008:159) and builds on trust (Arias & Johnson, 2013:831; Cohen *et al.*, 2012:530). Out of the Strengths Perspective this relationship should be where the role player believes in the boy as an individual (Jones-Smith, 2011:156; Sabalauskas *et al.*, 2014:122). Ranahan (2013:9-11) concurs that there is no other form of intervention which is as immediate and grounded in the present as the relationship. This immediacy of the relationship allows the child to experiment with new ways of acting and experiencing as they are living their lives. Several authors (Sahay, 2013:154; Swanzen,

2011:74) mention the importance of giving love, care and support to the sexually abused child. Different ways of sustaining such a deep/trusting relationship will be discussed.

Follow the MCSA victim's rhythm

It seemed that this is a very sensitive relationship, because of the intensified emotional reactions (Jackson *et al.*, 2013:10; Steyn *et al.*, 2014:15-28) associated with MCSA, as seemed in the first phase. During Phase 1 participants mentioned their anxiety of people (Steyn *et al.*, 2014:21). This anxiousness is also supported by research literature (Alaggia & Mishna, 2014:41; Gospodarevskaya, 2013:278). The vulnerability of the MCSA victims was evident in the first phase of the study (Steyn *et al.*, 2014:15-28). Due to this vulnerability it is therefore important to move gradually in this relationship with the sexually abused boy (Gil, 2011:10; Kiselica & Englar-Carlson, 2011:location 1863). In the third phase participants outlined this as a deep/trusting relationship where the MCSA victim as an individual needs to set the pace in the relationship (Alaggia & Mishna, 2014:45; Kiselica & Novack, 2011:location 2954). A participant mentioned that this establishment of the relationship with the MCSA victim is like a dance with him, in which the role player allows the MCSA victim to set the pace and give directions. The role players need to have patience in this relationship (Kiselica & Novack, 2011:location 3021, 3023), as it will be critically important patiently to accept that each MCSA victim might have his own pace. It will therefore take time to establish and maintain a relationship with the MCSA victim (Kiselica & Novack, 2011:2954, 2970).

Develop trust

A specific focus in this strengthening process should be on the development of trust. During the second and third phase the participants mentioned that this deep/trusting relationship should be based on trust. However the participants in Phase 1 mentioned their difficulty to

trust other people (Steyn *et al.*, 2014:22). The importance of confidentiality to counter this feeling of mistrust was outlined. According to several authors (Cohen *et al.*, 2012:529; Robinson, 2011:212; Stuart, 2013:3) the relationship between the MCSA victim and the role players provides the child with the experience of trusting another, which he can then take into other relationships. This experience of trust creates a positive internal working model of himself and his abilities within relationships, which means that he can go on to anticipate positive experiences of future relationships.

Spend time with the MCSA victim

On a more concrete level the strengthening of the relationship needs to include practical activities that will add to the strengthening of the relationship. According to data from the second and third phase it was evident that the role players need to spend time and do activities with the boy in order to build this deep/trust relationship. This is also supported by research literature (Barton, Gonzalez & Tomlinson, 2011:87; Solar, 2011:43). In the second phase participants mentioned the necessity of consistent contact between the role players and the MCSA victim to build the relationship.

Use of humour

Humour can also be included in this relationship. Suk-ching Chong and Leung (2012:35) support the use of humour. Humour can be a means to draw the attention away from the MCSA and to focus on sustaining this deep/trusting relationship. According to Kiselica and Englar-Carlson (2011:location 1839) humour is a vehicle to attain intimacy and to reduce tension.

Show positive affection

The role players need to show positive affection, without touching the MCSA victim. According to data this positive affection can include spending time together, talking with each other and using humour. Often touching is associated with MCSA and this can harm the relationship with the MCSA victim. This touching can trigger intensified emotional reactions with the sexually abused boy (Kiselica & Novack, 2011:location 3025). Armstrong (2012:122) mentions that personally greeting the child it can establish a positive rapport.

Facilitation of a Supportive Context for the MCSA Victim

These MCSA victims are very vulnerable, as already outlined. To ensure that these boys experience safety and care, a proposed support strategy should involve the facilitation of a supportive context for them (Ristuccia, 2013:251-264). According to Social Support Theory (House, 1981) sexually abused children with adequate support adjust easier after the abuse experience than those with low levels of support (Arias & Johnson, 2013:823; Cyr *et al.*, 2013:209; Mathews *et al.*, 2013:640). Several authors (Mathews *et al.*, 2013:640; Sperry & Widom, 2013:416; Van Toledo & Seymor, 2013:772) are of the opinion that social support serves as a 'protective' factor against people's vulnerability because of the effects of stress on health. It is associated with networking, which provides social support and aims to reduce stress. Different ways to facilitate this supportive context will be discussed.

Create safe spaces

The strengthening of the supportive context includes the creation of safe spaces and consistent supervision to the MCSA victim as individual. These safe spaces include physical and emotional spaces. The physical space includes the handling of anger, aggression and sexuality. The emotional space includes guilt and avoidance of re-experience of trauma

associated with the MCSA. Sabalauskas *et al.* (2014:125) mention that these safe spaces can include instances where the role players focus on the thought processes that lead these MCSA victims to act out, rather than focusing on the acting out behaviour itself. From this exploration, role players develop strategies with the boy, not for him, to shift their thinking to something more positive.

Throughout this study participants mentioned the MCSA victim's need to feel safe in all the different settings he is functioning in. Research literature (Bastiaanssen *et al.*, 2014:49; Cohen *et al.*, 2012:529; Ristuccia, 2013:251-264) support this need for safety. Several authors mention that safety can be advanced by providing supervision to these boys (Kenney, 2013:43-56; Rasmussen, 2013:128; Sahay, 2013:154; Soenen *et al.*, 2014:156). According to Soenen, D'Oosterlinck and Broekaert (2013:1302), as well as Wurtele (2012:2447) most disruptive behaviour takes place at times and places where there is little if any supervision. The role players should take the following precautions to ensure the safety of these boys.

Data from the second and third phase of this study outlined that everything needs to be in place to ensure that the sexually abused boy is not exposed to any further sexual abuse (Cohen *et al.*, 2012:530; Sahay, 2013:153). A way to accomplish this is to look into the room placements of these boys in the residential facilities. The ideal situation is to place these boys in single rooms. If this is however not possible not too many boys should be placed in one room and there should be safe spaces between the beds in a room to ensure that no physical contact can happen between the boys during night time. Boys of the same age and developmental stage should be placed together. It is also important to provide adequate monitoring, also during night time to ensure the safety of all the boys. Wurtele (2012:2447) suggests the use of surveillance cameras in strategic locations to advance supervision.

Participants from Phase 3 mentioned the unsupervised use of bathrooms during school time and at the residential facilities. It is important to ensure that these boys use the bathrooms only under proper supervision. Role players should structure their activities and lesson plans to have bathroom breaks regularly and therefore it would not be necessary for any boy to leave the classroom or residential facility group to use the bathroom without supervision. During break time and activity time the play area should be divided into different zones for the different age groups. This will minimise the chance of victimisation. Each area should have proper supervision.

Sometimes it might be necessary for the role players to intervene and remove the MCSA victim from a particular setting when the boy is becoming upset or restless. Then the role players can intervene in a positive manner. In these situations, the role players can avoid confrontation and the escalation of behaviour by sending the boy on an errand, thereby giving him time to calm down. Several authors (Armstrong, 2012:141; Mundschenk, Miner & Nastally, 2011:101) confirm that this should be done before the behaviour escalates and the role player should make it a positive request. Participants in the second and third phase mentioned that if however the boy does not calm down and starts to show disruptive behaviour there should be consistent and immediate consequences and the MCSA victim should take responsibility for his actions. According to Lewis, Romi and Roache (2012:871) the exclusion of a learner from a particular setting can be an effective means and immediate consequence for disruptive behaviour. However several authors (Greene, 2014:ix; Otten & Tuttle, 2011:6, 7, 166) are of the opinion that exclusion may encourage negative attitudes towards school and teachers. This kind of suspension can actually reinforce the problem behaviour, because some of these learners do not want to be in the classroom. In some cases exclusion can decrease undesirable behaviour, but it does not teach a more appropriate behaviour response. The use of positive behaviour support (Armstrong, 2012:122; Lewis,

Mitchell, Johnson & Richter, 2014:373-384; Sprague, Jolivet & Nelson, 2014:261-276), where positive and desired behaviour is reinforced, rather than using strategies of exclusionary discipline, can promote a more positive environment.

Structure environment to accommodate specific needs

The strengthening of a support network for MCSA victims also involves the setting of a highly structured environment by facilitating a routine. The facilitation of a routine creates security, consistency and predictability to the MCSA victim. This is supported by research (Bastiaanssen, Kroes, Nijhof, Delsing, Engels & Veerman, 2012:448; Boone, 2012:133; Quisenberry & Foltz, 2013:281; Solar, 2011:43; Suk-ching Chong & Leung, 2012:34). During the third phase the participants confirmed that in a structured and consistent environment, these MCSA victims feel safer, because they understand and know the guidelines and expectations. Better yet, if this environment is consistent across all settings, like at home, residential facility, class and counselling environment. It is, however, important to have a visual presentation (Otten & Tuttle, 2011:84) of a daily routine where all the boys can see it throughout the day. This visualisation can allow these boys to know exactly what activity will happen next and promote predictability.

In the second phase the participants mentioned that the daily routine should be structured properly with definite activities throughout the day. Participants from the first phase mentioned their struggle with less structured activities. This is also supported by several authors (Conley, 2013:45; Conn, Calais, Szilagyi, Baldwin & Jee, 2014:201; Nahgahgwon, Umbreit, Liaupsin & Turton, 2010:544). Bastiaanssen *et al.* (2012:449) add that these children should be stimulated to participate in activities. During the third phase it was suggested that in the classroom there should be activities, like reading, computers and games to keep the learners busy when their schoolwork is finished. Even at the residential facility the

free time should be structured, like a choice between sport, reading, art, dancing, puzzles, computers or swimming.

Part of this routine also includes the physical structuring of these learners (Bastiaanssen *et al.*, 2012:448; Mundschenk *et al.*, 2011:99). This structure creates an organised and productive environment (Munschenk *et al.*, 2011:99). It is important that they have a specific room and bed where they sleep every night, have the same placement in the classroom and dining hall at the residential facility. This consistency will add to the facilitation of a support network. According to Simonsen, Fairbanks, Briesch, Myers & Sugai (2008:357) more structure promote more appropriate behaviours.

The physical arrangement of these boys also impacts on their behaviour (Mundschenk *et al.*, 2011:99; Simonsen *et al.*, 2008:357). Data from the second and third phase implied that the physical space these boys are functioning in should be designed to minimise crowding and distraction. Crowding can have a negative impact on behaviour. The simplest way to minimise crowding is to increase the amount of space in the different settings that these boys are in. If these boys feel crowded they may experience challenges to self-regulate their behaviour. Role players should also be aware of things such as noise, lighting and temperature when designing the areas in which these boys should function in. Simonsen *et al.* (2010:186) confirms that crowding should be minimised.

The necessity of clear rules and boundaries for MCSA victims forms part of the supportive context for MCSA individuals. This is supported by several authors (Bastiaanssen *et al.*, 2014:49; Boone, 2012:43; Curby, Rimm-Kaufman & Abry, 2013:566; Soenen *et al.*, 2014:159; Vargas, 2013:75). During the third phase it was outlined that these rules and boundaries should be clear and easily understandable. It should be clear and behaviour specific (Bradshaw, Mitchell & Leaf, 2010:137; Reddy, Fabiano, Dudek & Hsu, 2013:684;

Vargas, 2013:75) and should be concise, like 10 words or fewer (Mundschenk *et al.*, 2011:100). These rules should rather focus on what the boy *should* do than *should not* do. This will make it a more positive approach (Jolivet, Patterson, Swoszowski, McDaniel, Kennedy & Ennis, 2014:67; Mundschenk *et al.*, 2011:100). Vagueness, repetition and complication can muddle the boy's understanding and thus interfere with compliance. Participants mentioned the importance that these rules and boundaries should be consistent in all the different settings and the consequences for not following these rules and boundaries should also be the same in the different settings, which is also supported by research literature (Conroy, Sutherland, Snyder & Marsh, 2008:26; Jolivet *et al.*, 2014:67). Therefore in the context of a clinic school it is important that the different role players have regular meetings to discuss a specific boy's behaviour, in order to apply the same rules, boundaries and consequences for not following these guidelines.

Coordinate support efforts

The use of a collaborative team could be very effective, as this enable the use of the special skills and knowledge of various role players (Flåm, 2009:72; Kutash, Acri, Pollock, Armusewicz, Olin & Hoagwood, 2014:55; Zabel, Kaff & Teagarden, 2013:255). Bruns, Walker, Bernstein, Daleiden, Pullmann & Chorpita (2014:257) added that if systems work separately it could be less effective in the support of the individual, as each system may maintain a separate plan for the child's care and may prescribe multiple supports that are duplicative and/or uncoordinated. This fragmentation can undermine support efforts. In the proposed support strategy the collaborative team includes different role players. According to JvH (2012) this collaborative approach enables the different role players to apply the proposed support strategy in the different settings, like at school, residential facility, home and counselling sessions in which these MCSA victims are functioning and thus optimise the level of support given to them. Therefore in the context of a clinic school it is important that

the same strategy be applied in all the different settings.

These learners are living in a residential facility during the week with child and youth care workers. Their role can be described as professional parenting (Bastiaanssen *et al.*, 2012:448; Bastiaanssen *et al.*, 2014:49). These learners attend the clinic school, which is also on the same premises as the residential facility. The teachers are responsible for attending to the academic needs of these learners. There are also psychologists, social workers and counsellors who are responsible for the support and counselling of these learners (RE, 2014).

The following figure shows a visual representation of the proposed support strategy.

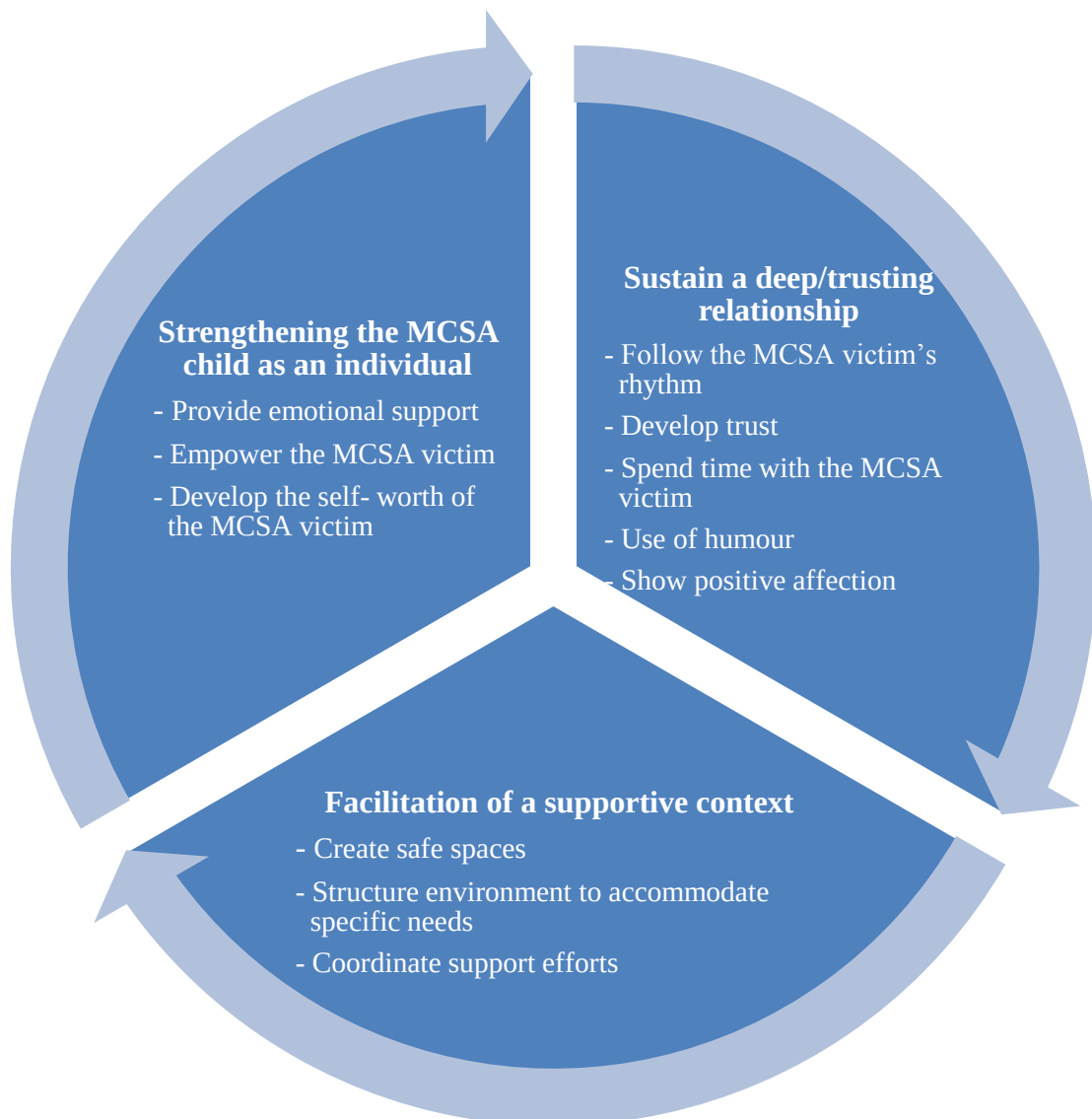


Figure 1: Conceptualisation of a proposed support strategy

DISCUSSION

A proposed support strategy that incorporates a focus on the development of the individual child who was a MCSA victim within a context of relationships, that respects and acknowledges the child as a person and provide a safe environment has been conceptualised. This attachment between the MCSA victim and the role players can serve as a protective factor (Bowlby, 2013; McLewin & Muller, 2006) against the negative consequences of MCSA, where the boy can turn to the role player whenever protection is needed (Mikulincer & Shaver, 2007).

Although separated for the purpose of discussion, these elements of the proposed support strategy should be seen as interdependent and therefore part of a comprehensive support process that needs to be applied simultaneously and consistently by the role players in each of the systems in which these MCSA victims are functioning. This multilevel approach of support focuses on the child as an individual, the relationships in which the MCSA victim are involved and the different contexts in which these MCSA victims are functioning. These contexts can include home, school, residential facility and the counselling environment.

Reflecting on the proposed support strategy, by applying theoretical perspectives to indicate that the role players working with these boys, do seem to grasp the complexity of the challenges that these children face. Their assumed position is confirmed by the emphasis that they place on communication between these role players. It is imperative to ensure the efficacy of the support. Therefore regular meetings are advised where feedback is given on how the MCSA victim is doing in the different settings, like at home, school, residential facility and counselling environment. Sabalauskas *et al.* (2014:125) mention that in the Strengths Perspective the role players discuss coping strategies and cognitive restructuring during these meetings, rather than having a focus on consequences and restitution. Kutash *et*

al. (2014:62) supports the importance of communication in the collaborative team. Then all the role players will know what is happening in the boy's life and important information can be passed on from one setting to the others. These meetings must also allow for the adaptation of the proposed support strategy, in order to streamline and coordinate it across the different settings for the particular boy. According to Molteni, Guldberg and Logan (2013:142) these meetings can also give the collaborative team time and a place to share ideas and good practice. The matter of confidentiality should, however, be addressed, so that this information be treated with care, in order for the MCSA victim to experience a trust relationship with the different role players.

The value of social support (Arias & Johnson, 2013:823; Sperry & Widom, 2013:416) to MCSA victims should be emphasised, as it can be seen as another protective factor against the negative impact of MCSA (Schönbucher *et al.*, 2014:571). Support to MCSA victims is an ongoing process and therefore the application of these strategies will never be able to reach an end. The role players need to take the complexity of support to MCSA victims into account, because of the vulnerability of these boys.

LIMITATIONS

Some limitations should be taken into consideration when interpreting the results of this study. During the first phase of the study the experiences of MCSA victims placed in a clinic school were explored. The first limitation is that the findings are limited to a small sample of participants who are placed in a clinic school. Qualitative research can still be generalised when people in other contexts take note of this study and apply in their different settings what they can identify with. A second limitation was the inclusion criteria which stated that the boys had to disclose the MCSA at a previous stage or their parents had to give a clear indication of such abuse. Because of low disclosure rates among MCSA victims it is possible

that some potential participants were left out in this study. The third limitation was the sensitive nature of the research topic. Due to ethical considerations some sensitive questions could not be included in the study. The researcher who conducted the in-depth interviews also received expert supervision by a registered social worker and registered educational psychologist throughout the research project to ensure that she was competent and equipped to conduct this research.

In the second and third phase a limitation was the inclusion criteria which stated that the participants needed to have at least five years' experience of working with MCSA victims and/or clinic schools. The teachers and child and youth care workers in the clinic schools usually do not work for an extended period of time at the specific setting. Therefore quite a number of teachers and child and youth care workers working at the two clinic schools did not fit these criteria and therefore could not be included in this population. However those participants who were included have a lot of experience of MCSA and/or clinic schools.

It should be noted, however, that parents' perceptions and inputs were not included, due to their limited availability for group or individual interviews. To compensate for this shortcoming the child and youth care workers, who serve as the learners' professional parents during the week were included.

FINAL CONCLUSIONS

MCSA is a reality with extreme emotional and behavioural consequences for the sexually abused boy in middle childhood. These boys placed in a clinic school need support to deal with these consequences and to overcome some of the emotional and behavioural difficulties they are experiencing. In the unique context of a clinic school different role players can act as a collaborative and coordinated team to support these boys more effectively to enhance the process to integrate them into the mainstream educational system again as soon as possible.

A supportive space is created for MCSA victims through the proposed support strategy where support can be provided continuously. This integrated and coordinated approach will enable the role players who form part of a collaborative team to provide multileveled support. This ensures a simultaneous focus on the individual, relational and contextual levels in which these boys are functioning.

SECTION 3

Section 3 includes the conclusions, recommendations, limitations, contributions and final word of this study.

1 Conclusions of the Study

There are two clinic schools with residential facilities in Gauteng Province in South Africa. Clinic schools form part of *Learner with Special Educational Needs* (hereafter referred to as LSEN) schools (Department of Education South Africa, 2001). At an international level clinic schools are referred to as “residential care” (Casey et al., 2010; Quisenberry & Foltz, 2013), “institutional youth care” (De Swart et al., 2012) or “alternative schools” (Lehr, Soon Tan & Ysseldyke, 2009; Simonsen, Britton & Young, 2010; Simonsen & Sugai, 2013). For the purpose of this research the term “clinic schools” was used. Clinic schools focus specifically on the behavioural and emotional difficulties of learners (De Swart et al., 2012; Simonsen et al., 2010; Simonsen & Sugai, 2013) who did not cope in the mainstream educational setting. These clinic schools aim to address the emotional and behavioural problems these learners are experiencing in order to integrate them into the mainstream educational setting again (Flick, 2011; Lee & Barth, 2011; Simonsen et al., 2010). Research (McNamara, 2010; Quisenberry & Foltz, 2013; Soenen, D’Oosterlinck & Broekaert, 2014) mentions that several children placed in clinic schools experienced abuse. According to JvH¹ (2012), a social worker at one of these clinic schools, many of these boys experienced male child sexual abuse (hereafter referred to as MCSA). It seems that MCSA contributes to these learners’ emotional and behavioural problems and they are not receiving sufficient support. Yet research literature states that social support can buffer the negative effects of negative life events (McLewin & Muller, 2006; Sperry & Widom, 2013) and children who receive social support in the aftermath of abuse, experience less negative outcomes (Schönbucher, Maier, Mohler-Kuo, Schnyder & Landolt, 2014; Yancey & Hansen, 2010). No support strategy that specifically focuses on support to MCSA victims is currently in place at the clinic schools (JvH, 2012; MvW, 2012; RE, 2014).

¹ In the case of personal communication, the initials of the persons were used to protect their identity.

SS (personal communication, March 14, 2012) became aware of the association between MCSA and the prevalence of behavioural and emotional difficulties experienced by these learners. It became evident that these MCSA victims are supported on an individual basis by various professionals such as psychologists, social workers, counsellors, teachers and child and youth care workers (hereafter referred to as role players). Yet, very limited support seems to be available to MCSA victims beyond the individual contact with the professionals. The lack of a broad-based support strategy, apparently leads to a delay in the re-integration of these learners into the mainstream educational setting. The proposed support strategy developed in this study is intended to contribute to the resolution of this vicious cycle, by providing guidelines for ways to support these MCSA victims on an ongoing basis through an integrated multilevel approach. The aim of this study was to propose such an integrated multilevel support strategy for sexually abused boys in their middle childhood placed in a clinic school. The research comprised three consecutive phases:

In Phase 1, reported in Article 1 published in CARSA (Steyn, Van Wyk & Kitching, 2014), the experiences of seven MCSA victims who are currently in a clinic school were explored in order to develop an understanding how to support these boys more effectively. This was done by conducting three in-depth interviews with each participant. Qualitative phenomenological research was used (Edmonds & Kennedy, 2013; Joyce & Sills, 2014; McWilliam, 2013). These boys were involved as participants in this research with the aim of including their voices in the research that intended to be research with children, and not research about children. Jackson, Newall and Backett-Milburn (2013) urge that neglected and abused children are a particularly vulnerable group whose voices have so often been ignored in the past. These children should therefore be involved and have some say in the decisions that are made about them. From the results (Steyn et al., 2014) it was evident that sexually abused boys placed in clinic schools exhibit intensified emotional reactions, as well as certain

problems associated with MCSA. It was concluded that these MCSA victims felt disempowered, had much difficulty with trust and relationships and experienced a lack of support in the current environment in the clinic schools.

During Phase 2, reported in Article 2, semi-structured individual interviews were conducted with twenty-four participants with knowledge and experience in the field of MCSA and/or clinic schools. The lack of support experienced by the MCSA victims was voiced as a major concern based on Social Support Theory which indicates that sexually abused children who are supported adjust easier after the abuse than non-supported children (Arias & Johnson, 2013; Sperry & Widom, 2013; Van Toledo & Seymor, 2013). Due to a lack of current support strategies which focus on support to MCSA victims, this phase of the study focused on the identification of critical aspects to support them.

The critical aspects identified in this study indicate the importance of consistency in the support that is provided for these MCSA victims. The consistency of the support is based in the relationships (Kiselica & Novack, 2011) between the role players and these boys. The relationship therefore needs to be trusting (Cohen, Mannarino, Kliethermes & Murray, 2012; Soenen et al., 2014; Stuart, 2013). Social Support Theory supports that a secure attachment to at least one trustworthy individual could be a protective factor against the consequences of MCSA. This led the researchers to the conclusion that aspects of secure attachment should be incorporated during the conceptualisation of the proposed support strategy.

In Phase 3, reported in Article 3, two focus groups were conducted with fourteen participants to assist with the conceptualisation of the proposed support strategy. During this phase the focus was on integrating the research literature, the experiences of MCSA victims, critical aspects to support these boys and practical ideas, in order to conceptualise the proposed support strategy.

The data from the three phases were integrated to propose a support strategy. The proposed support strategy consists of three main facets, namely:

- to strengthen the MCSA victim as an individual;
- to sustain a deep/trusting relationship with the MCSA victims and
- to facilitate a supportive context for these boys.

The first facet of the proposed support strategy is to **strengthen the MCSA victim as an individual**. This includes the provision of emotional support. This can be achieved by emotional regulation, where the boy's emotions are validated and he is taught to verbalise and show his emotions at a concrete level, as with an emotion chart (Alaggia & Mishna, 2014; Koren-Karie, Oppenheim, Yuval-Adler & Mor, 2013; Robinson, 2011). This can be an empowering process to the MCSA victim when he is able to show and verbalise his emotions rather than acting out when he is experiencing intensified emotions and reactions.

Another way to empower these MCSA victims is to introduce them to a safety plan (Barron & Topping, 2013; Kiselica & Novack, 2011; Zeuthen & Hagelskjær, 2013), where their personal safety skills are built and available resources are made known to them. According to the Strengths Perspective this will enable these boys to view themselves as capable of protecting themselves, as all their resources, knowledge and assets will be known to themselves and not just as helpless victims of their own circumstances, surroundings and overwhelming emotions.

The second facet of the proposed support strategy is to **sustain a deep/trusting relationship** with the MCSA victim. In order to achieve this it is critically important to follow the MCSA victim's rhythm when interacting with the boy (Alaggia & Mishna, 2014; Kiselica & Englar-Carlson, 2011; Kiselica & Novack, 2011). It will take time for these boys to develop trust (Phasha, 2008; Robinson, 2011; Stuart, 2013) in the role players and

therefore these role players need to spend time (Kiselica & Englar-Carlson, 2011; Kiselica & Novack, 2011) with the MCSA victims, in order to allow these boys to experience the role players as trustworthy, friendly and caring (Jones-Smith, 2011; Landreth, 2012; Sahay, 2013). When interacting with the MCSA victims the role players need to be relaxed and can incorporate humour to build this relationship (Barton, Gonzalez & Tomlinson, 2011; Kiselica & Englar-Carlson, 2011; Suk-ching Chong & Leung, 2012). The role players need to show positive affection (Kiselica & Novack, 2011) to these boys. It is therefore important that a secure attachment (Bowlby, 2013; Karakurt & Silver, 2014) is formed between the MCSA victim and the role players. If the above-mentioned is taken into consideration to sustain a deep/trusting relationship with the MCSA victim, the attachment will also be enhanced. Positive attachments can subsequently enhance resilience (Masten & Wright, 2010; Noble & McGrath, 2012), where the MCSA victims have the capacity to forge adaptive coping in the context of significant difficulties (Kelly & Gates, 2010; Rutter, 2012), like MCSA (Whitelock, Lamb & Rentfrow, 2013). Resilience, however, also requires supportive systematic initiatives (McLewin & Muller, 2006; Van Rensburg, Theron, Rothmann & Kitching, 2013) where the MCSA victims feel loved by, cared for or appreciated by another person (Wilson & Scarpa, 2013). Social support may buffer an individual against life stress (Arias & Johnson, 2013; Sperry & Widom, 2013; Van Toledo & Seymor, 2013).

The third facet of the proposed support strategy is the **facilitation of a supportive context** for the MCSA victims. Safe spaces (Sabalauskas, Ortolani & McCall, 2014) should be created where supervision (Bastiaanssen, Delsing, Kroes, Engels & Veerman, 2014; James, 2010; Rasmussen, 2013; Sahay, 2013; Soenen et al., 2014) is of the utmost importance. In this manner the role players are proactive and prevent possible exposure to any further sexual abuse (Cohen et al., 2012; Phasha, 2008; Sahay, 2013). When these MCSA victims show acting out behaviour it is important for the role players to intervene (Mundschenk, Miner &

Nastally, 2011). Due to the fact that the behavioural challenges are underpinned by power issues (Kiselica & Novack, 2011), it was decided to focus on the Strength Perspective in order to build on the MCSA victims' resources, possibilities, resilience and capacities. This could assist in empowering the MCSA victim. In dealing with these issues it is therefore critically important to approach them from a position of care (Mundschenk et al., 2011; Sahay, 2013; Soenen, D'Oosterlinck & Broekaert, 2013) and not from a position of power that constantly controls their behaviour in judgemental ways. In order to establish this position of care the focus should be on the relationship and attachment between the MCSA victim and the role players. The environment of the MCSA victims should be structured to accommodate specific needs. The setting of structured activities (Conley, 2013; Conn, Calais, Szilagyi, Baldwin & Jee, 2014; Nahgahgwon, Umbreit, Liaupsin & Turton, 2010), routine (Quisenberry & Foltz, 2013; Solar, 2011; Suk-ching Chong & Leung, 2012), boundaries and rules (Bastiaanssen et al., 2014; Curby, Rimm-Kaufman & Abry, 2013; Soenen et al., 2014) can assist these boys to feel emotionally safe.

The support efforts should be coordinated by the different role players. If the support offered to MCSA victims could be applied in all the settings we propose that the boys' functioning will be more effective. To achieve this, a collaborative team approach (Dresser et al., 2009; Flåm, 2009; Kutash et al., 2014; Zabel, Kaff & Teagarden, 2013) was suggested for the proposed support strategy, where there is feedback, communication and interaction between the different role players to streamline the proposed support strategy for every MCSA victim. This would assist the role players involved in each of the settings, in which these MCSA victims are functioning, to act pro-actively, as a collaborative team in providing adequate social support. According to the Strengths Perspective the role players will discuss coping strategies and cognitive restructuring, rather than just focusing on consequences and

correction (Sabalauskas et al., 2014). This can give the collaborative team the opportunity to share ideas and good practice (Molteni, Guldberg & Logan 2013).

The proposed support strategy is broad-based, considering the complexity of MCSA and therefore suggests the involvement of all the role players who are interacting with these boys in various settings within the school environment. All the role players should have knowledge of the dynamics of MCSA and understand their role in supporting these boys. Although the proposed support strategy is developed for MCSA victims placed in a clinic school, it would also be possible for other professionals to adapt this specific support strategy to their own particular setting for other MCSA victims.

The proposed support strategy is in line with Positive Community Psychology (Compton & Hoffman, 2013; Donaldson, 2011; Gilman, Huebner & Furlong, 2014), which aims to have an outlook of progress and positive development while the focus is on the activation of the personal transformation of the person's strengths and weaknesses (Benson & Scales, 2009). The proposed strategy is therefore intended to support these boys effectively and optimally within the context of a clinic school on an ongoing basis and complementary to the professional interventions, provided to ensure sustainability of the professional interventions.

2 Recommendations of the Study

The following recommendations are made regarding the implementation of the conceptualised support strategy:

Firstly, schools and role players need to acknowledge that MCSA might be associated with the serious behavioural and emotional difficulties often experienced by boys placed in a clinic school. The focus of treatment and support therefore needs to be shifted from only focusing on the behavioural and emotional difficulties to understanding how MCSA might be

contributing to the behavioural and emotional difficulties. Therefore sufficient training is necessary to all role players involved in clinic schools to understand the dynamics of MCSA.

Secondly, role players in clinic schools need to be made aware of the need for a broad-based support strategy that involves all those who interact with these boys, if they intend to prepare these boys effectively for re-integration into mainstream schooling.

Thirdly, role players need to function as a collaborative team with a defined leadership in order to coordinate the implementation of the proposed support strategy.

Fourthly, all role players and parents need training on the critical aspects to support MCSA victims, as well as the implementation of the conceptualised support strategy. Practical workshops are recommended, presented by a psychologist, for all the role players to help role players to use the new proposed support strategy in practice. During these workshops role players with diverse backgrounds will be enabled to share knowledge and skills on how to implement these strategies. Less experienced role players will also have the opportunity to observe how these critical aspects are applied by more experienced role players and professionals.

The following recommendations apply to research practice:

Firstly, further research is recommended to study the conceptualised support strategy in order to adapt to settings outside the context of this study. This will enable role players to apply this proposed support strategy for all MCSA victims, even outside the context of the clinic school. This generalisation implies that role players in other contexts read through the findings and see what is appropriate to their contexts.

Secondly, it could be of value if a collaborative team can be established to support these MCSA victims when they are placed out of the clinic school into a mainstream setting. This ongoing support can ensure that these MCSA victims function optimally, even outside the

clinic school setting where all the support was available on a continued basis. This collaborative team can include some of the same role players of the clinic school, as well as new role players from the mainstream school.

3 Limitations of the Study

Some limitations should be taken into consideration when interpreting the results of this study.

With reference to the first phase: A limited sample of MCSA victims was involved in this qualitative study. The inclusion criteria which stated that the boys should have disclosed the MCSA at a previous stage or their parents had to give clear indication of such abuse, contributed to this limitation, due to low disclosure rates among MCSA victims.

Additionally, the findings are based on the subjective reports of participants rather than on direct observation. Although considered as a limitation the inference that can be made from this sample certainly broadens our understanding of the support needs of these victims.

A second limiting aspect was the vulnerability of these MCSA victims and the sensitive nature of the research topic. Due to ethical considerations it was necessary for the researcher to conduct this research with the utmost care. This could limit the study as some sensitive questions could not be included in the interviews. The researcher who conducted the in-depth interviews was guided by her supervisors who are registered as an educational psychologist and social worker respectively throughout the research project to ensure that she was competent and equipped to conduct this research and continuously aware of the sensitive nature of the research..

With reference to the second and third phase the inclusion criteria stated that the participants needed to have at least five years' experience of working with MCSA victims and/or clinic schools. The teachers and child and youth care workers in the clinic schools usually do not work for an extended period of time at the specific setting. Therefore quite a few teachers and child and youth care workers working at the two clinic schools did not meet these criteria and therefore could not be included in this population. However those participants who were included have a lot of experience of MCSA and/or clinic schools. When considering the implementation of the conceptualised support strategy this high turn-over rate of the teachers and child and youth care workers could also be a limitation. To build and sustain a deep and trusting relationship between the MCSA victims and role players is crucial for the success of the proposed support strategy. It can, however, be difficult for these MCSA victims to trust the role players and build such a relationship, as suggested out of the research, when the role players are not involved with these boys for an extended period of time.

4 Contributions of the Study

As already outlined in Section 1, practitioners who work in the context of clinic schools confirmed the fact that many of these boys have been sexually abused and that the trauma of the sexual abuse may contribute to their problem behaviour. Currently MCSA victims placed in clinic schools are not supported optimally, due to a lack of support strategies that involve all the role players in these contexts.

Currently these MCSA victims are supported by professionals on an individual basis in the different settings where these boys are functioning. This is, however, not done in a

coordinated manner. This state of affairs results in the continuation of the problem behaviour and delays the integration of these learners into the mainstream educational settings.

The implementation of this proposed support strategy that coordinates the support efforts by the different role players could enable the setting of a supportive context for these boys. This would enable continuous support to MCSA victims. A supportive space is created for multilevel support where all the role players are incorporated in an integrated and coordinated approach.

This research gave an account of the experiences of MCSA of sexually abused boys placed in a clinic school in order to develop a better understanding of their support needs. These MCSA victims' opinions were viewed as highly valuable. What differentiates this study from other research is that the in-depth interviews with the participants were done with South African boys, still in their middle childhood, about their experiences of MCSA. Most other research was done with adult participants relating their retrospective accounts of MCSA in their childhood years. These boys' opinions were thus highly valued during Phase 1 of the study.

This study also confirmed the role of MCSA in the emotional and behavioural difficulties MCSA victims' experience. Therefore this study emphasised the importance rather to focus on the MCSA instead of the problem behaviours of these learners, in order to uplift these boys in their emotional and behavioural difficulties.

The study created new knowledge regarding the identification of critical aspects to support MCSA victims placed in a clinic school. The conceptualisation of the proposed support strategy for these MCSA victims could assist role players to support these boys more effectively. This kind of support may lead to the emotional and behavioural difficulties be addressed and subsequently to the reintegration of these learners into the mainstream

educational setting. Currently no support strategy is available at an international or national level to support these boys placed in a clinic school.

5 Final Word

The implementation of the proposed support strategy could assist the role players to support MCSA victims in a coordinated manner in a multilevel approach. When MCSA victims are supported effectively through such a proposed support strategy it can help these boys to adjust better in the aftermath of the abuse experience. Some of the negative consequences of MCSA might also be diminished. The proposed support strategy accordingly focuses on strengthening of the MCSA victim as an individual, and on attending to the development of their capacity to engage in healthy relationships within a safe and supportive environment. Through healthy and secure attachments MCSA victims can develop an inner resource which can promote resilience where these boys can cope well even in the context of significant challenges and negative events. The combinations of this support might contribute to the possible reintegration of these boys into mainstream schools or at least provide them the opportunity to develop optimally despite the trauma of the MCSA that they experienced.

SECTION 4

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Zabel, R. H., Kaff, M., & Teagarden, J. (2013). Promoting interdisciplinary practice: An interview with Steven R. Forness. *Intervention in School and Clinic, 49*(4), 255-260. doi: 10.1177/1053451213509483

Zeuthen, K., & Hagelskjær, M. (2013). Prevention of child sexual abuse: Analysis and discussion of the field. *Journal of Child Sexual Abuse, 22*, 742-760. doi: 10.1080/10538712.2013.811136

Appendix A: Permission Letter from Gauteng Department of Education



education
Department: Education
GAUTENG PROVINCE

For administrative use:
Reference no. D2013/153

GDE RESEARCH APPROVAL LETTER

Date:	14 August 2012
Validity of Research Approval:	14 August 2012 to 30 September 2012
Name of Researcher:	Steyn H.
Address of Researcher:	P.O. Box 2477
	Noordheuwel Extension 4
	Krugersdorp
	1756
Telephone Number:	083 595 9252
Fax Number:	086 601 1317
Email address:	helgasteyn@gmail.com
Research Topic:	An intervention strategy for sexually abused boys in their middle childhood placed at a Clinic school
Number and type of schools:	TWO LSEN schools
District/s/HO	

Re: Approval in Respect of Request to Conduct Research

This letter serves to indicate that approval is hereby granted to the above-mentioned researcher to proceed with research in respect of the study indicated above. The onus rests with the researcher to negotiate appropriate and relevant time schedules with the school/s and/or offices involved to conduct the research. A separate copy of this letter must be presented to both the School (both Principal and SGB) and the District/Head Office Senior Manager confirming that permission has been granted for the research to be conducted.

The following conditions apply to GDE research. The researcher may proceed with the above study subject to the conditions listed below being met. Approval may be withdrawn should any of the conditions listed below be flouted:

1. The District/Head Office Senior Manager/s concerned must be presented with a copy of this letter that would indicate that the said researcher/s has/have been granted permission from the Gauteng Department of Education to conduct the research study.

Making education a societal priority

Office of the Director: Knowledge Management and Research

9th Floor, 111 Commissioner Street, Johannesburg, 2001
P.O. Box 7710, Johannesburg, 2050 Tel: (011) 355 0506
Email: David.Makhado@gauteng.gov.za
Website: www.education.gpe.gov.za

Signature

2. The District/Head Office Senior Manager/s must be approached separately, and in writing, for permission to involve District/Head Office Officials in the project.
3. A copy of this letter must be forwarded to the school principal and the chairperson of the School Governing Body (SGB) that would indicate that the researcher/s have been granted permission from the Gauteng Department of Education to conduct the research study.
4. A letter / document that outlines the purpose of the research and the anticipated outcomes of such research must be made available to the principals, SGBs and District/Head Office Senior Managers of the schools and districts/offices concerned, respectively.
5. The Researcher will make every effort obtain the goodwill and co-operation of all the GDE officials, principals, and chairpersons of the SGBs, teachers and learners involved. Persons who offer their co-operation will not receive additional remuneration from the Department while those that opt not to participate will not be penalised in any way.
6. Research may only be conducted after school hours so that the normal school programme is not interrupted. The Principal (if at a school) and/or Director (if at a district/head office) must be consulted about an appropriate time when the researcher/s may carry out their research at the sites that they manage.
7. Research may only commence from the second week of February and must be concluded before the beginning of the last quarter of the academic year.
8. Items 6 and 7 will not apply to any research effort being undertaken on behalf of the GDE. Such research will have been commissioned and be paid for by the Gauteng Department of Education.
9. It is the researcher's responsibility to obtain written parental consent of all learners that are expected to participate in the study.
10. The researcher is responsible for supplying and utilising his/her own research resources, such as stationery, photocopies, transport, faxes and telephones and should not depend on the goodwill of the institutions and/or the offices visited for supplying such resources.
11. The names of the GDE officials, schools, principals, parents, teachers and learners that participate in the study may not appear in the research report without the written consent of each of these individuals and/or organisations.
12. On completion of the study the researcher must supply the Director: Knowledge Management & Research with one Hard Cover bound and an electronic copy of the research.
13. The researcher may be expected to provide short presentations on the purpose, findings and recommendations of his/her research to both GDE officials and the schools concerned.
14. Should the researcher have been involved with research at a school and/or a district/head office level, the Director concerned must also be supplied with a brief summary of the purpose, findings and recommendations of the research study.

The Gauteng Department of Education wishes you well in this important undertaking and looks forward to examining the findings of your research study.

Kind regards

David Makhado

Dr David Makhado

Director: Knowledge Management and Research

DATE: 2012/06/15

Making education a societal priority

Office of the Director: Knowledge Management and Research

9th Floor, 111 Commissioner Street, Johannesburg, 2001
 P.O. Box 7710, Johannesburg, 2000 Tel: (011) 355 0506
 Email: David.Makhado@gauteng.gov.za
 Website: www.education.gpg.gov.za

Appendix B: Letter of Consent for District Offices



Centre for Child, Youth and
Family Studies
Faculty of Health Sciences
North-West University
Potchefstroom
0027 21 864 3593 (tel)
0027 21 864 2654 (fax)

RESEARCHER:

I am currently a PhD student (in psychology) studying at the North-West University – Potchefstroom Campus. This letter is a friendly request to conduct some in-depth interviews with learners from clinic schools.

TITLE OF THE RESEARCH UNDERTAKEN:

A proposed support strategy for sexually abused boys in their middle childhood placed in a clinic school.

AIM OF THE STUDY:

The aim of this study is to develop a proposed support strategy to support sexually abused boys in their middle childhood placed in a clinic school.

PROCEDURES:

The procedure of obtaining the information required for the research will be done through interviews with six participants from clinic schools during school hours. The qualitative data (interviews) will be recorded digitally, transcribed and then analysed by the researcher.

RISKS AND DISCOMFORTS:

The researcher can foresee possible emotional discomfort or stress that may arise from the in-depth interviews. However, every effort will be made by the researcher to minimise the participants' discomfort. If at any time the participants feel to withdraw from the research

study, he will be free to do so. If the need arises, the researcher will offer a debriefing session and emotional support will be given to any participant who feels that he needs to work through the experiences and the aftermath of the interviews.

COSTS AND FINANCIAL RISKS:

There are no financial costs directly associated with participation in the study.

PARTICIPANT'S RIGHTS:

Participation in this research is totally voluntary and the participants may withdraw at any stage of the process without negative consequences and without any information being published.

CONFIDENTIALITY AND PRIVACY:

Confidentiality and privacy is promised. All data will be kept anonymous. Therefore, no one will be able to identify who the participants are. Identifying information will be locked away in a file cabinet with restricted access and computerised data will be protected by a password and encryption.

The researcher is working under the supervision of a study leader from the Centre for Child, Youth and Family Studies in the Faculty of Health Sciences, North-West University, Potchefstroom Campus, to ensure that she does not do anything unethical. Should you have any questions please feel free to contact Dr Carlien van Wyk. Contact number: (021) 864 3593.

CONCLUSION:

By signing below, you are indicating that you have read and understood the consent form and that the in-depth interviews may be conducted at the clinic schools.

Signed

Professional

Researcher

Date:

Date:

Appendix C: Letter of Consent for Clinic Schools



Centre for Child, Youth and
Family Studies
Faculty of Health Sciences
North-West University
Potchefstroom
0027 21 864 3593 (tel)
0027 21 864 2654 (fax)

RESEARCHER:

I am currently a PhD student (in psychology) studying at the North-West University – Potchefstroom Campus. This letter is a friendly request to conduct some in-depth interviews with learners from your school.

TITLE OF THE RESEARCH UNDERTAKEN:

A proposed support strategy for sexually abused boys in their middle childhood placed in a clinic school.

AIM OF THE STUDY:

The aim of this study is to develop a proposed support strategy to support sexually abused boys in their middle childhood placed in a clinic school.

PROCEDURES:

The procedure of obtaining the information required for the research will be done through interviews with six participants from your school during school hours. The qualitative data (interviews) will be recorded digitally, transcribed and then analysed by the researcher.

RISKS AND DISCOMFORTS:

The researcher can foresee possible emotional discomfort or stress that may arise from the in-depth interviews. However, every effort will be made by the researcher to minimise the participants' discomfort. If at any time the participants feel to withdraw from the research

study, he will be free to do so. If the need arises, the researcher will offer a debriefing session and emotional support will be given to any participant who feels that he needs to work through the experiences and the aftermath of the interviews.

COSTS AND FINANCIAL RISKS:

There are no financial costs directly associated with participation in the study.

PARTICIPANT'S RIGHTS:

Participation in this research is totally voluntary and the participants may withdraw at any stage of the process without negative consequences and without any information being published.

CONFIDENTIALITY AND PRIVACY:

Confidentiality and privacy is promised. All data will be kept anonymous. Therefore, no one will be able to identify who the participants are. Identifying information will be locked away in a file cabinet with restricted access and computerised data will be protected by a password and encryption.

The researcher is working under the supervision of a study leader from the Centre for Child, Youth and Family Studies in the Faculty of Health Sciences, North-West University, Potchefstroom Campus, to ensure that she does not do anything unethical. Should you have any questions please feel free to contact Dr Carlien van Wyk. Contact number: (021) 864 3593.

CONCLUSION:

By signing below, you are indicating that you have read and understood the consent form and that the in-depth interviews may be conducted at your school.

Signed

Professional

Researcher

Date:

Date:

Appendix D: Letter of Informed Consent for Children (Phase 1)



Centre for Child, Youth and
Family Studies
Faculty of Health Sciences
North-West University
Potchefstroom
0027 21 864 3593 (tel)
0027 21 864 2654 (fax)

RESEARCHER:

I am currently a PhD student (in psychology) studying at the North-West University – Potchefstroom Campus. This letter is a request to you for your child to participate in this study.

TITLE OF THE RESEARCH UNDERTAKEN:

A proposed support strategy for sexually abused boys in their middle childhood placed in a clinic school.

AIM OF THE STUDY:

The aim of this study is to develop a proposed support strategy to support sexually abused boys in their middle childhood placed in a clinic school.

PROCEDURES:

The procedure of obtaining the information required for the research will be done through interviews with your child during school hours. The qualitative data (interviews) will be recorded digitally, transcribed and then analyzed by the researcher.

RISKS AND DISCOMFORTS:

The researcher can foresee possible emotional discomfort or stress that may arise from the in-depth interviews. However, every effort will be made by the researcher to minimise your

child's discomfort. If at any time your child feels to withdraw from the research study, he will be free to do so. If the need arises, the researcher will offer a debriefing session and emotional support will be given to any participant who feels that he needs to work through the experiences and the aftermath of the interviews.

COSTS AND FINANCIAL RISKS:

There are no financial costs directly associated with participation in the study.

PARTICIPANT'S RIGHTS:

Participation in this research is totally voluntary and your child may withdraw at any stage of the process without negative consequences and without any information being published.

CONFIDENTIALITY AND PRIVACY:

Confidentiality and privacy is promised. All data will be kept anonymous. Therefore, no one will be able to identify who your child is. Identifying information will be locked away in a file cabinet with restricted access and computerised data will be protected by a password and encryption.

The researcher is working under the supervision of a study leader from the Centre for Child, Youth and Family Studies in the Faculty of Health Sciences, North-West University, Potchefstroom Campus, to ensure that she does not do anything unethical. Should you have any questions please feel free to contact Dr Carlien van Wyk. Contact number: (021) 864 3593.

Should you give consent, you will be contacted by the researcher to make the necessary arrangements. If you have any questions pertaining to your child's participation in this research study, you may contact the researcher by telephone.

CONCLUSION:

By signing below, you are indicating that you have read and understood the consent form and that your child may participate in this research study.

Signed

Professional

Researcher

Date:

Date:

Appendix E: Letter of Informed Consent for Role Players (Phase 2)



Centre for Child, Youth and
Family Studies
Faculty of Health Sciences
North-West University
Potchefstroom
0027 21 864 3593 (tel)
0027 21 864 2654 (fax)

RESEARCHER:

I am currently a PhD student (in psychology) studying at the North-West University – Potchefstroom Campus. This letter is a request to you, as a professional in the field, to participate in a focus group conducted by the researcher.

TITLE OF THE RESEARCH UNDERTAKEN:

A proposed support strategy for sexually abused boys in their middle childhood placed in a clinic school.

AIM OF THE STUDY:

The aim of this study is to develop a proposed support strategy to support sexually abused boys in their middle childhood placed in a clinic school.

PROCEDURES:

The procedure of obtaining the information required for the research will be done through semi-structured individual interviews with professionals in the field.

The qualitative data (interviews) will be recorded digitally, transcribed and then analyzed by the researcher.

RISKS AND DISCOMFORTS:

No risks or discomforts are foreseen during the interviews.

COSTS AND FINANCIAL RISKS:

There are no financial costs directly associated with participation in the study.

PARTICIPANT'S RIGHTS:

Participation in these semi-structured individual interviews is totally voluntary and you may withdraw at any stage of the process without negative consequences and without any information being published.

CONFIDENTIALITY AND PRIVACY:

You as a professional must please sign the consent form to partake in this study and give the researcher the permission to conduct a semi-structured individual interview with you. The semi-structured individual interviews will be audio-taped and transcribed by the researcher at a later stage. Anonymity and confidentiality of all participants will be ensured. All data will be kept anonymous. Therefore, no one will be able to identify who you are. Identifying information will be locked away in a file cabinet with restricted access and computerised data will be protected by a password and encryption.

The researcher is working under the supervision of a study leader from the Centre for Child, Youth and Family Studies in the Faculty of Health Sciences, North-West University, Potchefstroom Campus, to ensure that she does not do anything unethical. Should you have any questions please feel free to contact Dr Carlien van Wyk. Contact number: (021) 864 3593.

CONCLUSION:

By signing below, you are indicating that you have read and understood the consent form and that you agree to participate in this research study.

Signed

Professional

Researcher

Date:

Date:

Appendix F: Letter of Informed Consent for Focus Groups (Phase 3)



Centre for Child, Youth and
Family Studies
Faculty of Health Sciences
North-West University
Potchefstroom
0027 21 864 3593 (tel)
0027 21 864 2654 (fax)

RESEARCHER:

I am currently a PhD student (in psychology) studying at the North-West University – Potchefstroom Campus. This letter is a request to you, as a professional in the field, to participate in a focus group conducted by the researcher.

TITLE OF THE RESEARCH UNDERTAKEN:

A proposed support strategy for sexually abused boys in their middle childhood placed in a clinic school.

AIM OF THE STUDY:

The aim of this study is to develop a proposed support strategy to support sexually abused boys in their middle childhood placed in a clinic school.

PROCEDURES:

The procedure of obtaining the information required for the research will be done through focus groups with professionals in the field.

The qualitative data (interviews) will be recorded digitally, transcribed and then analyzed by the researcher.

RISKS AND DISCOMFORTS:

No risks or discomforts are foreseen during the interviews.

COSTS AND FINANCIAL RISKS:

There are no financial costs directly associated with participation in the study.

PARTICIPANT'S RIGHTS:

Participation in these focus groups is totally voluntary and you may withdraw at any stage of the process without negative consequences and without any information being published.

CONFIDENTIALITY AND PRIVACY:

You as a professional must please sign the consent form to partake in this study and give the researcher the permission to include you in a focus group. The group session will be audio-taped and transcribed by the researcher at a later stage. Anonymity and confidentiality of all participants will be ensured. All data will be kept anonymous. Therefore, no one will be able to identify who you are. Identifying information will be locked away in a file cabinet with restricted access and computerised data will be protected by a password and encryption.

The researcher is working under the supervision of a study leader from the Centre for Child, Youth and Family Studies in the Faculty of Health Sciences, North-West University, Potchefstroom Campus, to ensure that she does not do anything unethical. Should you have any questions please feel free to contact Dr Carlien van Wyk. Contact number: (021) 864 3593.

CONCLUSION:

By signing below, you are indicating that you have read and understood the consent form and that you agree to participate in this research study.

Signed

Professional

Researcher

Date:

Date:

Appendix G: Journal Guidelines

ARTICLE 1

CHILD ABUSE RESEARCH IN SOUTH AFRICA

Reference of published article

Steyn, H., Van Wyk, C., Kitching, A.E. (2014). Boys in middle childhood placed in a clinic school: Experiences of sexual abuse. *CARSA*, 15(1):15-28.

Preparing articles for submission

The submitted articles should always conform to CARSA's house style. As the journal develops, it is envisaged that it will contain full-length articles, shorter debates, book reviews and software reviews. The following information is provided regarding the length of articles:

- full-length articles should not exceed a word count of 8000 (tables excluded)
- shorter articles (in the form of shorter debates) should not exceed a word count of 3000 (tables excluded)
- book reviews should not exceed a word count of 1000
- software reviews should not exceed a word count of 3000.

Tables, figures, illustrations and references are excluded from the word count. Book reviews and software reviews will be initiated by the editor and review editors. They will commission individuals to do the reviews. Prospective authors are expected to abide by language guidelines regarding issues of gender and race and disability. Empirical research should adhere to acceptable standards of descriptive and inferential statistics and empirical data should be manipulated statistically using an acceptable statistical program such as the Statistical Package for the Social Sciences (SPSS) or SAS.

The inferences regarding qualitative analysis should also be accompanied by an explanation of the techniques used or should utilise statistical packages such as SQR.NUD.IST which are recognised for this type of analysis.

Style

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

9 January, 2000. Bold, italics and underscore should be formatted as such in the original document. The recommended style for reference purposes is the abbreviated Harvard technique, for example, "Child abuse is rising (Author 1999:10)" OR "According to Author (1999:10), child abuse is rising". In the case of legal articles, footnotes will be allowed. To work toward uniformity in the alphabetical bibliography at the end of an article, the following examples of format are given:

Books:

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

Articles:

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

Non-sexist language

Gender specific nouns and pronouns should not be used to refer to people of both sexes. The guidelines on sexist, racist and other discriminatory language should be observed. The

following is intended to assist contributors to refrain from sexist language by suggesting non-sexist alternatives.

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

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

ARTICLE 2**JOURNAL OF CHILD SEXUAL ABUSE**

Manuscript Format: All manuscripts submitted to the *Journal of Child Sexual Abuse* must be written in English, APA format, and should not exceed 30 double-spaced pages, including abstract, references, tables, and figures. All parts of the manuscript should be typewritten in Times New Roman font, size 12pt, double-spaced, with margins of at least one inch on all sides. Number manuscript pages consecutively throughout the paper. Authors should also supply a shortened version of the title suitable for the running head, not exceeding 50 character spaces. Headings must follow APA format with bold, italics, and indentation as appropriate. The title page should also include author address and contact information for correspondence, affiliation, and eight keywords or phrases for abstracting. Each article should be summarised in an abstract of not more than 120 words. Avoid abbreviations, diagrams, and reference to the text in the abstract.

References. References, citations, and general style of manuscripts should be prepared in accordance with the most recent APA Publication Manual. Cite in the text by author and date (Smith, 1983) and include an alphabetical list at the end of the article.

Examples:

Journal: Anderson, A.K. (2005). Affective influences on the attentional dynamics supporting awareness. *Journal of Experimental Psychology General* , 154 , 258-281. doi: 10.1037/0096-3445.134.2.258

Book: Weschsler, D. (1997). *Technical manual for the Wechsler Adult Intelligence and Memory Scale - III* . New York, NY: Psychological Corporation.

Chapter in a Book : Chow, T.W., & Cummings, J.L. (2000). The amygdale and Alzheimer's disease. In J.P. Aggleton (Ed.), *The amygdale: A functional analysis* (pp. 656-680). Oxford, England: Oxford University Press.

Tables and Figures. Tables and figures (illustrations) should not be embedded in the text, but should be included as separate sheets or files. A short descriptive title should appear above each table with a clear legend and any footnotes suitably identified below. All units must be included. Figures should be completely labeled, taking into account necessary size reduction. Captions should be typed, double-spaced, on a separate sheet.

ARTICLE 3**SOCIAL WORK/MAATSKAPLIKE WERK****Author guidelines**

The Journal publishes articles, book reviews and commentary on articles already published from any field of social work. Contributions may be written in English or Afrikaans.

1. All articles should include an abstract in English of not more than 100 words.
2. All contributions will be critically reviewed by at least two referees on whose advice contributions will be accepted or rejected by the editorial committee.
3. All refereeing is strictly confidential (double blind peer-review).
4. Manuscripts may be returned to the authors if extensive revision is required or if the style or presentation does not conform to the Journal practice.
5. Articles of fewer than 2,000 words or more than 10,000 words are normally not considered for publication.
6. Manuscripts should be typed in 12 pt Times Roman double-spaced on A4 paper size.
7. Use the Harvard system for references.
8. Short references in the text: When word-for-word quotations, facts or arguments from other sources are cited, the surname(s) of the author(s), year of publication and page number(s) must appear in parenthesis in the text, e.g. "... (Berger, 1967:12).
9. More details about sources referred to in the text should appear at the end of the manuscript under the caption "References".
10. The sources must be arranged alphabetically according to the surnames of the authors.
11. Note the use of capitals and punctuation marks in the following examples. 12.

TWO AUTHORS: SHEAFOR, B.W. & JENKINS, L.E. 1982. Quality field instruction in social work. Program Development and Maintenance. New York: Longman.

COLLECTION: MIDDLEMAN, R.R. & RHODES, G.B. (eds) 1985. Competent supervision, making imaginative judgements. New Jersey: Prentice-Hall.

ARTICLE IN COLLECTION: DURKHEIM, E. 1977. On education and society. In: KARARABEL, J. & HALSEY, A.H. (eds) Power and ideology in education. New York: Oxford University Press.

JOURNAL ARTICLE: BERNSTEIN, A. 1991. Social work and a new South Africa: Can social workers meet the challenge? Social Work/Maatskaplike Werk, 27(3/4):222-231.

THESIS: EHLERS, D.M.M. 1987. Die gebruik van statistiese tegnieke vir die ontleding van gegewens in maatskaplikewerk-navorsing. Pretoria: Universiteit van Pretoria. (M tesis)

MINISTRY FOR WELFARE AND POPULATION DEVELOPMENT 1995. Draft White Paper for Social Welfare. Government Gazette, Vol. 368, No. 16943 (2 February). Pretoria: Government Printer.

NEWSPAPER REPORT: MBEKI, T. 1998. Fiddling while the AIDS crisis gets out of control. Sunday Times, 8 March, 18.

INTERNET REFERENCES: McKIERNAN, G. 1998. Beyond bookmarks: schemes for organising the Web [on line]. Rev. 18 June. Available:

<http://www.public.iastate.edu/CYBERSTACKS/CTW.htm>

SUBMISSION PREPARATION CHECKLIST

As part of the submission process, authors are required to check off their submission's compliance with all of the following items, and submissions may be returned to authors that do not adhere to these guidelines.

The submission has not been previously published, nor is it before another journal for consideration (or an explanation has been provided in Comments to the Editor).

1. The submission file is in OpenOffice, Microsoft Word, RTF, or WordPerfect document file format.
2. Where available, URLs for the references have been provided.
3. The text is single-spaced; uses a 12-point font; employs italics, rather than underlining (except with URL addresses); and all illustrations, figures, and tables are placed within the text at the appropriate points, rather than at the end.
4. The text adheres to the stylistic and bibliographic requirements outlined in the Author Guidelines, which is found in About the Journal.
5. If submitting to a peer-reviewed section of the journal, the instructions in Ensuring a Blind Review have been followed.