Guidelines for trauma-sensitive social work forensic assessments

J van Huyssteen

orcid.org/0000-0002-8325-4705

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Supervisor: Prof A Fouché

Co-supervisor: Prof H Walker-Williams

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Student number: 24949043

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DECLARATION

I declare that the study "Guidelines for trauma-sensitive social work forensic assessments" is my own work, and that I followed the referencing and editorial style as prescribed by the Publication Manual (7th edition) of the American Psychological Association (APA) to indicate and acknowledge all sources used in this dissertation.

Jean van Huyssteen December 2020

Student number: 24949043 Date

PREFACE

THIS DISSERTATION CONSISTS OF THREE SECTIONS:

SECTION A: Overview of the study

SECTION B: Step One: Literature review

Step Two: Empirical study: Qualitative secondary analysis (Manuscript 1).

Reports of trauma-causing factors and resulting negative outcomes in a group of women who experienced childhood sexual abuse.

Step Three: (Manuscript 2).

Guidelines to do trauma-sensitive social work forensic assessments.

SECTION C: Conclusions, limitations, recommendations, and a combined reference list for sections A, B, and C.

Section A provides an overview of the study. Section B consists of three steps. Step one includes the literature review, which was conducted to obtain a better understanding for the background of this study. Step two consists of a manuscript on the findings of an empirical study which employed qualitative secondary analysis (QSA) conducted on two pre-existing data sets of the Survivor to Thriver (S2T) collaborative strengths-based group intervention programme treatment sessions for women who had experienced childhood sexual abuse (CSA). Step three constitutes a manuscript on the proposed guidelines to do trauma-sensitive social work forensic assessments that was formulated from the literature review and findings of the empirical study (QSA).

Lastly, Section C provides the conclusions drawn from the study, with specific focus on the contributions and limitations of the study as well as recommendations for future research.

It is worth noting that the reader can expect some duplication of content across the three sections taking into consideration the article formatting that has been chosen for the study.

LANGUAGE EDITOR DECLARATION

Wendy Barrow
Language Practitioner
(Translation and academic editing)

PO Box 435, Parys, 9585
082 776 0852
wl.barrow@yahoo.com

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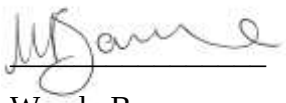
EDITING CERTIFICATE

This certificate serves to confirm that I am a qualified and certified editor. I confirm that the mini-dissertation with the title: **Guidelines for trauma-sensitive social work forensic assessments** has undergone a professional language edit (checking of grammar, spelling, punctuation and register). The onus rests on the author of the document to work through the proposed changes and accept or reject these changes.



Wendy Barrow

BA Languages (UFS)
BA Hons. (Languages studies) *Cum Laude* (UFS)
MA (Translation Studies) (NWU)
Member of SATI and PEG

ABSTRACT

The main aim of this study was to formulate guidelines for trauma-sensitive social work forensic assessments by means of a literature review and empirical study. Three objectives were formulated in order to achieve the aim of the study. These objectives were each planned according to three sequential steps.

The first objective (step one) was a literature review which identified trauma-causing factors and resulting negative outcomes of childhood sexual abuse (CSA), as well as a conceptual framework: Finkelhor and Browne's (1985) Traumagenic Dynamics Model, influencing contextual factors (such as child-specific, family-specific, and abuse-specific factors); and theory and principles of a trauma-sensitive approach. In addition, the role and duties of forensic social workers when conducting forensic assessments were highlighted.

Due to the sensitive nature of the topic and the vulnerability of the participants, the second objective (step two), an empirical study, employed qualitative secondary analysis (QSA) of an existing data set so as to identify reports of trauma-causing factors and negative outcome related to CSA. The QSA was conducted by using two data sets collected during treatment sessions of the Survivor to Thriver (S2T) collaborative strengths-based group intervention programme for women survivors of CSA. The thematic analysis of this data identified three themes as trauma-causing factors contributing to the child's degree of trauma experienced, namely: child-specific factors, family-specific factors, and abuse-specific factors. Nine sub-themes were identified in this data set, with this uniquely South African sample contributing to an additional sub-theme of parentification categorised under the main theme of family-specific factors. The themes and sub-themes corresponded with the seminal work of Finkelhor and Browne's (1985) Traumagenic Dynamics Model and influential contextual factors.

Objective three (step three) formulated guidelines so as to inform trauma-sensitive social work forensic assessments, which was deduced from the empirical findings (step two) and the literature review (step one). The guidelines were formulated using three principles (recognise, respond, and report) which reflected a trauma-sensitive approach and integrated as well as acknowledged the role and duty of the forensic social worker in South Africa.

Key terms

childhood sexual abuse; forensic social work assessments; trauma-causing factors; negative outcomes; trauma-sensitive; guidelines; qualitative secondary analysis; South Africa

OPSOMMING

Die hoofdoel van hierdie studie was om riglyne vir trauma-sensitiewe maatskaplikewerk forensiese evaluerings te ontwikkel deur middel van ’n literatuuroorsig en ’n empiriese studie. Drie doelwitte is geformuleer om sodoende die doel van die studie te bereik. Hierdie doelwitte is volgens drie opeenvolgende stappe beplan.

Die eerste doelwit (stap een) was ’n literatuuroorsig en het faktore wat trauma veroorsaak en gevolglike negatiewe uitkomste in kinderseksuelemisbruik (KSM) geidentifiseer, sowel as ’n konsepsuele raamwerk: Traumageniese Dinamiese Model van Finkelhor en Browne (1985), beïnvloedbare kontekstuele faktore (soos kinderspesifieke, familiespesifieke en misbruikspesifieke faktore), en ook teorie en beginsels van ’n trauma-sensitiewe benadering wanneer daar met oorlewendes van KSM gewerk word. Die rol en plig van maatskaplike werkers wanneer hulle forensiese evaluerings uitvoer, is verder uitgelig.

Weens die sensitiewe aard van die onderwerp en die kwesbaarheid van die deelnemers, het die tweede doelwit (stap twee) gebruik gemaak van ’n empiriese studie, naamlik kwalitatiewe sekondêre analise (KSA) van ’n bestaande stel data om aanmeldings van faktore wat trauma veroorsaak en negatiewe uitkomste wat met KSM verband hou, te identifiseer. Die KSA is uitgevoer deur gebruik te maak van twee stelle data wat gedurende sessies van die *Survivor to Thriver (S2T)* medewerkende, kragte-gebasseerde ingrypingsprogram vir vroue oorlewendes van KSM. Die tematiese analise van hierdie data het drie temas geïdentifiseer as faktore wat trauma veroorsaak en bydra tot die kind se graad van trauma wat ervaar is, naamlik: kinderspesifieke faktore, familiespesifieke faktore en misbruikspesifieke faktore. Nege subtemas is in hierdie stel data geïdentifiseer, met hierdie unieke Suid-Afrikaanse proefstuk wat bygedra het tot ’n bykomende subtema van verouerliking wat onder die hooftema van familiespesifieke faktore gekategoriseer is. Die temas en subtemas stem ooreen met die seminale werk van Finkelhor en Browne (1985) se Traumageniese Dinamiese Model, wat deel van die konseptuele raamwerk van hierdie studie gevorm het.

Doelwit drie (stap drie) het riglyne geformuleer om trauma-sensitiewe maatskaplikewerk forensiese evaluerings in te lig, wat afgelei is uit die empiriese bevindings (stap twee) en die literatuuroorsig (stap een). Die riglyne is geformuleer met behulp van drie beginsels (herken, reageer en meld aan) wat die trauma-sensitiewe benadering gereflekteer en geïnkorporeer het, en ook die rol en plig van die forensiese maatskaplike werker in Suid-Afrika erken het.

Sleutelwoorde

kinderseksuelemisbruik; forensiese maatskaplikewerk evaluerings; faktore wat trauma veroorsaak; negatiewe uitkomste; trauma-sensitief; riglyne; kwalitatiewe sekondêre analise; Suid-Afrika

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SECTION A

OVERVIEW OF THE STUDY

1.1 Introduction

The purpose of this study was to formulate guidelines for trauma-sensitive social work forensic assessments by means of a literature review and empirical study. The empirical study employed qualitative secondary analysis (QSA) of data from the Survivor to Thriver (S2T) collaborative strengths-based group intervention programme. The following section includes the contextualisation and problem statement, contribution of the study, research questions, and the aim and objectives of the study. Lastly, the research methodology is discussed. A comprehensive literature review that includes the conceptual framework for the study is included in Section B, step 1; step 2 in Section B reports on the findings of the QSA; and step 3 of Section B integrates the literature review and QSA to formulate guidelines.

1.2 Contextualisation and problem statement

The prevalence and devastating long-term impact of CSA is well-documented in literature. A body of research found that the effect of CSA is very complex and may manifest in a wide range of negative outcomes experienced in childhood and which may continue into adulthood. This includes mental-health difficulties such as depression, anxiety, personality disorders, and post-traumatic stress disorder (PTSD) (Dolan & Whitworth, 2013; Ullman et al., 2014). In addition, several researchers also report that survivors experience sexual problems, for example, sexual risk behaviours and intimacy problems (Hodges & Myers, 2010; Walsh et al., 2014). Furthermore, intrapersonal difficulties like low self-esteem and self-concept issues as well as interpersonal difficulties, for example, relationship problems and trust difficulties are also experienced by survivors (Hodges & Myers, 2010; Kerlin, 2013; Singh et al., 2014). Similar findings were reported in South African studies (Mathews et al., 2013; Penning & Collings, 2014).

Although any sexual abuse ordeal is potentially very traumatic for a child, the degree of trauma experienced and the effectiveness with which the child is assisted to process the trauma, will be influenced by context-specific factors, namely: family, child, and abuse-specific factors or dynamics (Spies & Bezuidenhout, 2006; Yancey & Hansen, 2010). According to Kenny (2018), a child will cope better with the abuse if they feel loved and supported by the family and also if they are believed by the family when they disclose the CSA. Collin-Vézina et al. (2015) on the other

hand, state that when a family responds unsupportively or if they overreact, greater long-term devastating trauma outcomes may result for the child. Furthermore, the degree of disruption that follows the disclosure may also influence the amount of trauma the child will experience (Hunter, 2015) and the age of the child may also greatly affect the impact of the trauma quantity (Balfe et al., 2019). As such, different age groups, according to their cognitive developmental phase, may interpret the CSA events differently, which has an influence on the amount of trauma they will experience or be subjected to. Bucchianeri et al. (2013) further state that a child who has good mental and psychological health prior to the abuse, may be better able to withstand the proposed damaging long-term effects of the abuse. Overall, the nature, number, frequency, and duration of the CSA will contribute to the quantity or magnitude of traumatisation experienced by the child (Collin-Vézina et al., 2015; Spies & Bezuidenhout, 2006). Research conducted by Kenny (2018) indicates that the level of threat experienced by the child during the abuse may create additional anxiety and fear, which in turn, may further impact the severity of trauma that the child experiences. Kenny (2018) further states that if the perpetrator is known to the child, the traumatic effects of the abuse will be more severe. Within the South African context, research done by Rapholo (2019) in the Bapedi tribe, further emphasises the influence of witchcraft, cultural beliefs, and societal rules and norms inhibiting children to disclose CSA, contributing to the trauma level. As such, the context-specific dynamics appear to all work together in determining the level or magnitude of the trauma experienced by the child victim of CSA.

In South Africa, reporting of CSA to the South African Police Service (SAPS) is mandated in terms of section 54 of the *Sexual Offences and Related Matters Amendment Act* 32 of 2007 (South Africa, 2007). Subsequently, children are expected to provide a detailed version of the traumatic ordeal during a statement to the SAPS (Fouché & Fouché, 2015). In South Africa, a *single child witness* is approached with caution as there exists a common perception that children are suggestible and unreliable witnesses (Meintjies, 2000; Van der Merwe, 2009a). Therefore, during the investigation phase, cases of CSA are often referred to professionals, mostly social workers, with specialised knowledge and skills to conduct a forensic assessment. This group of social workers are commonly known as "forensic social workers" (FSWs). In South Africa, the Regulations relating to the requirements and conditions for registration of a speciality in forensic social work was published in the Government Gazette in May 2020 (Department of Social Development, 2020). Interested persons were invited to submit substantiated comments on the proposed regulations to the Minister of Social Development— this proposal remains pending at the time of writing of this research study. However, these regulations will come into operation upon publication as a government notice (Department of Social Development, 2020).

Further to this, a forensic assessment includes the use of forensic social work techniques and tools, so as to compile a report with accurate information, in order to establish facts or evidence that can be used in a court of law (Fouché & Fouché, 2015). Rapholo and Makhubele (2019) further emphasise the importance of forensic assessments in order to elicit disclosure and a precise report from alleged child victims to be used in court. The purpose of FSWs in South Africa, are thus to facilitate an evidence-based disclosure and test the veracity of the child's CSA claims (Fouche & Fouché, 2015), which is why FSWs mainly deal with children who are allegedly sexually abused and potentially traumatised. Therefore, during a forensic assessment, a forensic social worker (FSW) will not only focus on the child's verbal account of events but also be mindful of the emotional and behavioural reactions that the child may present characterised by negative outcomes as a result of the traumatic CSA experience. Hence, it is imperative for FSWs to have an in-depth knowledge and understanding of how CSA trauma may affect children and how it may have had an impact on the child's physical, emotional, and psychological functioning as well as manifest in certain emotional and behavioural responses. In addition to having the necessary skills and techniques to perform forensic assessments (Lamb et al., 2011), FSWs thus need to ensure that they conduct these assessments from the fundamental principles of trauma awareness, in a trauma-sensitive manner, and that a trauma-sensitive approach is followed during such a forensic assessment. According to Macdonald et al. (2012), trauma-sensitive means that the adverse consequences of sexual abuse of a child must be conceptualised into the consequences of trauma and must then be used as such and be reflected in the structure and content of the interview or assessment process of the child.

A body of research (Bowen & Murshid, 2016; Johnson, 2017; Mersky et al., 2019) indicates that the following need to be taken into consideration in order to promote a trauma-sensitive context during forensic interviews: the short and long-term effects of the child's trauma exposure; the relationship between the trauma exposure and challenges that the child is currently experiencing, for example, the legal process; the impact the trauma has on the child's beliefs about themself[1] and other significant people; the impact that these beliefs have on the child's willingness and ability to engage with the FSW in the assessment process; and lastly, incorporating intervention techniques that include trust, safety, choice, collaboration, and empowerment. Subsequently, the FSW must remain mindful of how the traumatic CSA ordeal may have had an impact on the child's physical, emotional, and psychological functioning and that traumatised children can behave differently during forensic interviews. Moreover, each child will handle their trauma differently, and each

[1] The APA (7th edition) endorses the use of the pronoun they, them, etc.

child will also present their trauma differently to the world, often presenting this trauma in the form of various symptoms that can also manifest during the forensic interview.

Some of the immediate symptoms that can be an indicator that the child has experienced trauma, can be the following: acute traumatic responses, for example, clinging behaviour or irritability (Mathews et al., 2013); fear, anxiety and PTSD (De Witt, 2016; Macdonald et al., 2012); regression, for example, thumb sucking, needing a security blanket or loss of bladder control (Kenny, 2018); depression, low self-esteem, and anger (Kottenstette et al., 2020; Mathews et al., 2013); eating disorders, for example, feeding difficulties in the young and anorexia nervosa in adolescents (Kenny, 2018; Louw & Louw, 2014); and sexualised behaviour, for example, developmentally inappropriate sexual knowledge (Mesman et al., 2019). In addition, it should be kept in mind that the forensic interview itself may cause further stress and trauma for the child due to the unfamiliar interview situation and that it is expected of them to share painful and intimate information with a strange person (Lamb et al., 2011). Further to this, other traumatic experiences, for example, divorce and removal from their parents or care takers, may also contribute to the child's trauma. This study will, however, only focus on the documented trauma caused by experiences of CSA.

Although any sexual abuse ordeal is very traumatic for a child, the effect and degree of trauma experienced by the individual child will be influenced by a range of different context-specific factors or variables. Literature reports that these factors can be divided into three themes, namely: family-specific factors, abuse-specific factors, and child-specific factors (Kenny, 2018; Spies & Bezuidenhout, 2006; Yancey & Hansen, 2010). Family-specific factors are defined as those factors that are associated with other family members or significant other people in the child's life, focusing on parental reaction to the disclosure, parental support of the child, parental stress and coping, and other family stressors, for example, multi-problem families and domestic violence, which are all influential on the child's adjustment and level of the trauma experienced (Kenny, 2018; Spies & Bezuidenhout, 2006). Abuse-specific factors include the level of threats and emotional manipulation by the perpetrator, duration and extent of the abuse, and the identity of the perpetrator (Kenny, 2018; Spies & Bezuidenhout, 2006; Yancey & Hansen, 2010). The child-specific factors focus on any inherent characteristics specific to the child, for example, the exposure to sexual activities they are not developmentally or emotionally ready to cope with, previous internalisations regarding trauma as well as the child's temperament and personality (Spies & Bezuidenhout, 2006; Yancey & Hansen, 2010).

The seminal work by Finkelhor and Browne (1985) proposes a more systematic understanding of the unique trauma-causing factors and effects of CSA on victims resulting in CSA being seen as a complex trauma. This was coined the Traumagenic Dynamics Model (Finkelhor & Browne, 1985). To date, the Traumagenic Dynamics model, also referred to as trauma-causing factors, as proposed by Finkelhor and Browne (1985), provides a useful framework, which is widely used among FSWs in South Africa, in order to inform their understanding of the CSA trauma experiences of child survivors. This framework is also used in court reports and expert testimony (Spies & Bezuidenhout, 2006). In the Traumagenic Dynamics Model, Finkelhor and Browne (1985) conceptualised that four traumagenic dynamics, namely: traumatic sexualisation, betrayal, stigmatisation, and powerlessness are at the core of the psychological injury inflicted by the CSA (Finkelhor & Browne, 1985). This model also explains the resulting emotional, behavioural, and psychological difficulties associated with traumatic CSA experiences. In this regard, the FSW, who is working in direct contact with an abused child, is often confronted with the emotional and behavioural manifestations of the child and these are required to be understood, and not misinterpreted, in light of the unique complex trauma that was endured. As such, the knowledge of the model of these dynamics can be used to enhance the understanding of the FSW in terms of the traumatic experiences that sexually abused and/or victimised children have to endure and also how these may present as negative outcomes. In addition, what has been highlighted in literature, is that the value of such knowledge on these traumagenic dynamics for assessment and intervention, may prepare and assist FSWs to fully understand the child victim and thereby work mindfully and successfully with the vulnerabilities of sexually traumatised children (Lucio & Nelson, 2016; Van der Merwe, 2009b).

Much research has been conducted on exploring how the four trauma-causing factors of Finkelhor and Browne (1985) may impact the child victim. Recently a scoping review, conducted by Henning (2017), focusing on women survivors of CSA, found that the majority of published studies on this topic are conducted in minority-world countries such as the United States of America (Makhija, 2014), Australia (Dolan & Whitworth, 2013), and Europe (Revell et al., 2008). The term *minority* is used for wealthier regions of the world or otherwise known as developed countries and only constitutes a small percentage of the world population (Madrid Akpovo et al., 2018). Only three empirical studies exploring trauma-causing factors in female survivors of CSA in South Africa have been conducted. The one study by Ramasar (1997) included 16 participants and found that betrayal and stigmatisation are the two main trauma-causing factors evident in that study. In the case of betrayal, women experienced that significant others did not provide support; they had negative responses upon disclosure; and they had an inability to both trust men and form

trusting interpersonal relationships. With regards to stigmatisation, they internalised victim-blaming and their guilt over the abuse impaired their sense of self-worth. The other two studies by Fleming and Kruger (2013) and Human (2015) included one participant each and found that traumatic sexualisation is the key factor that women survivors experience as the consequence of feeling immature at the time of the sexual abuse, resulting from the physical responses that created confusion and disrupted their perception of sexuality. One participant also experienced stigmatisation and feelings of shame due to society's perception of females who had been raped, being powerlessness, and lacking assertiveness in their intimate relationships. Although some authors attempted to contribute towards a better understanding of the trauma-causing factors in the context of CSA, only the above three studies report on how these trauma dynamics present in South African samples of women survivors of CSA. These studies are, however, limited in terms of their small samples. Another study, a literature review conducted by Van der Merwe (2009b), attempted to contribute towards a better understanding of the trauma-causing factors in the context of CSA and suggests the value of these traumagenic factors for assessment and intervention, in fully understanding the victims, and thereby promoting the need to work more actively and effectively with the vulnerabilities of these sexually-traumatised children. Furthermore, it is not only the therapists that require enhanced knowledge about these trauma-causing factors and resulting negative outcomes but also FSWs who are required to conduct assessments for court procedures and ultimately have to deal with the traumatised child victims of CSA. However, no studies to date that focus on generating knowledge about the four trauma-causing factors and resulting negative outcomes during and after CSA to assist forensic social workers in working in a more trauma-sensitive approach were found. As such, a need to contextualise trauma-causing factors and negative outcomes within a South African sample is imperative in order to formulate guidelines for forensic social workers to assist them in working within a trauma-sensitive approach within the South African context.

All professionals who are working with child victims of CSA require enhanced knowledge of these trauma-causing factors and their resulting negative outcomes. In the case of FSWs, who are required to conduct assessments for court procedures and ultimately work with the traumatized child CSA victims, advanced knowledge is imperative in order to evaluate the allegations. In the uniquely South African context, which includes a broad diversity of different ethnic groups, a further understanding of the socio-economic and cultural systems which influence disclosure is also imperative (Rapholo & Makhubele, 2019). This study intends to formulate guidelines to provide FSWs with an enhanced understanding of the unique trauma-causing and contextual factors as well as the negative outcomes related to CSA using three principles (recognise, respond,

and report [3-R]) which reflect a trauma-sensitive approach and integrates and acknowledges the role and duty of the forensic social worker in South Africa.

The intent was thus to equip FSWs with trauma-sensitive knowledge in order to *recognise* the signs and symptoms of CSA trauma on the child victim, to *respond* with trauma-sensitive skills when handling the situation, and to *report* the observations in process notes after the forensic interview to be taken into consideration when the court report is prepared.

The purpose is to guide FSWs in conducting trauma-sensitive assessments by recognising, responding to, and reporting the emotional and behavioural messages that the child relays or presents with during the forensic assessment, in the context of the child's past trauma-causing experiences. In addition, no studies to date, have focused on generating knowledge about the four trauma-causing factors and their resulting negative outcomes during and after CSA with the aim of informing forensic social work practice so as to encourage working from a more trauma-sensitive approach when conducting forensic assessments. As such, a need to contextualise trauma-causing factors within a South African sample appears imperative. Furthermore, in order to honour diversity in a diversely rich country like South Africa, more knowledge is needed to inform practice with more inclusive samples. Subsequently, further research is needed to expand the knowledge base on this topic and explore the dynamics presented in a South African sample of women CSA survivors.

Due to the sensitive and traumatic nature of CSA, gaining access to these vulnerable populations can be restricting and ethically challenging. As a result, qualitative secondary analysis (QSA) of existing data sets was considered. The researcher obtained permission to use an existing data set from three groups of adult women survivors of CSA in the Vaal Triangle, Gauteng Province, South Africa. These women participated in a collaborative strengths-based group intervention programme entitled Survivor to Thriver (S2T) developed by Walker-Williams and Fouché in South Africa in 2013. The data was collected during the period 2013-2018. Two sets of data of treatment sessions from the S2T collaborative strengths-based group intervention programme will be analysed. The data of the two groups, collected over two different time frames, will hopefully support and strengthen the emerging findings regarding trauma-causing factors. Although the data collected was only on women, the devastating impact on men survivors is no way discounted and should receive urgent attention in future research studies. Therefore, this study aims to investigate the trauma-causing factors and negative outcomes by conducting qualitative secondary analysis (QSA) of existing data sets.

In summary, FSWs are required to have a broad knowledge base and understanding of the trauma caused by CSA experiences when they conduct an interview and assess sexually abused children. Although Finkelhor and Browne's (1985) Traumagenic Dynamics Model provides a useful framework, few studies have been conducted in South Africa, and as such, more research on South African samples are needed to inform practice. Therefore, this study aims to answer the following primary research question:

> *"How can a literature review and empirical study inform the formulation of guidelines for trauma-sensitive social work forensic assessments?".*

Guidelines will be proposed for forensic social workers so as to encourage them to work from a trauma-sensitive approach and address the needs of the traumatised child.

1.3 Contribution of the study

The contribution of this study will be twofold, firstly, it will be incorporated with existing literature in order to contribute to the existing body of knowledge on how trauma-causing factors manifest in childhood as reported by South African female survivors of CSA; and secondly, the study will inform guidelines for forensic social workers so as to promote conducting trauma-sensitive forensic assessments. The findings of this study will also highlight further research gaps that require exploration in this regard.

1.4 Research questions

The primary research question is:

- *How can a literature review and empirical study inform the formulation of guidelines for trauma-sensitive social work forensic assessments?*

To answer the primary research question, the following secondary research questions will be investigated:

- *What literature is available in order to better understand trauma-causing and contextual factors, resulting negative outcomes in the context of CSA and trauma-sensitive approaches?*

- *What traumatic experiences and negative outcomes of childhood sexual abuse were reported by women survivors who participated in S2T group treatment intervention sessions can inform trauma-sensitive social work forensic assessments?*

- *How can guidelines be formulated from the empirical findings and the literature review, so as to reflect a trauma-sensitive approach and integrate and acknowledge the role and duty of the forensic social worker in South Africa?*

1.5 Aim and objectives

1.5.1 Aim

The main aim of the study is to formulate guidelines for trauma-sensitive social work forensic assessments by means of a literature review and empirical study.

Three objectives were formulated in order to achieve the aim of the study.

1.5.2 Objectives

I. To conduct a literature review to explore what is known from literature so as to obtain a better understanding of trauma-causing and contextual factors in addition to resulting negative outcomes in the context of CSA and trauma-sensitive approaches.

II. To conduct a QSA of an existing data set (the Survivor to Thriver (S2T) collaborative strengths-based group intervention programme for women survivors of CSA) so as to identify reports of trauma-causing factors and negative outcomes related to childhood sexual abuse.

III. To formulate guidelines deduced from the empirical findings and the literature review, which reflects a trauma-sensitive approach and integrated and acknowledged the role and duty of the forensic social worker in South Africa.

1.6 Research methodology

This study followed a qualitative research approach. Qualitative research aims to gain a better understanding of how humans socially interact and experience their surroundings by giving meaning to symbols, rituals and social roles and structures, thus, a deeper meaning of human experiences is generated (Maree, 2007; Rubin & Babbie, 2016). This method of research further makes use of linguistic words and not numerical data and employs meaning-based and not

statistical forms of data-analysis, thus, richer observations and meaning from data is extracted that is not easily deduced from numbers. The qualitative research approach was chosen as the researcher's paradigm is embedded in social constructivism. A paradigm can be seen as the organising principles or lens through which reality is interpreted and understood (Maree, 2007). The social constructivist paradigm underlines numerous subjective realities with the difficulty of being objective (Rubin & Babbie, 2016). For the purpose of this research, a flexible approach that valued subjective processes was used that evolved as more observations were gathered and multiple meanings of individual experiences were considered.

This study consists of a literature review and empirical study (QSA), which inform the formulation of guidelines.

Table 1 depicts a design map and illustrates the steps that were followed in order to answer the research questions and to achieve the overall objectives of the study.

Table 1: Design map

Primary research question	How can a literature review and empirical study inform the formulation of guidelines for trauma-sensitive social work forensic assessments?		
	Step one	Step two	Step three
Secondary research questions	• What literature is available in order to better understand trauma-causing and contextual factors, resulting negative outcomes in the context of CSA and trauma-sensitive approaches?	• What traumatic experiences and negative outcomes of childhood sexual abuse were reported by women survivors who participated in S2T group treatment intervention sessions can inform trauma-sensitive social work forensic assessments?	• How can guidelines be formulated from the empirical findings and the literature review, so as to reflect a trauma-sensitive approach and integrate and acknowledge the role and duty of the forensic social worker in South Africa?
Objective	• To conduct a literature review to explore what is known from literature so as to obtain a better understanding of trauma-causing and contextual factors, resulting negative outcomes in the context of CSA and trauma-sensitive approaches.	• To conduct QSA of an existing data set (the Survivor to Thriver (S2T) collaborative strengths-based group intervention programme for women survivors of CSA) so as to identify reports of trauma-causing factors and negative outcomes related to childhood sexual abuse.	• To formulate guidelines deduced from the empirical findings and the literature review, which reflects a trauma-sensitive approach and integrated and acknowledged the role and duty of the forensic social worker in South Africa.
Research design	• Literature review.	• Qualitative secondary analysis.	• Integration of findings from the literature review and empirical findings within a

			trauma-sensitive approach and role and duties of FSWs in SA.
Sampling, participants and data collection method	• Search strategy • Screening and article selection	• Utilise two data sets of S2T group intervention treatment sessions. • In total 16 sessions of women survivors of CSA.	
Data analysis	• Data extraction	• Thematic analysis. • Coding. • Independent coding. • Consensus discussions.	• Thematic analysis. • Coding. • Independent coding. • Consensus discussions.
Outcomes	• Identified a conceptual framework • Identified trauma-causing factors and resulting negative outcomes	• Identified themes and sub-themes	• Formulated guidelines for conducting trauma-sensitive forensic assessments.

This study was conducted in three steps, as depicted in the design map (Table 1), namely a literature review, empirical study and formulation of guidelines. Each step will now be discussed.

1.6.1 Step one: Literature review

A literature review is normally done in order to: 1) provide an overview of recent as well as older research that has been done, which is relevant and research appropriate to the current proposed research question; and 2) identify gaps between what has been researched and written on the topic and what has not (Maree, 2007; Rubin & Babbie, 2016). The aim of conducting a literature review in this study was to obtain a better understanding of trauma-causing factors in the context of the severe phenomenon of childhood sexual abuse. Although the researcher wanted to conduct the research with an open mind, she regarded it necessary to start out with the understanding of the current knowledge base on the topic. A research gap was identified in the literature review, as very little research regarding trauma-causing factors as a result of CSA, specifically in the South African context could be found, as well as limited studies about conducting trauma-sensitive social work forensic assessments.

The secondary research question driving this part of the study is:

> *What literature is available in order to better understand trauma-causing and contextual factors, resulting negative outcomes in the context of CSA and trauma-sensitive approaches?*

First the search strategy will be discussed, following how the screening and selecting of articles took place, as well as how the data was extracted and synthesised. Thereafter the necessary training conducted so as to perform a literature review will be mentioned. Lastly, the conceptual framework for this study will be defined.

1.6.1.1 Search strategy

The literature review was conducted by developing a search strategy, which included identifying: 1) keywords; and 2) different electronic databases (which were systematically searched) to obtain relevant previous research information regarding the current research topic. The following keywords were used to identify relevant literature: (*childhood sexual abuse* OR *child sexual abuse* OR *childhood sexual assault* or *child sexual assault*) AND (*forensic social work assessments* OR *forensic assessments* OR *social work assessments* OR *forensic social work

interviews* OR *forensic interviews*) AND (*trauma-causing factors* OR *trauma factors* OR *traumagenic factors* OR *traumagenic dynamics*) AND (*trauma-sensitive* OR *trauma-informed* OR *trauma-sensitive approach* OR *trauma-informed practice*) AND (*guidelines* OR*forensic social work guidelines* OR *social work guidelines* OR * forensic guidelines*) AND (*qualitative secondary analyses*) AND (*South Africa*). Databases searched were Google Scholar and EbscoHost.

1.6.1.2 Screening and article selection

Firstly, the title and abstract of the articles were screened. The full-length articles that seemed appropriate to the research, were then studied. These articles and author(s) names were downloaded through Endnote. Keyword-specific folders were used in order for easy access to key-word related information. The reference lists of identified articles were also utilised to guide the researcher to more relevant literature.

1.6.1.3 Data extraction and synthesising

Most of the identified and often used full-length articles were downloaded on the researcher's computer and were saved in a specific folder. Whilst the appropriate full-length articles were studied, the relevant sections were highlighted in order for easy screening when the information was needed. In order to broaden the scope of literature used, the researcher also employed the use of her own text books as well as library academic books.

1.6.1.4 Training attended

In preparation to conduct the literature review, the researcher attended training courses in this regard, namely: 1) a full week training in Research Methodology, which included literature reviews, presented by Prof. Wim Roestenburg, NWU Potchefstroom Campus, 21-25 January 2019 as well as a full day, once monthly, research class presented by Prof. Wim Roestenburg for the period February 2019 – August 2019; 2) Online Tutorial: Search Strategies, INASP, 23 November 2019; and 3) an online workshop: Scoping reviews, 6 August 2020, presented by Mrs Brits and Mrs Kays-Ebrahim, NWU, Vaal Triangle Campus.

1.6.1.5 Conceptual framework

The conceptual framework for this study will include: 1) theory on a trauma-sensitive approach; 2) the Traumagenic Dynamics Model of Finkelhor and Browne 1985); and 3) context-specific,

trauma-causing factors. Firstly, the term "trauma-sensitive" or "trauma-informed" will be discussed and means that the social, behavioural and psychology professions must account for the possibility that sexually abused children may have experienced some form of previous trauma and must, therefore, conceptualise the consequences of trauma as such and reflect it in the structure and content of the interview or assessment process of the child (Macdonald et al., 2012). Secondly, the Traumagenic Dynamics Model of Finkelhor and Browne (1985) propose a systematic understanding of the emotional, behavioural and psychological difficulties associated with the traumatic experience of CSA. They conceptualised that four traumagenic dynamics, namely: traumatic sexualisation, betrayal, stigmatisation, and powerlessness are at the core of the psychological injury inflicted by abuse (Finkelhor & Browne, 1985). Lastly, the context-specific factors contributing to the trauma that the child will experience as a result of CSA will be looked at and can be divided into family-, abuse-, and child-specific factors (Spies & Bezuidenhout, 2006; Yancey & Hansen, 2010).

1.6.2 Step two: Empirical study (QSA)

Due to the sensitivity of the topic and the vulnerability of the participants, this empirical study employed QSA of an existing data set so as to identify reports of trauma-causing factors and negative outcomes related to childhood sexual abuse. The secondary research question driving this study is:

> *What traumatic experiences and negative outcomes of childhood sexual abuse were reported by women survivors who participated in S2T group treatment intervention sessions can inform trauma-sensitive social work forensic assessments?*

First, the research design (QSA) will be defined followed by a discussion on the background of the primary S2T research study as well as the integrity of this study. Moreover, the population of the primary study, purpose of the study and sampling methods used in this research will be discussed. Lastly, data analysis methods and the trustworthiness of the data will be explicated.

1.6.2.1 Research design

This empirical part of the study employed QSA on two pre-existing data sets of treatment sessions of adult women survivors of CSA participating in the S2T collaborative strengths-based group intervention programme. Qualitative secondary analysis entails the re-use of pre-existing qualitative data collected from previous studies with the purpose of studying new research

questions (Heaton, 2008; Irwin & Winterton, 2011). This study employed the use of available transcripts from 16 sessions of two groups of treatment sessions of the S2T collaborative strengths-based group intervention programme. Written consent was obtained from the primary researchers (Addendum 3) and the S2T participants so as to use the data for the purpose of this study.

According to Heaton (2008) there are five potential ways in which existing qualitative data can be re-used in QSA:

1. Supplementary analysis: this is to get a more in depth understanding of aspects of the data that was not explored in the primary study.

2. Supra-analysis: where the focus and aim of the secondary study exceeds those of the original study.

3. Re-analysis: is to re-examine data to validate or confirm findings of a primary study.

4. Amplified analysis: when two or more data sets are combined or compared for purposes of a secondary analysis.

5. Assorted analysis: re-use of existing data in conjunction with the collection and analysis of primary qualitative data for the same study.

During this research, the researcher was to follow the supra-analysis approach. The primary study focused on the efficacy of the S2T collaborative strengths-based intervention programme. This study aimed to conduct QSA of two groups of data sets of treatment sessions of the S2T collaborative strengths-based group intervention programme, by asking a research question not previously explored in the primary study and thereby exceeding the original primary study by answering a new empirical and conceptual question, namely:

> *What traumatic experiences and negative outcomes of childhood sexual abuse were reported by women survivors who participated in S2T group treatment intervention sessions can inform trauma-sensitive social work forensic assessments?*

Although QSA allows for the answering new research questions from existing data, the effectiveness of QSA as a research method sometimes poses challenges and/or a threat of a conflict of interest(s) (Irwin & Winterton, 2011). The semi-structured ways in which data is collected can result in data sets with variable depth, which may not always be suitable for a secondary study and

the researcher must furthermore interpret and analyse data collected by other researchers (Heaton, 2008). A further issue is that of informed consent from the research participants and how the re-use of their data is going to be kept confidential while being re-used by a new researcher (Heaton, 2008).

Consequently, Irwin and Winterton (2011) are of the opinion that there are substantial reasons why QSA can be used to find fresh insights from already existing data. They indicate that the researcher can engage with the data without preconceptions; they can potentially provide rich, descriptive information; they can conclude new findings from old data; and they can reach sensitive and vulnerable populations. Further to this, according to Sherif (2018), QSA can reveal additional detail on the same research topic; the research can be analysed with a new theoretical framework not applied in the primary study; and the research questions can be answered more thoroughly than in the primary study.

1.6.2.2 Background on the primary study: The Survivor to Thriver (S2T) Collaborative Strengths-based Group Intervention Programme

The S2T collaborative strengths-based group intervention programme follows a strengths-based and supportive approach and focuses on women survivors of CSA's strengths in order to facilitate resilience processes and post-traumatic growth-enabling outcomes from their traumatic CSA experiences (Fouché & Walker-Williams, 2016). This intervention covers four treatment outcomes (Walker-Williams & Fouché, 2017).

1. Providing a supportive space for sharing the trauma story, experiencing heightened emotional awareness and validating the group members' experiences (drawing on cognitive behavioural therapy and cognitive processing therapy principles of cognitive processing);

2. normalising symptoms (emerging from the psychodynamic approach) and reframing trauma messages (cognitive behavioural therapy and post-traumatic growth model);

3. active adaptive coping drawing on psychological inner strengths (psychodynamic and post-traumatic growth model); and

4. transforming from meaning making to personal growth by re-sharing the trauma story "for a change" from a new perspective (post-traumatic growth model).

The sample in both groups included adult women that were exposed to CSA. They all experienced contact sexual abuse as children and the perpetrator was known to them. They were all residing in the Vaal Triangle within the larger Gauteng Province in South Africa. A quasi-experimental design was used during a pilot study conducted in 2013/2014 and included 10 women (Walker-Williams & Fouché, 2017). The benefits of this collaborative strengths-based group intervention programme were further tested by the researchers over a four-year period. The second group included eight women and commenced in 2014 and ended in 2015. The pilot study on the third group of seven women commenced in 2017 and ended in 2018. The sample inclusion criteria for the groups were: 1) CSA before the age of 18 years old; 2) disclosure of the CSA; 3) had received some form of crisis intervention as a child; 4) could function reasonably well in day to day life; and 5) were willing to participate voluntarily in the S2T intervention programme at a community location. (Walker-Williams & Fouché, 2017). The group sessions ranged from six to nine sessions and the duration of these sessions where approximately two hours. Follow-up sessions were also held after a period of time. The group sessions were held at a central and private community location. The sessions were facilitated by two group facilitators (a social worker and a clinical psychologist). After the group sessions, the data was professionally transcribed (Walker-Williams & Fouché, 2017). Ethical clearance was obtained for the primary study (ethics number: NWU 0041-08-A1 [Group 1-3, 2013-2018], Addendum 2). For the purpose of this study, only the data from Group 2 and Group 3 were analysed.

1.6.2.3 The research integrity of the primary study

The participants of the primary study were recruited as follows: The researchers approached clinical, counselling, and educational physiologists working in private practice in the Vaal Triangle as well as social workers employed at organisations, for example, the Alpha Trauma Centre, Vereeniging; Child Welfare, Vanderbijlpark; and NG Welsyn, Vereeniging as gatekeepers. These gatekeepers had to qualify by having experience in working with women who had experienced CSA. The gatekeepers screened for and identified possible candidates according to the primary study's inclusion criteria. The inclusion criteria also included being speakers of Afrikaans and English, as these were the primary languages of the group facilitators although all cultural groups were included. The exclusion criteria included women who suffered from psychotic symptoms, and women who suffered from substance abuse, as these behaviours were seen to have the potential of hindering the recovery process of other participants in the group.

For the purpose of this study, only data from Group 2 and Group 3 will be used. The demographic composition of Group 2 included three white and five black ladies; and Group 3 included five white and two black ladies. Thus, eight white and seven black ladies in total were included in this study.

The gatekeepers were requested to obtain informed consent from the participants in order to disclose their personal details to the researchers. After the consent was obtained, the researchers telephonically contacted the prospective participants. The research programme and their participation were explained to the participants and they were invited to attend an information session. During this information session, the nature and purpose of the programme was explained to them. The participants also completed an informed consent form stipulating their voluntary participation in the programme. The recruitment was conducted during 2012-2013, prior to the Department of Health Guidelines, which came into effect in 2015. Therefore, the primary researchers could obtain the informed consent, and it was also not mandatory to allow a 24-hour cooling-off period for informed consent. The consent form also included giving consent for the transcriptions of the recorded group sessions to be used for QSA and for post-graduate students, under the supervision of the primary researchers, to have access to this data for research purposes. The participants were also given the opportunity to withdraw from the programme at any time without reprisal.

During the group intervention sessions, the participants were encouraged to treat all personal information that was discussed during the sessions as confidential. The confidentiality of the voice recordings was also high priority. After each session, the voice recording was transferred from the recording device to one of the primary researcher's computers.

Risks to the participants were reduced by only selecting women who had already disclosed their CSA experiences and who had received some form of therapeutic intervention. Besides having received previous therapy, participating in the S2T could still elicit strong emotional reactions. Both primary researchers, being a social worker and a clinical psychologist, were adequately qualified to deal with and handle these reactions, if and when they arose. To be fully prepared for any unforeseen circumstances, additional, external psychological counselling services were also made available for any participant should the need have arisen. The primary researchers also offered extra support outside the group context. Group members also received the researchers' telephone numbers in the event that the need for support or counselling arose before the next group session. Participants were also given access to a support WhatsApp group where communal

support discussions took place between sessions. This WhatsApp group was administrated by the primary researchers and group facilitators.

For the purpose of this research study, this researcher received the audio files for Group 2 and Group 3. The data from Group 2 had already, according to ethical standards, been transcribed by another post-graduate student. The data for Group 3 had not yet been transcribed and thus the researcher contracted a professional transcriber to transcribe these sessions. A confidentiality agreement was signed between the primary researcher, the student conducting the research, and the professional transcriber. After the professional transcriber completed the transcriptions, the primary researchers checked the transcriptions for accuracy. The audio files were then deleted from all computers. The transcriptions were securely locked in a cabinet, separate to the cabinet storing the data and consent forms from Group 1 and Group 2. These cabinets were in a locked venue in the Social Work building of the NWU, Vaal Triangle Campus.

Two articles were published to date confirming the enabling resilience processes and post-traumatic growth outcomes of the participants from Group 1 (Walker-Williams & Fouché, 2017, 2018). This research found similar positive outcomes after analysing the data from Group 2 and Group 3.

1.6.2.4 Population of the primary study

This population is very vulnerable and gaining access to them may be challenging and restricting. Therefore, the researcher made use of existing data that was collected during group treatment sessions with women survivors of CSA. These women all participated in the S2T collaborative strengths-based group intervention programme. All participants in the study were recruited by the primary researchers that consisted of a social worker and clinical psychologist who were also the founders of the S2T group treatment sessions.

Three groups of women participated in the S2T programme. The first group included 10 women and commenced in 2013 and ended in 2014. A previous master's study examined the trauma-causing factors for this group of women, and was not included in this study. Only the second group (8 participants, 2013-2014) and the third group (7 participants, 2017-2018) were included. The group sessions were conducted at a private community venue that was easily accessible for the participants. The sessions were facilitated by a social worker and a clinical psychologist. Facilitators employed strengths-based probing questions and supported the group with empathy

and understanding. After the group sessions, all the data was transcribed, ethically managed, securely stored, and professionally and ethically analysed (Walker-Williams & Fouché, 2017).

Table 2: Demographic Characteristics of Participants (N=15)

Characteristic	No.
Age group	
18-25	7
26-30	2
31-45	4
46-50	0
51-60	2
Nationality	
South African	15
Foreign	0
Race	
White	8
African	7
Higher	11
Secondary	4
Occupation	
Employed	8
Student	6
Unemployed	1
Relationship status	
Single	8
Married	6
Cohabitating	1

Characteristic	No.
Children	
No	12
Yes	3
Type of abuse	
Contact	15
Noncontact	0
Perpetrator	
Known	15
Unknown	0
Age of CSA onset in years	
3	1
5	3
6	4
8	2
9	2
10	2
13	1
Duration of abuse in years	
1 - 2	2
3 - 4	7
5 - 6	4
7 - 10	2

Table 3: Biographical Information of S2T Group Members

Participants	**Total**			**Race**	**Average Age**
	Initial	**Post-Test**	**Delayed post-test**		
Group 2 (2014/2015)	8	5	5	3 White 5 African	25 years
Group 3 (2017/2018)	7	4	4	5 White 2 African	39 years
Research Procedure					
Ethics number	NWU 00041-08-A1 (Group 2, 2014/2015), Addendum 2				
	NWU 00041-08-A1 (Group 3, 2017/2018), Addendum 2				
Ethics	Informed consent (Group 2, 2014/2015)				
	Informed consent (Group 3, 2017/2018)				

**Group 1 was not included in this study as the data had already been used for publication*

1.6.2.5 Purpose of this study

The purpose of the study was to conduct QSA on data collected from two groups of treatment session of the S2T collaborative strengths-based group intervention programme. Although the primary research was conducted on adult women, a very rich source of data about their CSA experiences were reported. The researcher analysed the datasets about their traumatic CSA experiences in order to investigate the primary research question:

> *"How can a literature review and empirical study inform the formulation of guidelines for trauma-sensitive social work forensic assessments?".*

1.6.2.6 Sampling method

This research conducted QSA and used two secondary data sets from the primary S2T collaborative strengths-based group intervention programme study. The sampling of the primary study was done by Professor Fouché and Professor Walker-Williams. Ethical clearance was obtained for the primary study (Addendum 2) as well as consent from participants for the re-use of data for future secondary analysis. Due to the secrecy and sensitive nature of CSA, it was impossible to randomly select women. Therefore, purposive sampling was used. The previous

researchers approached various professionals like social workers and psychologists in the Vaal Triangle area to act as gatekeepers. The gatekeepers screened for possible participants according to the inclusion and exclusion assessment criteria. The gatekeepers obtained informed consent from the participants to disclose their details. The researchers then made telephonic contact with those who had agreed to participate. The researchers met the women and explained the nature and purpose of the program. Participants completed an informed consent form undertaking their voluntary participation in the programme.

1.6.2.7 Data analysis method

Thematic analysis was employed to analyse the two data sets. This provided a systematic method of categorising and organising the qualitative data. Thematic analysis is a useful and flexible analytic method to analyse qualitative data. Thematic analysis searches for themes or patterns, analyses them, and then reports on them (Braun & Clarke, 2006). The researcher was assisted by an independent coder who also analysed the data sets. Themes and sub-themes were finalised after consensus discussions with the independent coder, researcher and the study leaders.

Braun and Clarke (2006) advocate for the use of the following six phases in analysing the data during thematic analysis:

1. Familiarising yourself with the data through the transcriptions of the verbal data, by reading the data while making notes and then re-reading the data.
2. Generating initial codes to identify a feature of the data that appears interesting to analyse and that can be assessed in a meaningful way regarding the phenomenon.
3. Searching for themes and sorting the initial code list into potential themes.
4. Reviewing themes and refining them against the entire data set.
5. Defining and naming themes and further refining the themes, as well as writing a detailed analysis that describes the true meaning of each theme.
6. The final analysis and writing of the report to tell the complicated story of the data in a logical and interesting way focusing on the prevalence of the theme(s).

The primary research question: *How can a literature review and empirical study inform the formulation of guidelines for trauma-sensitive social work forensic assessments?* remained the focus in analysing the data. Unique abstracts from the data were quoted as evidence of the trauma-

causing factors of CSA. This evidence was analysed in a practical way for FSWs to implement in their assessments with children. Consultations with the primary researchers who conducted the primary study took place on a regular basis to ensure that the findings were representative and a true reflection of what happened during the group sessions. Consensus discussions with an independent coder were held on a regular basis to verify any inconsistencies in the findings.

1.6.2.8 Trustworthiness of data

According to Connelly (2016), "trustworthiness of a study refers to the degree of confidence in data, interpretation and methods used to ensure the quality of a study" (p. 435). Thus, if research can be regarded as trustworthy, it will contribute usefully to the field of research. The trustworthiness of research is judged according to its credibility, dependability, confirmability, and transferability (Connelly, 2016). Credibility is the most important criteria in trustworthiness and it can be defined as the confidence in the truth of the study and the research findings (Connelly, 2016).

Table 4: Trustworthiness

Credibility	• Findings were verified by the study leaders who are experienced in the field of CSA in South Africa. • An independent coder was used.
Dependability	• Process notes were kept during the study to document decision making processes. • The study leaders screened the information collected during the analysis. • An example of theme development is depicted in the audit trail (Addendum 5).
Confirmability	• The findings were peer-reviewed by the study leaders who are experts in the field of CSA.
Transferability	• The research topic and methodology were made available to other researchers to apply to their context of work.

The trustworthiness of this study was ensured by allowing the findings to be verified by the study leaders who are experienced in the field of CSA. According to Connelly (2016), the dependability refers to the stability of the data over time and over the conditions of the study. The dependability in this research was done by keeping process notes and involving the two primary researchers in the screening of the information collected during the analyses. Confirmability refers to the degree to which the results of an inquiry could be confirmed by other researchers (Connelly, 2016). For confirmability in this research, the findings were peer-reviewed by the primary researchers who are experts in the field of CSA.

This study employed QSA and, as such, makes use of existing data that was obtained through ethically accepted and approved standards. The researcher aimed to stay empathetic and neutral to the evidence and data and strived to be non-judgemental in approaching the data. A systematic approach was followed in reading and understanding the data and it was done consecutively to make sure that the data was interpreted correctly. Participant quotes were used in the research to indicate the specific trauma-causing factors that were discussed. The researcher made use of regular consultation sessions with her supervisors who are experts in the field of CSA. An independent coder was also used. This all ensured that data analysis and interpretations were clear and credible.

1.6.3 Step three: Formulation of guidelines

1.6.3.1 Definition of guidelines

Rosen and Proctor (2003) define guidelines as a set of methodically compiled statements that consist of empirically-tested knowledge and procedures to help professionals select and implement the most appropriate and effective interventions for the most desired outcome. Guidelines can further be described as a series of steps to be followed towards the appropriate challenge, using professional expertise based on evidence-based research findings, whilst considering the client's unique circumstances and characteristics (Lucio & Nelson, 2016).

1.6.3.2 Definition of social work guidelines

In the social work context, Kirk (1999) refers to guidelines as the use of specific treatment recommendations, applying evidence-based social work treatment methods, within the background of organisational processes and procedures to support therapy and recovery whilst addressing the client's symptoms and challenges directly. Rosen et al. (2002) refer to social work

guidelines as a set of knowledge statements to assist practitioners and clients in finding, selecting, and using the most appropriate therapy or intervention for client-specific circumstances.

Since the literature review of this study revealed that very limited guidelines in forensic social work is available, the purpose of developing guidelines can be regarded as managing basic challenges of social work practice, namely, encouraging FSWs to use evidence-based and appropriate knowledge in the form of guidelines to successfully conduct forensic assessments and to further encourage knowledge development that can be utilised in forensic social work practice. As literature (Rosen & Proctor, 2003) distinguishes between practice standards and practice guidelines, guidelines allow for greater flexibility, as the FSW can implement these guidelines according to their own knowledge as well as the child's specific circumstances.

The research question driving this part of the study is:

> *How can guidelines be formulated from the empirical findings and the literature review, so as to reflect a trauma-sensitive approach and integrate and acknowledge the role and duty of the forensic social worker in South Africa?*

The guidelines were formulated so as to inform trauma-sensitive social work forensic assessments, which were deduced from the empirical findings and the literature review, using three principles (recognise, respond, and report) which reflect a trauma-sensitive approach and integrates as well as acknowledges the role and duty of the forensic social worker in South Africa.

1.7 Ethical considerations

Prior to commencement of the research, ethical approval was gained from the Health Research Ethics Committee (HREC) of the North-West University (NWU) to obtain permission and ethical clearance to conduct this study (Addendum 1).

For the QSA, the researchers of the primary study obtained informed consent from participants in the two S2T groups (2014-2018). Confidentiality and anonymity were assured in the primary study by not mentioning the names of the participants in the transcripts. The audio recordings were further locked in a secure location at the Social Work building of the NWU, Vaal Triangle Campus, as stipulated in the Health Professions Act 56 of 1974 (Department of Health, 2006). The participants voluntarily participated in the primary study. They further gave consent that the data may be used by other researchers in future QSA studies. Rubin and Babbie (2016) note that when

this data is used in other studies, it exempts the participants from further possible traumatisation or anxiety triggers. This researcher also obtained written consent from the primary researchers to use the existing data sets for the purpose of conducting QSA in this research study (Addendum 3).

1.8 Summary of findings

1.8.1 Step one: Literature review

The literature review identified a research gap and revealed that limited literature is available regarding forensic social work in general as well as trauma-causing factors within the South African context. Inadequate information regarding doing forensic social work assessments whilst acknowledging the cultures of different ethnic groups is available. Furthermore, guidelines to do forensic social work assessments in the unique South African context is also not readily obtainable. The literature review further identified the conceptual framework for this study, that included: 1) theory and principles of a trauma-sensitive approach, 2) the Traumagenic Dynamics Model of Finkelhor and Browne (1985); and 3) context-specific trauma-causing factors, namely: family-, abuse-, and child-specific factors.

1.8.2 Step two: QSA

The findings from the two S2T data sets correlate with the three main themes found in literature regarding the context-specific trauma-causing factors experienced by children during CSA, namely the family-, abuse-, and child-specific factors. Additionally, parentification, not categorised internationally under the abovementioned themes, was identified in this research. The findings further supported the Traumagenic Dynamics Model of Finkelhor and Browne (1985), and contributed to the global knowledgebase on trauma-causing factors and the negative outcomes of CSA.

1.8.3 Step three: Formulation of guidelines

Guidelines to do trauma-sensitive social work forensic assessments were formulated in this part of the study by contextualising the findings from the empirical study within the literature review. A trauma-sensitive approach was incorporated with the trauma-causing experiences and negative outcomes of CSA to inform the guidelines. The guidelines were formulated in the framework of recognising, responding to, and reporting (3-R) the emotional and behavioural messages that the child relays or presents during the forensic assessment in order to enable FSWs to conduct forensic

assessments in a trauma-sensitive manner. The guidelines were further formulated to be used specifically in the uniquely South African context.

1.9 Limitations of the study

1.9.1 Step one: Literature review

Regarding the literature review, only studies that were done in English were used and, therefore, valuable research done in other languages may have been overlooked. The use of certain search terminology by the researcher may have restricted the scope of identifying valuable resources, but the researcher did try to counteract this limitation by using various different search terms.

1.9.2 Step two: QSA

The generalisability of the results was limited as a result of the small sample size of participants in the two S2T intervention treatment groups that were used as data. Furthermore, the fact that secondary data is used in QSA can be regarded as another limitation as the data was not gathered to answer the research question for this study. Data may thus not include comprehensive information and experiences relating to the specific research question, namely the trauma-causing factors relating to CSA. The data was obtained from adult women, and therefore, their reflection on the trauma they suffered as a result of CSA that they experienced as small children may have, over time, lost certain aspects and intensity. A further limitation is that only women and not men were included.

1.9.3 Step three: Formulation of guidelines

As the proposed guidelines were formulated from the empirical study in this research, only the trauma-causing factors and related symptoms that became evident in this research were used. The framework for formulating the guidelines was further based on a trauma-sensitive approach and a FSW nature and role and, therefore, does not include all possible trauma-causing factors or symptoms that traumatised children can present with. If the data was obtained from children, they maybe could have reported different or additional trauma-causing factors or symptoms that could have then been incorporated in order to establish more comprehensive guidelines.

1.10 Contributions of the study

1.10.1 Step one: Literature review

This literature review offered a deep understanding of the complex nature of CSA and provided rich evidence of the trauma-causing factors and negative outcomes in the context of CSA by incorporating the Traumagenic Dynamic Model of Finkelhor and Browne (1985) with context-specific factors, namely, family-, abuse- and child-specific factors. The literature review also contributed to an in-depth understanding of the trauma-sensitive approach used in doing forensic social work assessments. A research gap was further identified in the literature review as limited research is available regarding trauma-causing factors as a result of CSA in the South African context as well as guidelines to conduct trauma-sensitive social work forensic assessments in South Africa. This research gap can thus be utilised for future research.

1.10.2 Step two: QSA

To the researcher's knowledge, this QSA study further provided the first known summary of reports of trauma-causing factors as arising from the data sets of groups 2 and 3 of female South African participants of the S2T strengths-based group intervention programme. Although Finkelhor and Brown's (1985) Traumagenic Dynamics Model was acknowledged and used as a valuable framework for this research, this study indicated that trauma-causing factors can also be categorised in other themes, namely child-specific factors, family-specific factors, and abuse specific factors. Furthermore, the findings from the secondary analysis emphasised the importance of conducting research in the uniquely South African context were cultural influences play an important role. Parentification, as a contributing factor to more trauma-related symptoms were identified where the child must take the mother role upon themself in the absence of a strong mother figure. This exceptional South African scenario is not often referred to in existing literature.

1.10.3 Step three: Formulation of guidelines

As limited guidelines for forensic social workers practicing in the South African context could be found in literature, these proposed guidelines will hopefully guide these professionals to do forensic assessments in a trauma-sensitive way as well as assist them to work in this challenging field.

1.11 Layout of the study

Table 5: Layout of the study

Section A	Overview of the study		
Section B	Step one	Step two	Step three
	Literature review	Qualitative secondary analysis	Guideline formulation
Journal publication	No publication	Health and Social Care in the Community	Journal of Child Sexual Abuse
Addenda		Addendum 6	Addendum 7
Section C	Conclusions, Limitations, Recommendations, and Combined Reference List		

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SECTION B

PREFACE

Section B consists of three research reports each answering a secondary research question.

It is presented in a sequence from step one to step three.

1. **STEP ONE IS A LITERATURE REVIEW TO ANSWER SECONDARY RESEARCH QUESTION 1.**

The following secondary research question will be answered in step one:

> *What literature is available in order to better understand trauma-causing and contextual factors, resulting negative outcomes in the context of CSA and trauma-sensitive approaches?*

2. **STEP TWO IS AN EMPIRICAL STUDY NAMELY A QUALITATIVE SECONDARY ANALYSIS OF AN EXISTING DATA SET TO ANSWER SECONDARY RESEARCH QUESTION 2.**

Step two will answer the second secondary research question, namely:

> *What traumatic experiences and negative outcomes of childhood sexual abuse were reported by women survivors who participated in S2T group treatment intervention sessions can inform trauma-sensitive social work forensic assessments?*

3. **STEP THREE PROPOSES GUIDELINES BASED ON THE LITERATURE REVIEW AND FINDINGS OF THE EMPIRICAL STUDY TO ANSWER SECONDARY RESEARCH QUESTION 3.**

Step three will answer the last secondary research question:

> *How can guidelines be formulated from the empirical findings and the literature review, so as to reflect a trauma-sensitive approach and integrate and acknowledge the role and duty of the forensic social worker in South Africa?*

All the research reports have been prepared for publication apart from step one, which is a literature review. For the sake of consistency, the formatting remains consistent throughout, irrespective of the journal guidelines.

STEP ONE: LITERATURE REVIEW

This part of the study will consist of a literature review where international, as well as South African existing literature, will be studied.

The secondary research question that motivated this part of the study is as follows:

> *What literature is available in order to better understand trauma-causing and contextual factors, resulting negative outcomes in the context of CSA and trauma-sensitive approaches?*

2.1 Introduction

The aim of conducting the literature review in this study was to obtain a better understanding of trauma-causing factors and resulting negative outcome of childhood sexual abuse (CSA), as well as a conceptual framework: Finkelhor and Browne's (1985) Traumagenic Dynamics Model, influencing contextual factors (such as child-specific, family-specific, and abuse-specific factors); and theory and principles of a trauma-sensitive approach. In addition, the role and duties of forensic social workers when conducting forensic assessments were included.

In this section, the method and search strategy will firstly be explained. The prevalence of CSA will be examined and the impact and effects of CSA will be defined. The developmental phases of children will then be discussed and emphasis will be placed on the cognitive, emotional, and sexual development of children. Thereafter, the conceptual framework for this study will be debated, according to the Traumagenic Dynamics Model of Finkelhor and Browne (1985), in addition to contextual factors and the trauma-sensitive approach. The key terms and terminology and the scope of practice for specialised forensic social workers will then be explained. Lastly, attention will be given to forensic assessments.

2.2 Method

A literature review is normally done in order to provide an overview of recent as well as older research that has been done, which is relevant and research appropriate to the current proposed research question. Furthermore, a literature review identifies gaps in what has been researched and written on the topic and what has not (Maree, 2007; Rubin & Babbie, 2016). Hallberg (2010) further defines the purpose of a literature review to identify a suitable research design and a data

collection method. He further describes how the conceptual framework of a study is then conceptualised from the literature review.

The conducting of a literature review in this study aimed to gain a better understanding of trauma-causing factors in the context of childhood sexual abuse. Although the researcher wanted to conduct the research with an open mind, she regarded it necessary to start out with the understanding of the current knowledge base on the topic. As a literature review also defines a possible research gap (Rubin & Babie, 2016), the aim was further to explore what existing literature and guidelines are available in the forensic social work field, specifically in the South African context.

In preparation to conduct the literature review, the researcher attended training courses in this regard, namely: 1) a full week training in Research Methodology, which included literature reviews, presented by Prof. Wim Roestenburg, NWU Potchefstroom Campus, 21-25 January 2019 as well as a full day, once monthly, research class presented by Prof. Wim Roestenburg for the period February 2019 – August 2019; 2) Online Tutorial: Search Strategies, INASP, 23 November 2019; and 3) an online workshop: Scoping reviews, 6 August 2020, presented by Mrs Brits and Mrs Kays-Ebrahim, NWU, Vaal Triangle Campus.

2.3 Search strategy

The literature review was conducted by developing a search strategy, which firstly included identifying key-words followed by systematically searching different electronic databases to obtain relevant previous research information regarding the current research topic.

2.3.1 Keywords

The following keywords were used to identify relevant literature: (*childhood sexual abuse* OR *child sexual abuse* OR *childhood sexual assault* or *child sexual assault*) AND (*forensic social work assessments* OR *forensic assessments* OR *social work assessments* OR *forensic social work interviews* OR *forensic interviews*) AND (*trauma-causing factors* OR *trauma factors* OR *traumagenic factors* OR *traumagenic dynamics*) AND (*trauma-sensitive* OR *trauma-informed* OR *trauma-sensitive approach* OR *trauma-informed practice*) AND (*guidelines* OR* forensic social work guidelines* OR *social work guidelines* OR * forensic guidelines*) AND (*qualitative secondary analyses*) AND (*South Africa*).

2.3.2 Databases

Databases searched were Google Scholar and EbscoHost.

2.3.3 Screening and selection of articles

The researcher firstly screened the title and abstract of the article and if the information seemed appropriate to the research, the full-length article was studied. The reference lists of identified articles were also used to guide the researcher to more relevant information. After the appropriate articles were identified, the article and author(s) names were downloaded through Endnote in keyword-specific folders to enable the researcher to gain easy access to keyword related information. Many of the appropriate and often used full-length articles were downloaded and were saved in a specific folder on the researcher's computer. The relevant full-length articles were studied by the researcher whilst highlighting the appropriate sections of the article in order for easy screening when the information was needed. The researcher also employed the use of her own as well as library academic books to broaden the scope of literature used.

2.4 Contextualising *child sexual abuse*

In order to provide context of the phenomenon of CSA, a definition and discussion on the prevalence and impact thereof will be presented.

2.4.1 Defining child sexual abuse

There is no universal definition to define CSA. Internationally, the agreement appears to be that CSA can be defined as: any unwanted or inappropriate act of sexual nature to a child under the age of 18 years with the perpetrator being at least five years older than the child (Stoltenborgh et al., 2015). In other words, CSA occurs when someone with an advanced knowledge, age or power engages a more naïve, vulnerable or weaker person into a sexualised relationship with or without the consent of the younger person. Sexual abuse also includes any touching by an adult of a child's body when the adult's purpose or motive for the touching is to arouse or gratify the adult's sexual desires (Kenny, 2018; Littleton et al., 2018).

The World Health Organisation (WHO, 2017), further defines CSA as a sexual activity where a child or adolescent is involved in an activity that is not accepted by society. Furthermore, the child is not competent to understand the activity, the child is not developmentally and/or cognitively prepared for the act and the child cannot give consent to such an act. These acts include a range of

activities such as intercourse, attempted intercourse, oral-genital contact, fondling of genitals above or under clothes, exposing children to sexual activity or pornography and the exploitation of a child for prostitution or pornography (Singh et al., 2014).

In South Africa, sexual abuse is defined according to the *Criminal Law Sexual Offences Amendment Act* 32 of 2007. This law states that:

> sexual abuse occurs when any person engages a child (a person under the age of 18) with or without the consent of the child, in a sexual act. A sexual act is defined as an act of sexual penetration or an act of sexual violation. Sexual penetration can be seen as any sexual form of penetration to any extend whatsoever by the genital organ, any body part and/or object by one person into, or beyond, the genital organs, anus or mouth of another person.

The *Criminal Law Sexual Offences Amendment Act* 32 of 2007 further states that:

> sexual violation includes any act which causes direct or indirect contact between the genital organs, anus or breasts of one person and any part of the body of another person, including any object resembling or representing the genital organs or anus of a person or animal; the mouth of one person and the genital organs, anus, breasts or mouth of another person; any other part of the body of another person that could cause sexual arousal or stimulation; masturbation of one person by another person; insertion of any object resembling or representing the genital organs of a person or animal, into or beyond the mouth of another person.

For the purpose of this research since a South African data sample will be used, sexual abuse will be understood in terms of the abovementioned Act.

2.4.2 Prevalence of CSA

Extensive studies show that CSA is an international problem of considerable extent, which affects the lives of millions of children. Stoltenborgh et al. (2015) conducted a comprehensive meta-analysis where they combined prevalence figures of CSA from 217 publications, including 331 independent samples with a total of 9 911 748 participants. They found the global prevalence of CSA between 18-21.1% amongst girls and 7.6-13.8% amongst boys. Child sexual abuse cases involving girls is the highest in Australia at 21.5% and the highest for boys in Africa at 19.3%.

Figure 1 summarises the prevalence of CSA globally:

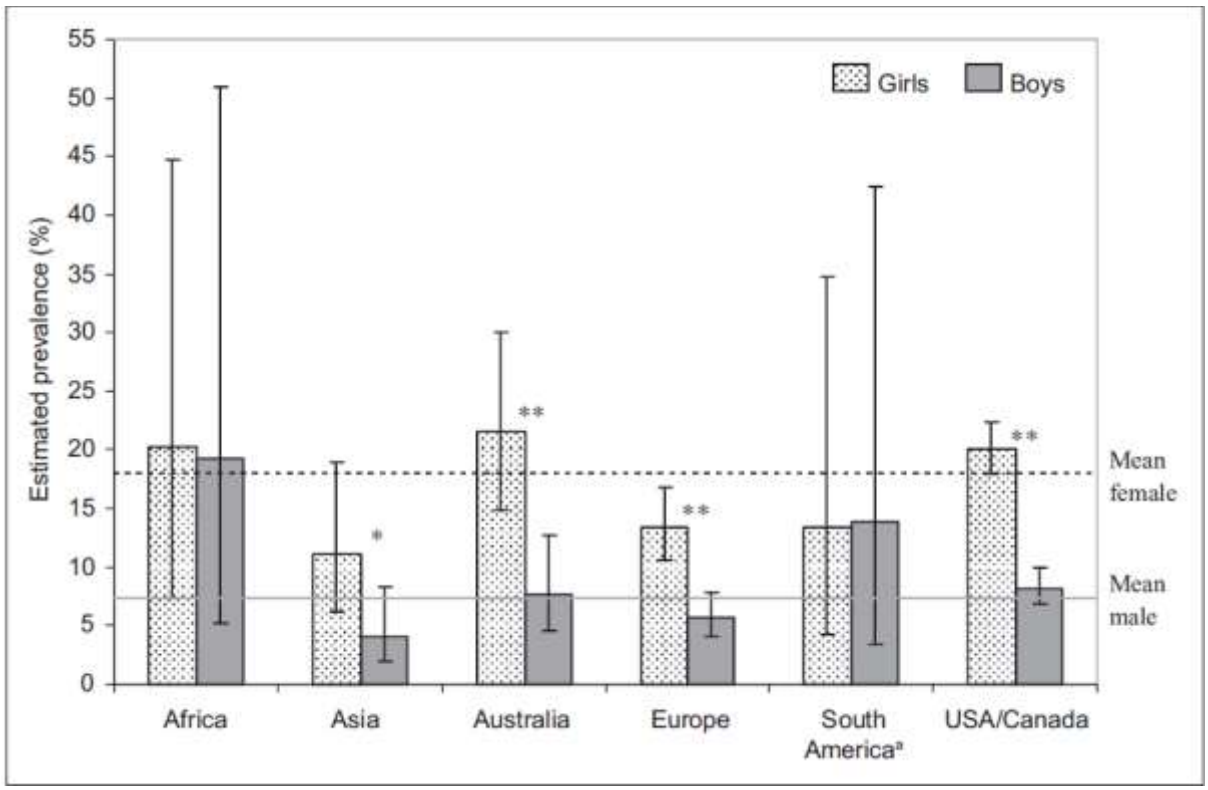

Figure 1: Global prevalence of CSA (Stoltenborgh et al., 2015, p. 87)

Furthermore, the WHO (2017) also found that the combined prevalence rate for boys and girls is the highest in Africa (Pereda et al., 2009). In addition, a survey by Ige et al. (2012) found that the prevalence in Nigeria is 25.5% for girls and 43.1% for boys. Similarly, high statistics have been reported in Tanzania, indicating at least one incident of sexual abuse before the age of 18 years being reported by one in seven boys and one in three girls (Ige et al., 2012).

The extensive statistics that are available internationally for CSA, vary considerably and cannot always be directly compared or generalised. Reasons for this may be that no universal definition for CSA exists, as was explained previously under the section "Child sexual abuse defined." Another reason may be the documented differences in methodology. However, all statistics suggest that CSA remains a global problem of distressing concern (Barth et al., 2013; Korkman et al., 2019; Pereda et al., 2009).

The first national representative study on the prevalence of CSA in South Africa, was conducted by the Optimus Foundation (Artz et al., 2016). Their survey found that between 18 000 and 20 000 CSA cases are reported to the police annually. They further state that one in three children reported

some form of sexual abuse by the age of 18 years. Boys reported higher lifetime prevalence rates of sexual abuse (36.8%) compared to girls (33.9%). Furthermore, in South Africa, black children had the highest risk of sexual abuse at 35.7%, as opposed to coloured[2] children at 35.4%, white children at 27.1% and lastly Indian children at 25%. Another South African study that was done in the Eastern Cape Province of South Africa, found that 39.1% of women and 16.7% of men had reported CSA (Jewkes et al., 2010). According to the South African Police Service statistics (2018), 23 488 sexual crimes against children were reported in South Africa from April 2017 to March 2018. It is clearly seen from the above-mentioned references, that CSA in South Africa estimates to be in the vicinity of over 20 000 cases per annum. These figures are even suspected to be higher, as it is only estimated that one out of nine cases of CSA is reported to the police (Jewkes et al., 2010). It is clearly seen from the above documented literature that CSA, internationally as well as in South Africa, is very concerning and is a global traumatic phenomenon.

2.4.3 Impact and effects of CSA

A body of research found that the effect and impact of CSA is very complex and manifests in a wide range of negative symptoms and behavioural problems in adulthood. Negative symptoms and behavioural problems include mental-health difficulties such as depression, anxiety, personality disorders, and post-traumatic stress disorder (Dolan & Whitworth, 2013; Ullman et al., 2014). In addition, several researchers also report that survivors experience sexual problems, for example, sexual risk behaviours like prostitution and multiple sexual partners (Hodges & Myers, 2010; Walsh et al., 2014). Intimacy problems can also occur (Kenny, 2018). Furthermore, intrapersonal difficulties like low self-esteem, low self-concept, and body-image concerns, for example, eating disorders are experienced (Kerlin, 2013; Louw & Louw, 2014). Interpersonal difficulties, for example, relationship problems and communication problems can occur (Penning & Collings, 2014; Singh et al., 2014). Behavioural problems include, for example, lower academic performance and absence from school as well as violating the law (Louw & Louw, 2014; Singh et al, 2014). Although this research does not focus on the physical impact of sexual abuse, it is worth mentioning the extreme consequences that sexual abuse can have on a person's physical well-being, for example, early pregnancy or sexually transmitted diseases (Kenny, 2018).

[2] Internationally referred to as mixed-race ancestry

As seen from the previous section, the impact and effect of sexual abuse has long-term and devastating outcomes not only during childhood, but also that these effects may be carried into adulthood. The above-mentioned literature depicts the impact of CSA are experienced globally (Dolan & Whitworth, 2013; Hodges & Myers, 2010; Kenny, 2018; Singh et al., 2014) and has just as big an impact on the South African population (Louw & Louw, 2014; Mathews & Collin-Vézina, 2019; Penning & Collings, 2014), which is the focus of this research study.

Table 6 summarises the effect and impact of childhood sexual abuse:

Table 6: Impact of CSA

Category	**Findings**	**Country**	**Authors**	**Participants in study adults/children**
Mental Health	Depression	USA	Bucchianeri et al., 2014	Adolescents
		SA	Mathews et al., 2013	Children
		Global	Singh et al., 2014	Children
	Anxiety and panic disorders	Australia	Dolan & Whitworth, 2013	Adults
		USA	Kenny, 2018	Children
		SA	Louw & Louw, 2014	Children
	Personality disorders	Australia	Dolan & Whitworth, 2013	Adults
		SA	Mathews et al., 2013	Children
		Global	Singh et al., 2014	Children
	Post-traumatic stress	USA	Cowie, 2019	Children
		SA	Mathews et. al, 2013	Children
		SA	Ullman et al., 2014	Adults
	Guilt and anger	USA	Kenny, 2018	Children
		SA	Spies & Bezuidenhout 2006	Children
		USA	Van der Kolk, 2017	Children

Category	Findings	Country	Authors	Participants in study adults/children
Sexual Problems	Sexual risk behaviour Example: prostitution and excessive masturbation	SA UK Global	Mathews, et al., 2013 Martellozzo et al., 2016 Singh et al., 2014	Children Children Children
	Intimacy problems	USA SA USA	Hodges & Myers, 2010 Spies & Bezuidenhout 2006 Walsh et al., 2014	Adults Children Adults
	Re-Victimisation	USA SA SA	Kenny, 2018 Mathews et al., 2013 Penning & Collins, 2014	Children Children Adolescents
Intrapersonal Difficulties	Low self- esteem	SA USA Global SA	De Witt, 2016 Kerlin, 2013 Singh et al., 2014 Spies, 2006	Children Adults Children Children
	Self-concept	SA USA USA	De Witt, 2016 Kenny, 2018 Kerlin, 2013	Children Children Adults
	Body image concern and eating disorders	SA Global	Louw & Louw, 2014 Singh et al., 2014	Children Children
	Substance abuse	UK Global	Cowie, 2019 Singh et al., 2014	Children Children
Interpersonal Difficulties	Lack of trust	USA SA Global	Hodges & Myers, 2010 Penning & Collins, 2014 Singh et al., 2014	Adults Adolescents Children
	Relational problems and	UK	Balfe, 2019	Children

Category	Findings	Country	Authors	Participants in study adults/children
	insecure relations	SA	Van der Merwe, 2009	Children
	Communication problems	USA	Bucchianeri, 2014	Children
	Reduced social competence	USA Global	Kenny, 2018 Singh et al., 2014	Children Children
Behavioural Problems	Violation of laws and social conduct	SA Global SA	Louw & Louw, 2014 Singh et al., 2014 Spies & Bezuidenhout 2006	Children Children Children
	Lower academic performance and absence	SA SA Global	De Witt, 2016 Louw & Louw, 2014 Singh et al., 2014	Children Children Children
	Exhibition of violent behaviour	USA USA	Bal et al., 2014 Kenny, 2018	Adolescents Children
	Increased tendency to grow up as perpetrators	Australia USA	Dolan & Whitworth, 2013 Kenny, 2018	Adults Children
Physical Problems	Vaginal bleeding and infections	USA USA	Kenny, 2018 Kelly & Curran, 2019	Children Children
	Urinary tract infections	USA USA	Kenny, 2018 Melmer & Gutovitz, 2017	Children Children and Adolescents
	Sexually transmitted infections	USA USA	Bechtel, 2010 Hornor, 2017	Children and Adolescents Children
	Early pregnancy	USA USA	Kenny, 2018 Melmer & Gutovitz, 2017	Children Children and Adolescents

The following table is also a summary of the impact of childhood sexual abuse compiled by Kenny (2018). Finkelhor and Browne's seminal model (1985) has also been taken into consideration when this summary was compiled. This table gives specific attention to the impact of trauma over a specific period of time:

Table 7: Short and long-term effect of CSA (adapted from Kenny, 2018, p. 209)

Immediate effects	**Intermediate effects**	**Later effects**	**Outcomes**
-traumatic -sexualisation -betrayal -stigmatisation -powerlessness	-loss of self-efficiency -fears / anxiety -depression -regressive behaviour -acting-out	-self-blame -guilt -suppressed rage -hopelessness -loss of trust -social isolation	-PTSD / depression / suicidality -substance abuse -re-victimisation -poor academic / social / work / health / outcomes

In the previous section, the impact of CSA was discussed. In the subsequent section, the developmental phases of children will be explained, referring to cognitive, emotional, and sexual development.

2.5 Developmental phases of the child

In order to work with children, all FSWs should have a comprehensive knowledge and understanding of child development. The age and developmental phase of each individual child must be taken into consideration when a forensic assessment is conducted. The concept of child development does not have a single meaning and over the years many researchers have given their own meaning to the term. Development can broadly be described as a series of change over time from birth to death and can be divided into the following areas of development: physical development (growth and physical changes in the body); cognitive development (thinking processes); emotional development (internal feelings and reactions); social development (a child's behaviour influenced by other people); moral development (a child's values and norms) and personality development (all the characteristics of the individual that influences their behaviour and interaction with their environment) (De Witt, 2016; Louw & Louw, 2014). The aforementioned researchers further state that development in the different areas is interrelated and

also child specific, meaning that each child develops according to their own potential and characteristics. Initially, when Child Development was regarded as a field of science, many theories by different researchers were developed in this regard (Lourenço, 2016; Louw & Louw, 2014; Schlein, 2016). A theory can be seen as an organised set of ideas that is developed to give meaning to and make predictions about development (Lourenço, 2016; Louw & Louw, 2014; Schlein, 2016). For the purpose of this study, two of the many influential theories concerning child development will be discussed, namely Piaget's cognitive development theory (1936) and Erikson's psychosocial theory (1950).

2.5.1 The cognitive development of children

2.5.1.1 Piaget's four stages of cognitive development

Jean Piaget (1896-1980) describes cognitive functioning as a child's natural interaction with their environment in order to make sense of how their world works on both a physical and social level (Feldman, 2004; Lourenço, 2016; Louw & Louw, 2014). This theory specifies that a child moves through four stages of cognitive development, namely: sensorimotor, preoperational, concrete operational, and formal operational (Bart, 2004; Feldman, 2004; Kesselring & Müller, 2011). The progression from one phase to another is always a gradual process and a child may still present with characteristics from the previous stage whilst already moving to the next stage. For the purpose of this research, only the preoperational and concrete operational phase will be discussed, as according to literature (Fouché, 2008; Smith, 2014) the majority of children that are sexually abused are in middle childhood, which falls within these specific phases.

Table 8: Piaget's four stages of cognitive development

STAGE	APPROXIMATE AGE	CHARACTERISTICS
Sensorimotor	Birth to 2 years	• Sensory and motor adjustments that allow infants to exercise some control over the environment.
Preoperational	2 to 7 years	• Start to use language (words) and symbols (pictures and drawings) and symbolic play. • Knowledge is still very much tied to own perceptions and egocentrism.
Concrete operational	7 to 11/12 years	• Logical thinking develops. • Capable of thought processes but only on a concrete level. • Can manipulate categories, classifications and hierarchies into groups.
Formal operational	12 and older	• Abstract level of thinking. • Speculates on hypothetical possibilities. • Conceptualises about many simultaneously interacting variables.

Summarised from de Witt (2016, p. 15); Lourenço (2016, pp. 123-127); and Louw and Louw (2014, p. 26).

2.5.1.1.1 Preoperational phase

This phase is mainly characterised by illogical thinking, being egocentric, language development, symbolic thinking and playing, and the ability to only focus on one aspect at a time (De Witt, 2016; Lourenço, 2016; Louw & Louw, 2014). Some of the most important aspects from this phase that will directly influence the outcome of the forensic assessment, will now be discussed:

- **Centration:**

Centration is described by Kesselring and Müller (2011) as the tendency of a child to only focus on one aspect of what they observe and to ignore the rest. As such, during the assessment, the forensic social worker must make sure that the child only focuses their attention on the question that is asked, and not be side-tracked by other activities or stimuli in the room.

- **Realism:**

Realism is a term used by Piaget (1936) to describe a child's inability to distinguish between emotional and physical occurrences, and what is internal and external (Bart, 2004). Children in this phase will, for example, regard thinking and speaking as the same act (De Witt, 2016). The forensic social worker must not use abstract terms and only name concrete emotions, for example, sad, angry, happy, etc. The FSW must further ensure that what the child says is what they mean. If the child, for example, uses specific words for body parts, the FSW should ask them to clarify what these words mean.

- **Causality:**

The preoperational child's inability to understand cause and effect is described by De Witt (2016) as causality. The child cannot distinguish between cause-and-effect meanings of "why" and therefore the FSW cannot ask "why" questions during the assessment.

- **Transductive reasoning:**

This refers to the child's reasoning from one situation to another that occurred close together, whether it is logical or not (Feldman, 2004), for instance, when a child's parents get divorced, the child may think that it was because they were naughty. During the forensic interview, the child can, for example, relay that the sexual abuse occurred because they were responsible for that by visiting the perpetrator. The FSW must further be aware that the child does not have the narrative abilities of an adult and therefore inconsistencies in their description of the events can occur.

- **Syncretism:**

Syncretism refers to the grouping of non-related facts or ideas together in a confusing manner (Feldman, 2004; Lourenço, 2016). A child can thus relay facts together about the sexual abuse on their own subjective and egocentric judgement, although the facts or incidents do not belong together. This can have the consequence of not relaying accurate information during the forensic assessment.

- **Symbolic play:**

During symbolic play, children use their imagination and pretend that they are someone else (Louw & Louw, 2014). This can be used during the assessment where a child can be asked to play out their experiences.

The preoperational phase can, therefore, be summarised as a phase in which children start to form their own ideas about the world around them but their ideas are still basic and not logical. The forensic social worker must thus be well aware of the way in which children verbalise their cognitive thoughts, so as to prevent the relaying of incorrect facts and information during the assessment.

2.5.1.1.2 Concrete operational phase

Forensic social workers with extensive knowledge of and experience in the field, reported that the majority of sexual abuse cases in the South African context are reported in middle childhood (Fouché, 2008; Smith, 2014). Middle childhood is described as the period of approximately six to twelve years of age and correlates with Piaget's (1936) concrete operational phase, as it is an important period of cognitive, social, emotional and self-concept development, where the child begins to form a better understanding of their world (De Witt, 2016; Louw & Louw, 2014). As most forensic assessments are conducted in this age group, certain tasks that a child must cognitively achieve in the concrete operational phase will now be discussed.

- **Classification / Decentration**

Classification or decentration refers to the grouping together of certain objects or organising characteristics together that have the same properties (Bart, 2004). Classification/Decentration implies that a child in the concrete operational phase can also understand multiple classifications, meaning that they can classify objects on more than one dimension, for example, size, colour and shape or that one problem can have more than one answer (Lourenço, 2016). A child can thus focus on more than one aspect of a situation simultaneously, which means that during the forensic assessment the FSW can ask the child for more detail regarding the abuse (Fouché, 2008). The child will be able to give information regarding the context in which the abuse took place, as well as give detailed and descriptive information regarding the physical surroundings in addition to both the reactions and emotions of the alleged perpetrator and the victim themselves (Smith, 2014).

- **Conservation**

Conservation is the ability to understand that certain characteristics of an object remain the same regardless of the transformation it undergoes. This refers to properties such as length, volume, quantity and mass of an object (Feldman, 2004). A well-known conservation experiment as cited by Louw and Louw (2014) which is conducted by pouring the same volume of water in two identical glasses so as to show that each glass will appear exactly the same, and then continues where water from one glass is then poured into a taller and narrower glass, will appear for a child in the pre-operational phase that the taller glass contains more water. However, a child in the concrete operational phase will understand that it is still the same volume of water. This experiment also illustrates reversibility, when the child can visualise that the water, once poured back to the original glass, will return to the same level as before (Louw & Louw, 2014). Thus, the implication of conservation and reversibility during the forensic assessment means that a child that has mastered this concept can relay and understand, for example, that the perpetrator's penis in its normal state looks different than his larger erected penis but it is still the same penis (Smith, 2014).

- **Declining egocentrism**

According to Piaget (1936) young children have the tendency to view the world from their own perspective and they do not recognise that other people have different viewpoints (Kesselring & Müller, 2011). The aforementioned researchers further state that during the concrete operational phase, children socialise more with friends and learn that their friends have their own opinions and they start to see things from someone else's perspective. According to Fouché (2008) children in middle childhood might still be egocentric and as a result, may experience feelings of guilt as they feel responsible for the abuse or blame themselves for not doing something to stop or prevent the abuse. Children might also be manipulated by the perpetrator to keep quiet about the abuse because of their feelings of guilt concerning the consequences that the perpetrator might suffer as a result of their disclosure (Smith, 2014). It is thus important to take the declining in egocentrism into consideration during the forensic assessment, as this may inhibit a child from disclosing the sexual abuse as a result of the consequences it may have for their family as well as the perpetrator.

In the above discussion, it was demonstrated that the advanced cognitive development of children in the concrete operational phase enables them to communicate effectively about their sexual abuse experience. Thus, these children can relay accurate and detailed information, but still only on a

concrete level and only information that is direct and real. They thus still have the inability to think abstractly and hypothetically.

In the following section, the emotional development of children will be discussed.

2.5.2 The emotional development of children

2.5.2.1 Erikson's stages of emotional development

In order to grow and function optimally, children must master certain emotional developmental stages. The FSWs must be well aware of these stages, as a child who experiences trauma, like sexual abuse, may often regress to previous behaviour patterns (Spies & Bezuidenhout, 2006). Erikson (1950) divides a child's emotional development into five stages (Abshor, 2017; Louw & Louw, 2014). Each stage is characterised by a crisis where the child must orientate themselves between two poles in their interaction between themselves and society. Once this crisis has been mastered, they can move on to the following stage. The five stages of a child's emotional development are as follows:

- **Infancy: Age 0 to 1 year**

Crisis: Basic trust versus mistrust (Develop: hope)

A baby is born as a helpless infant and must develop feelings of basic trust in themselves, their parents and the world whilst at the same time overcome a feeling of basic mistrust (Schlein, 2016). A child's relationship with their mother or caregiver is of utmost importance in the development of trust and is based on the quality of nurturing and care that they receive from their parents (Erskine, 2019). Should the infant receive constant and responsive care from their parents, this will result in them learning to trust their world in general (Fouché, 2008). A healthy balance between trust and mistrust will develop over time where a child will start exploring new situations. When these situations are handled badly, children will feel insecure and will mistrust their environment. It is thus important that a child, during the forensic assessment, feels emotionally secure in order to be able to share information about their traumatic sexual abuse experience.

- **Toddler: Age 1 to 3 years**

Crisis: Autonomy versus shame and guilt (Develop: will-power)

During this stage, a toddler develops more muscle control, which enables them to become more independent and gives them a sense of autonomy (Jeti & Yusuf, 2018). This physical development and being able to move around freely brings them into contact with rules, which can lead to the possibility of failure, leading them to doubt their own abilities and to experience shame (Abshor, 2017). Parents should, therefore, encourage their child to be independent, but at the same time protect them from unnecessary feelings of guilt, shame and failure. Fouché (2008) is of the opinion that a child must be given the opportunity to make choices during the forensic assessment. This will then give the child a sense of independence and control, and by making choices, the child will learn to accept responsibility for their own behaviour.

- **Early childhood: Age 3 to 6 years**

Crisis: Initiative versus guilt (Develop: purpose)

De Witt (2016) describes how a child in this age group develops a sense self-worth while busy mastering the environment around them. During this period, an important task of learning is to show initiative while avoiding feelings of guilt. The child's greater freedom of movement and independence allows them to explore their environment with added purpose. The child can sometimes find themselves in new situations with unfamiliar rules and once these rules are transgressed, they may be left feeling guilty (Schlein, 2016). Balanced emotional development in this stage thus means the purposeful and confident striving for goals, without feeling guilty or taking initiative that could offend others. Fouché (2008) states that the FSW can set boundaries during the assessment, whilst still encouraging the child to take initiative and experience purpose without feeling guilty.

- **Middle childhood: Age 6 to 12 years**

Crisis: Industry versus inferiority (Develop: competence)

This stage usually covers the biggest part of the child's primary school years. Children master new skills at home, in school, and in the world in general that equip them for later life (Erskine, 2019). The influence of their parents become less and that of the teachers and peers become more important. Being successful in handling these situations can result in good feelings, but failure may have a negative impact on the child's self-concept (Jeti & Yusuf, 2018). In the forensic assessment environment, Fouché (2008) reports that children must be exposed to age-appropriate mediums and activities that will strengthen the value of their own abilities with the result of

enhancing their sense of self-worth. Age appropriate interview media that can be used during forensic assessments are, for example, free drawings, body outline diagrams or anatomical drawings (Faller, 2007; Lamb et al., 2018). It must be clearly mentioned that these media or tools must be acknowledged in the interview protocol as well as in the legal context.

- **Adolescence: Age 12 to 18 years**

Crisis: Identity versus role confusion (Develop: reliability)

During this stage, the adolescent goes through a crisis in order to try and establish a sense of identity. This identity crisis mainly consists of three components, namely: "*Who am I?*"; "*To which group(s) do I belong?*"; and "*What do I wish to achieve?*" (Spies & Bezuidenhout, 2006). In order to try and work out this identity crisis, adolescents experiment with various different roles, which can result in confusion. If this confusion is not resolved, Fouché (2008) indicates that this can result in them becoming unable to make decisions and choices regarding their role in life in general, but also regarding sexual orientation. The ultimate aim is, thus, to become sure of their identity while they are aware that there are other identity choices that they also could have been made. Forensic social workers must, therefore, remain cognisant that adolescents that have experienced trauma as a result of sexual abuse, may experience negative internalisations, for example, "I am powerless", "I am responsible" or "I am damaged" (Spies & Bezuidenhout, 2006). During the forensic assessment, the normal emotional development of a child must also be kept in mind, as children who have experienced trauma, may regress and the child's behaviour must not be interpreted or labelled as a difficult child or a defiant, lying child (Fouché, 2008).

Thus, in summary, the emotional age of children will influence the way in which they will conduct themselves during forensic interviews. As younger children find it more difficult to relay their emotions, older children have greater ability to share their emotions verbally (Newlin et al., 2015). In the next section, the sexual development of children will be discussed.

2.5.3 The sexual development of children

The FSW must have an advanced knowledge of the sexual development and sexual behaviour of children when doing forensic assessments. Normal sexual behaviour can very easily be interpreted as unacceptable behaviour or an assumption can wrongly be made that sexual abuse occurred. Literature concurs that the sexual development of children and their interest in sexuality is a continuous process throughout childhood, starting at a very young age and continuing right

through to adolescence (Flanagan, 2011; Kenny, 2018; Louw & Louw, 2014). Penile and clitoral erections by foetuses in utero have been reported as well as infant babies touching their genitals, and masturbation by children even as young as eight months old (Flanagan, 2011; Kuehnle & Connell, 2012; Mesman et al., 2019). During middle-childhood most sexual games are driven by pure curiosity and exploration, but as they grow older, children become more inhibited and socially informed regarding the context in which it is acceptable to express sexual behaviours (Vosmer et al., 2009). The sexual activity of adolescents is regarded as a normal consequence of physical development. They talk about sex and get more and more involved in sexual relationships with the opposite sex (Flanagan, 2011). Normal sexual development can be described as the discovery of a child's own sexuality in terms of their sexual needs, how to satisfy these needs as well as having the understanding of their gender role and successfully identifying with that (De Witt, 2016). Although normal sexual development can be defined, no consensus about what constitutes normal and abnormal sexual behaviour can be reached between professionals (Flanagan, 2011; Smith, 2014; Vosmer et al., 2009). To understand these different viewpoints, the factors that inform normal and abnormal sexual behaviour must be discussed. Louw and Louw (2014) are of the opinion that the norms and values of different cultures may influence the expression of sexual activity. Their view is supported by Vosmer et al. (2009) noting that the cultural context has a significant impact on which sexual behaviours of children is permitted and which behaviours are regarded as problematic. Kenny (2018) and de Witt (2016) describe that society also determines what sexual behaviour is socially acceptable or not. The child's own familial context also determines what is acceptable or not within the family rules and functioning (Balfe et al., 2019; Louw & Louw, 2014). Lastly, the professional's own values and assumptions can also influence their opinion on what is regarded as normal or abnormal sexual behaviour (Vosmer et al., 2009).

It thus became evident in the above-mentioned discussion, that most children engage in some form of sexual behaviour during childhood, which can be regarded as totally normal. Sometimes, the normal sexual development of children is faced with challenges due to various reasons and, thus, their healthy sexual development is compromised. The following table illustrates the normal and abnormal sexual behaviour of children.

Table 9: Normal and abnormal sexual behaviour of children

NORMAL SEXUAL BEHAVIOUR	ABNORMAL SEXUAL BEHAVIOUR
• Looking at own genitals • Looking at other's genitals • Touching own or other's genitals • Showing own genitals to others. • Talk and ask questions about sexuality Older children: • Show of interest in opposite sex • Looking at nude photos or pornography • Drawing sexual organs	• Sexual behaviour between children that are developmentally dissimilar • Sexual behaviour continues after reprimanded to stop • Constant attempts to observe people's nudity whilst intruding their privacy • When children ask to be touched or kissed in genital areas. • Initiate sexual activities with adults
Masturbation / Self-soothing: • -in private • -massaging of genitals or rubbing bodies against furniture or toys by infants or toddlers	Masturbation: • excessively • interfering with normal activities • with objects
Sexual play: • age difference less than 4 years • both consent • spontaneous • absence of force or coercion	Sexual play: • 4 years or more age difference • use of dominance or threats • when one or more of the following are involved: oral-genital contact; anal-genital contact; genital-genital contact; digital penetration of the vagina or anus; penetrating the vagina or anus with objects

Table summarised from Kuehnle and Connell (2012); Mesman et al. (2019); Smit (2014); Vieth (2018) and Vosmer et al. (2009).

Research has indicated that sexually abused children show more emotional and behavioural problems than non-sexually abused children, where the behavioural problems often manifest as sexually inappropriate behaviour or sexualised behaviour (Bal et al., 2004; Ige et al., 2012; Kuehnle & Connell, 2010). These researchers further refer to the "dose" effect and indicate that higher levels of sexualised behaviour are present in children who suffered more intrusive sexual abuse, threats or force, or a greater number of abusers. Other factors that were found to be related

to sexualised behaviour include being actively involved in the sexual abuse, the experience of sexual arousal during the abuse, visually watching the perpetrator in sexual acts, being groomed by the perpetrator, self-blame, as well as a history of physical and emotional abuse (Balfe, et al., 2019; Kuehnle & Connell, 2009; Steelhammer, 2003).

Developmentally inappropriate sexual behaviour or sexualised behaviour was, over time, broadly regarded in literature as possible indicators of sexual abuse (Balfe et al., 2019; Flanagan, 2011; Kenny, 2018; McInnes & Ey, 2019). The Traumagenic Dynamics Model of Finkelhor and Browne (1985) that is used as the conceptual framework for this research study, also indicates that age-inappropriate sexualised behaviour will be one of the adverse outcomes of sexual abuse (Finkelhor & Browne, 1985). Consequently, the diagnostic value of sexualised behaviour as an indicator of sexual abuse in forensic assessments is regarded as insignificant by another body of researchers (Everson & Faller, 2012; Poole, 2012; Vosmer et al., 2009). During assessments, the FSW must thus be cognisant of not misinterpreting the normal sexual behaviour of children or sexual behaviour originating from non-abuse sources as an indicator of sexual abuse. Very common non-abuse factors associated with raised levels of sexualised behaviour in children, is the exposure to adult sexual activities, such as nudity and pornography, as well as self-soothing behaviours (like masturbation) as a result of family problems and stress (Everson & Faller, 2012; Poole, 2012). It is further described in literature that many children who are sexually abused present no behavioural indicators to adults, which would raise concern and, therefore, the absence of behavioural change cannot be seen as an indicator that sexual abuse did not occur (Poole, 2012; Vosmer et al., 2009). In conclusion, it can be stated that during the forensic assessment, various alternative hypotheses must be tested to interpret the child's presenting sexual behaviour. The uniqueness of each child's individual context must be taken into consideration and a wide range of collateral sources must be investigated in order to verify the substantive evidence.

In the next section, a conceptual framework is provided for the study.

2.6 Conceptual framework for the study

The purpose of a conceptual framework is to have a broad understanding of theories and prior research findings that will assist and direct research and can be regarded as the anchor of a study (Maree, 2007). Although any sexual abuse ordeal is very traumatic for any child, the effect and degree of trauma experienced by the individual child, that subsequently may result in negative outcomes, will be influenced by a range of different contributing factors or dynamics. As such, a

single theory or model is not best in attempting to understand the trauma-causing factors in the context of CSA. Therefore, to create an understanding of the trauma-causing factors and resulting negative outcomes, the Traumagenic Dynamics Model of Finkelhor and Browne (1985) was used in addition to contextual child-specific, family-specific, and abuse-specific factors as reported in literature, so as to provide a lens through which to interpret and integrate the empirical findings in the formulation of the trauma-sensitive social work guidelines. In order to contextualise how the findings should be incorporated into a guideline, concepts from a trauma-sensitive approach are considered. The subsequent section discusses the model of Finkelhor and Browne as well as the contextual factors and the trauma-sensitive approach.

2.6.1 Finkelhor and Browne Traumagenic Dynamics Model

The trauma associated with CSA is unique and very complex. Earlier researchers, Finkelhor and Browne (1985), conducted seminal work on the trauma associated with CSA and proposed a more systematic understanding of the effects of CSA on victims resulting in CSA being contextualised as a unique and complex trauma. The framework further explains the resulting emotional, behavioural, and psychological difficulties associated with such traumatic CSA experiences. In their Traumagenic Dynamics Model, they conceptualised that four traumagenic dynamics, namely: traumatic sexualisation, betrayal, stigmatisation, and powerlessness are at the core of the psychological injury inflicted by abuse (Finkelhor & Browne, 1985).

Traumatic sexualisation explains a child's sexuality with regards to their sexual thoughts and behaviour that are developmentally inappropriate and interpersonally dysfunctional as a result of the CSA (Revell et al., 2008). The behavioural impact of traumatic sexualisation is widely known. Young children present with sexual preoccupations and repetitive inappropriate sexual behaviour such as masturbation or compulsive sex play. They also appear to show sexual knowledge and interests that are inappropriate for their age, especially young children who would otherwise not be troubled with such matters at their developmental stage (Van der Merwe, 2009). These behaviours may be carried over into adulthood. Adult women appear to display an aversion to sex, experience difficulty with arousal and orgasm, and appear to have negative attitudes towards their bodies and sexuality (Hodges & Myers, 2010).

Betrayal occurs when a child does not feel protected during the CSA ordeal or is not believed by a trusted adult when the abuse is disclosed. Betrayal can thus be the consequence of when a person they were attached to and dependent on, causes them further pain and harm (Hunter, 2015; Wang

& Heppner, 2011). Children do not only experience betrayal by offenders, but also by family members that have failed to protect or believe them (Hunter, 2011). Betrayal manifestation constitutes an intense need to regain trust and security and exhibits in excessive clinging and dependent behaviours. This behaviour is often in search of a relationship that will hopefully give back the trust that was taken away by the traumatic experience (Karakurt & Silver, 2014). Child victims of CSA may develop a misconception of moral standards when a significant adult betrays their trust through sexual manipulation (Henning, 2017). The effects of the betrayal may be carried over into adulthood in the form of impaired judgment by not recognising being vulnerable to abusive intimate and sexual relationships. Some people withdraw from intimate adult relationships due to mistrust and suspicion of the partner's motives (Human, 2015).

Powerlessness is described by Baker (2015) as a child's unsuccessful repeated attempts to avoid or halt the abuse. The child's personal body and mind space is repetitively invaded, controlled, and over-powered by the sexual abuser against the child's will. A major effect of powerlessness is fear and anxiety, manifesting in nightmares and phobias (Taylor & Norma, 2013). In adults, powerlessness is noted as depression and even suicidal thoughts as victims often feel unable to cope with their situations and environments (Baker, 2015; Valdez et al., 2013).

Stigmatisation refers to the negative self-image that a child develops as a result of the CSA, such as feelings of shame and guilt and being bad (Collin-Vézina et al., 2015). Children who keep the abuse secret, may increase their experience of stigmatisation as it reinforces their sense of being different and, as such, a low self-esteem may develop (Baker, 2015). When the sexual abuse is known to others, negative labels such as having poor morals and being "spoilt or damaged goods" are assigned to the child (Finkelhor & Browne, 1985, p. 533). As a result of such stigmatisation, certain losses are also experienced, such as the loss of childhood innocence and safety, which may result in long-term consequences and a struggle to cope maturely in a grown-up world. Adults may experience a loss of self-confidence, true character and identity, as well as a loss of happiness and freedom (Kays Ebrahim et al., 2018).

As such, the traumagenic dynamics can be used to enhance the understanding of sexually victimised children as well as to anticipate possible problems to which these children may subsequently be vulnerable to. In addition, the value of such knowledge concerning traumagenic dynamics can assist in the assessment and intervention of sexually traumatised children (Van der Merwe, 2009). Furthermore, the framework as proposed by Finkelhor and Browne (1985), is widely used among FSWs in South Africa, so as to inform their understanding of the trauma

experiences of child survivors of CSA and their court reports and expert testimony. Therefore, this valuable framework will be useful in building on the knowledge base so as to allow for forensic interviews to become more trauma-sensitive and will be incorporated with the contextual factors, discussed next, to be used as the conceptual framework for this research study.

2.6.2 Contextual factors

Sexual abuse can be regarded as very traumatic circumstances for any child, but the effect and degree of trauma experienced by the individual child will be influenced by a range of different factors or variables. Literature reports that these context-specific factors can be divided into three themes, namely: family-specific factors (focusing on the non-supportive response(s) of parents and significant caregivers or others to disclosure); abuse-specific factors (focusing on emotional manipulation and threats by the perpetrator); and child-specific factors (focusing on the child that is exposed to sexual activities they are not developmentally, emotionally or physically ready to cope with) (Kenny, 2018; Spies & Bezuidenhout, 2006; Yancey & Hansen, 2010). These different areas of the child's functioning are interdependent and the trauma of the abuse in one area will affect their other areas of functioning as well. These factors will now be described.

2.6.2.1 Family-specific factors

Family-specific factors are defined as those factors that are associated with other family members or significant other people in the child's life (Yancey & Hansen, 2010). These factors include parental reaction to the disclosure; parental support of the child; parental stress and coping; and other family stressors, for example, multi-problem families and domestic violence (Kenny, 2018; Spies & Bezuidenhout, 2006). It is important to investigate these family-specific factors as these are related to the adjustment of the child after the abuse and will have a direct influence on the level of trauma the child will experience. Yancey and Hansen (2010) are of the opinion that the support of the parent may even be more influential on the child's adjustment and level of trauma compared to factors related to the abuse itself. This opinion is shared by Godbout et al. (2014), mentioning that children with non-supportive parents experience higher levels of anxiety and trauma, irrelevant of the specific abuse-related factors. In the following section, family-specific factors that became evident in this research and have a direct influence on the child's level of trauma, are discussed.

- **Minimised or prevented disclosure:** Hunter (2015) regards disclosure in itself as a traumatic process for a child, with the additional level of traumatisation as a result of the

sexual abuse as a factor delaying the disclosure. He emphasises that the level of traumatisation that the child experiences must be regarded as the main factor in disclosing. Various researchers (Brits, 2020; Collin-Vézina et al., 2015; Spies & Bezuidenhout, 2006) state that the parent's initial response to the child's disclosure will have a significant impact on whether or not and to what extent the child will further disclose. A survey done by Lamb et al. (2011), reports instances where children clearly anticipated their parents' likely reactions to disclosure very well, mentioning that children who expected negative reactions, were less likely to further disclose. Lamb's research further identifies that the awareness of negative reactions from parents can be regarded as a barrier to disclosure, which results in the child not telling and living with the secret, contributing to the child's degree of trauma experienced. Many participants reported that the fear of consequences and negative reactions of their parents would prevent them from sharing their childhood abuse experience with their parents. Various research supports this factor as an inhibiter of disclosure (Allnock & Atkinson, 2019; Collin-Vézina et al., 2015; Hershkowitz et al., 2007). It is further demonstrated in literature (Cummings, 2018; Faller, 2007: Faller, 2015) that another core factor that predicts disclosure is the amount of support that the child receives from their parent whilst disclosing. In this regard, literature has demonstrated that only 37% of parents show a supportive reaction to disclosure, while 63% of parents are non-supportive (Lamb et al., 2011). Not only is the support from the parent important, but also the way that the child perceives this support and assistance. Support from the parents is an important factor in minimising the level of trauma that the child will experience. Clear evidence was found in this research, from analysing the participant quotes, that most participants did not have support from significant people in their lives and mentioned that they did not have somebody that they could trust. In the uniquely South African context, which includes a broad diversity of ethnic groups, the influence of cultural systems and beliefs also influence disclosure, as children are influenced not to talk about sexual abuse to outside people as the dignity or status of the family is of utmost importance (Rapholo, 2019).

- **Parents did not believe child:** A study done by Taylor and Norma (2013) indicates that 66% of their respondents specified a fear of not being believed by significant others. Hunter (2011) even describes the fear of not being believed together with the fear of being punished, as the two most powerful barriers to disclosure. In line with these findings, it is well known from literature (Alaggia, 2010; Hershkowitz et al., 2007; Hunter, 2011; Kenny,

2018) that not being believed when a child discloses can inhibit them from further disclosure. In order to take the step to disclose with the hope of being believed, it is necessary and important for the child to have somebody that they can confide in and trust. Hardy (2017) indicates that such a person is not always available due to a lack of close relationships with family members. Furthermore, being believed by the parent could increase the possibility for further disclosure, instead of possibly living with the secret even into adulthood, which results in compounding the trauma (Spies & Bezuidenhout, 2006). Kenny (2018) cites that a number of children encountered disbelief of their disclosure by mainly their mothers and grandmothers and that not being believed, after disclosure, in particular by the mother, intensified the trauma.

- **Parents denied abuse:** As highlighted in the previous section, parents not believing a child is closely related to their response of denying the disclosure. Children often experience direct disbelief from their mothers or other family members, as a result of them denying the abuse with the consequence of rejecting the child's disclosure (Taylor & Norma, 2013). Another form of denial takes place when the parent normalises or minimises the severity of the event or when the child is accused of not remembering the incident correctly or making up false allegations (Mayhall, 2012; O'Donohue & Benuto, 2012). When a significant adult reports that a child does not present with any symptoms, it can sometimes also be regarded as the parents denying the abuse (Yancey & Hansen, 2010).
- **Blamed for abuse:** Literature confirms that child victims are often blamed by their non-supportive significant adults for the sexual abuse that took place (Godbout et al., 2014; Miller & Cromer, 2015). Zinzow et al. (2010) further explain that the symptoms that the child experiences as a result of the blame, has more devastating effects on the child than the blame itself. Hunter (2015) further supports these findings by stating that blame, experienced from the significant mother, often leaves the child in a position to choose between their own well-being and that of the family, resulting in feelings of hatred and anger towards their mother and, in turn, themselves. Further research (Alaggia, 2010; Brenner & Ben-Amitay, 2015; Makhija, 2014) describes how being blamed by a non-supportive significant other plays a noteworthy role in relation to the variability of trauma symptoms that a victim experiences. The fear of being blamed for the abuse upon disclosure, consequently, can also be regarded as a barrier to disclosure (Lamb et al., 2018; Mayhall, 2012)

- **Not physically or emotionally protected:** A body of research has documented that the absence of protection from parents or primary caregivers may lead to the child feeling vulnerable and leads to the exposure of sexual abuse, thus resulting in the traumatisation of the child (Alaggia, 2010; Hardy, 2017; Mayhall, 2012; Zinzow et al., 2010). Similarly, Karakurt and Silver (2014) reported on the lack of protection during abuse, specifically from the victim's mothers. Apart from the protective adult being physically absent when protection was needed, the belief that the adult knew about the ongoing abuse but failed to act upon it, may also leave the child with a feeling of not being protected (Hunter, 2015; Winnett, 2013). Overall, this lack of protection from significant adults often results in the child feeling betrayed (Hardy, 2017; Karakurt & Silver, 2014; Kenny, 2018). In addition, it has also been reported that children expressed blame and anger towards the unprotecting parent (Mayhall, 2012; Zinzow et al., 2010).
- **Parentification:** Parentification is described as where victims reported having no strong mother figure or the mother was absent and they were therefore forced to take the mother role upon themselves (Mayhall, 2012; Winnett, 2013). This can be the result of disturbed or detached family relationships and low maternal affection (Hunter, 2015). In the unique South African context, in which this research was conducted, cultural influences also play a role in parentification as it may be regarded as acceptable in certain cultural groups for a young child to take on the caring and nurturing role of younger siblings.
- **Physical violence:** Domestic violence can be described as a pattern of abuse behaviours that include a wide range of physical, emotional, and sexual maltreatment that one or more people inflict towards one another, usually with the misuse of power and authority, occurring in intimate relationships or in families (Collin-Vézina et al., 2015; Makhija, 2014; Yancey & Hansen, 2010). Physical violence or abuse refers to any physical act of aggression such as slapping, kicking, and punching whilst emotional abuse can include humiliation and screaming (Louw & Louw, 2014). Collin-Vézina et al. (2015) indicate how violence and dysfunction in the family may contribute to a child's general feeling of being scared and unsafe. Further research explains that domestic violence frequently co-occurs with sexual abuse, thereby escalating the effects of these co-occurring traumas (Gonzalez & McCall, 2018; Singh et al., 2014; Stoltenborgh et al., 2015). Lastly, it can be mentioned that domestic violence and dysfunction in the family may also be identified as a barrier to disclosure (Allnock & Atkinson, 2019; Lamb et al., 2011).

2.6.2.2 Abuse-specific factors

In the previous section, family-specific factors as variable to the degree of trauma that a child suffers as a result of the CSA was discussed. The second trauma-related variable that needs to be addressed, is the impact of abuse-factors on the trauma level of a child. Abuse-specific factors include the level of threats, duration and extent of the abuse, and the identity of the perpetrator (Kenny, 2018; Spies & Bezuidenhout, 2006; Yancey & Hansen, 2010). It is important to understand the impact of these factors on the victim so as to become more sensitive regarding the trauma-related symptoms that the child could present with in a forensic assessment.

- **Threats:** The use of threats by the perpetrator against the victim may contribute to the severity of the abuse especially when force, intimidation, and weapons are used to threaten a child (Singh et al., 2014; Yancey & Hansen, 2010). The presence of threats is likely to lead to various negative outcomes like fear and anxiety in a victim, which may leave the child feeling helpless and out of control in the situation (Spies & Bezuidenhout, 2006). These feelings that the child experiences may be visible and be expressed through various inappropriate behaviour(s), which may be an indicator of a child's heightened trauma levels. Research by Kenny (2018) explains that threats are a bigger risk factor for traumagenic dynamic symptomatology for older children, as these children have a broader knowledge of inappropriate sexual conduct and also have a greater understanding of the meaning and implications of the threats that are imposed upon them by the abuser. A very consistent finding regarding threats is that threats may constrict a child's opportunity to disclose, as a result of fearing the outcome of disclosing, for example, where disclosure could result in a family member being harmed or taken from their home (Alaggia, 2010; Allnock & Atkinson, 2019; Mayhall, 2012). Another trauma-causing factor, closely related to threats, is the power dynamic between the child and the perpetrator (Godbout et al., 2014; Zinzow et al., 2010). Power dynamics include two categories of manipulation by the perpetrator, namely, manipulation in the form of direct threats (threats of disclosure or threats of violence) or manipulation through grooming (Zinzow et al., 2010). This research, further relayed that power dynamics were very relevant when there was secrecy in the family as well as in the complexity of the abuser/victim relationship, when the victim was depending on the abuser as the breadwinner for the house. Thus, threats and power dynamics can be regarded as a big risk factor and can lead to negative trauma-related outcomes.

- **Duration and exposure to abuse:** Another abuse variable that has a direct impact on the trauma level of a child is the duration, presence, and degree of exposure that the child has to the perpetrator (Kenny, 2018; Yancey & Hansen, 2010). The duration of the abuse can have a negative outcome on the victim's traumatic experience. The longer the period of time that a child is abused, the more likely and severe the negative symptoms will be that the child will display (Spies & Bezuidenhout, 2006; Yancey & Hansen, 2010). The aforementioned researchers also indicate that the more frequent the abuse takes place and the more abuse incidents the victim is exposed to, the more negative and severe the traumagenic dynamic symptomatology will present. Spies and Bezuidenhout (2006) highlight that these traumagenic symptoms are a result of the disempowerment of the child over a period of time, leaving the child with intense feelings of fear and powerlessness, probably the most detrimental effect of sexual abuse. It is further argued in literature that the closer the victim-perpetrator relationship is, the more severe the impact of the abuse on the child will be (Cummings, 2018; Gonzalez & McCall, 2018; Yancey & Hansen, 2010). Victims abused by a significant person like their father or stepfather, usually present with more trauma-related symptoms than children who were abused by extra-familial perpetrators (Kenny, 2018; Makhija, 2014). A further complicating factor documented is when the perpetrator is closely related to the child, which implies that the perpetrator may have more access to the child and thus the child may be more regularly exposed to the perpetrator, which will in turn again impact the severity and duration of the abuse and the trauma-related symptoms (Yancey & Hansen, 2010). Intra-familial abuse, as mentioned above, results in the betrayal of the child's trust, as the child realises that the person they love and rely on is not trustworthy (Spies & Bezuidenhout, 2006). Again, these circumstances are more likely to lead to negative trauma-related outcomes for the child.
- **Grooming**

  The last factor that will shortly be discussed as an abuse-specific variable is grooming. According to the *Sexual Offences Amendment Act* 32 of 2007, sexual grooming, in the South African context is described as:

  > Any act committed by a person with the intention to encourage, persuade, facilitate and/or diminish or reduce any resistance or unwillingness of a child, in order to ultimately engage the child in a sexual act (*Sexual Offences Amendment Act*, 32 of 2007).

  During the grooming process, the child's trust in a significant person is yet again betrayed. The child initially sees the abuser as friendly, giving emotional safety and is non-

threatening and this results in the child experiencing a degree of favouritism. This trusting relationship ultimately leads to sexual abuse and betrayal (Kenny, 2018).

2.6.2.3 Child-specific factors

The last trauma-related variable is the child-specific factors that influence the effectiveness in which the child copes and handles the trauma related to the CSA. These factors include any inherent characteristics specific to the child, for example, the cognitive and emotional developmental phase of the child as well as the child's sexual maturity. It further includes previous internalisations regarding the trauma in general, the sexual abuse related trauma, and lastly, the child's temperament and personality (Spies & Bezuidenhout, 2006; Yancey & Hansen, 2010). For the purpose of this research, the internalisation of self-blame, sexual objectification and immaturity, and developmentally inappropriate sexual exposure will be discussed.

- **Self-blame:** Being exposed to CSA over a period of time, cognitively engages victims in trying to work out why the abuse occurred, leading to internalised self-blame (Ullman et al., 2014; Zinzow et al., 2010). The sexual abuse of a child often leaves the child with feelings of low self-worth, embarrassment, and shame, causing them to blame themselves and feel that the abuse was their fault. Self-blame is positively correlated with the frequency, duration, and severity of the abuse (Ullman et al., 2014; Zinzow et al., 2010). The age of the child at the onset of abuse is also regarded as an indicator for self-blame (Ullman et al., 2014; Zinzow et al., 2010). Self-blame, as a coping strategy, is internalised more often by older children as they accept more personal responsibility for sexual encounters at their age. Self-blame can also be the result of the perceptions the child creates from the reactions of significant others in their lives (Collin-Vézina et al., 2015). As such, receiving constant external blame from the family for the abuse over a period of time can result in the child internalising self-blame. Overall, the abovementioned authors appear to be in agreement that self-blame is possibly the most difficult internalisation to change in the child victim or adult survivor.
- **Sexual objectification and immaturity:** When a child is emotionally and sexually not maturely developed when the sexual abuse happens, the child will not be sufficiently equipped to fully comprehend the situation. The child is thus engaged in sexual behaviour for which they were not physically or emotionally prepared for when the incident occurred. This can result in a lack of understanding of sexuality and confusion, which can lead to trauma-related symptoms for the child (Collin-Vézina et al., 2015). The child is unable to

emotionally handle the impact of the incident due to the immaturity of their sexually under-developed body. As a result of this, the child's sexuality is shaped in developmentally inappropriate and dysfunctional ways (Henning, 2017). Sexual objectification can be described as the use of a child's innocent body for no other reason than the self-gratification of the abuser, so as to satisfy their own sexual needs. Thus, the child's body is objectified and the child is sexually exploited and treated as a sexual object (Karakurt & Silver, 2014). Sexual objectification also often includes emotional and physical boundary violations where the perpetrator disrespects the victim's personal space and privacy. Research by Henning (2017) indicates that the consequence of victims perceiving themselves as a sexual object, may result in feelings of being disrespected as a female, feeling unworthy of love, and feeling stigmatised, which may in turn lead to further negative outcomes where the child engages in promiscuous sexual behaviour as they believe that this is the way to obtain affection and love.

- **Exposure to adult sexual activities and pornography:** Adverse experiences of being exposed to adult sexual behaviour or pornography at an immature cognitive or emotional developmental age, can have a subsequent impact on the trauma level of a child. When a child is exposed to these actions, negative and anxiety provoking responses are common. Research done in the United Kingdom reported that children show negative responses of shock (27%), confusion (24%), related feelings of disgust (23%), and nervousness (21%) on first exposure of inappropriate sex (Martellozzo et al., 2016). This research further indicates that younger children were more likely to experience negative responses by what they had seen, for example, feeling more disturbed than older children. When children are visually exposed to unwanted sexual images that they are not developmentally ready for, they are not always capable of organising or making meaning of these experiences in a comprehensible manner (Van der Kolk, 2017). Furthermore, if children do not have the opportunity to articulate what they have seen and observed, their behaviour revolves around keeping the secret and thereby contributes to additional trauma-related actions and behaviours. As a result, they may present with helplessness, fearful reactions, uncontrolled emotional reactions as well as sexual acting out behaviours. In addition, when a physical and emotional immature child is exposed to inappropriate sexual activities, their perception of sexuality and the meaning of sex is distorted (McGuinness, 2019) and this may result in evoking sexual fantasies or maladaptive sexual beliefs.

In the previous section, the model of Finkelhor and Browne (1985) as well as the contextual factors were discussed. The last part of the conceptual framework, namely the trauma-sensitive approach, will now be defined.

2.6.3 Trauma-sensitive approach

The term *trauma-sensitive* or *trauma-informed* is quite a new concept and no general or universal definition exists in literature. In 2001, Harris and Fallot (as cited in Knight, 2019), were some of the first researchers that introduced this term. Using this term, they meant that social, behavioural and psychology professions must account for the possibility that their clients may have experienced some form of previous trauma. Since then, a body of researchers has further expanded this term of which the core characteristics are, according to Knight (2019): trust, safety, choice, collaboration, and empowerment. According to Macdonald et al. (2012), trauma-sensitive means that the adverse consequences of sexual abuse of a child must be conceptualised into the consequences of trauma, and must then be used as such, and be reflected in the structure and content of the interview or assessment process of the child. For the purpose of this study, guidelines were developed to guide forensic social workers (FSWs) in conducting trauma-sensitive assessments by recognising, responding to, and reporting (3-R) the emotional and behavioural messages that the child relays or presents with during the forensic assessment, in the context of the child's past trauma-causing experiences. Working from a trauma-sensitive approach thus means that the FSW understands and has a well-informed awareness and knowledge of the prevalence and symptoms of CSA trauma and should be sensitive to traumatic triggers during the forensic assessment.

In the previous section, the conceptual framework for this study was debated. Next, forensic social work will be contextualised and the key terms and terminology will be explained.

2.7 Contextualising *forensic social work*

In this section, the key terms and terminology of forensic social work will be explained as well as the role and duty of forensic social workers, after which, forensic assessments will be contextualised in the South African context.

2.7.1 Key terms and terminology

According to the Regulations relating to the requirements and conditions for registration of a speciality in forensic social work (Department of Social Development, 2020), the following definitions are currently applicable in South Africa:

Table 10: Key terms and terminology

Forensic social work	Forensic social work is a specialised field in social work that focuses on the interface between the legal system and the secondary client (the individual, family, organisation or institution being assessed) and is characterised by the primary function of providing expert testimonies in courts of law.
Forensic social worker	A forensic social worker means a registered social worker with advanced scientific and specialised knowledge, skills, training and education and experience in forensic social work, who provides the court with written or oral impartial and factual expert testimony.
Forensic social work investigation	A forensic social work investigation means conducting a process of forensic assessments using forensic social work knowledge, techniques and tools in order to compile a forensic social work report with accurate information to establish facts or evidence that can be used in courts of law.
Expert testimony	Expert testimony means a written and/or oral evidence provided by a person who is qualified and has specialised knowledge, skills and training and experience regarding scientific, technical, or professional matters.

Retrieved from the Department of Social Development (2020, p. 99).

2.7.2 Role and duty of forensic social workers in South Africa

In South Africa, forensic social work is defined according to the Regulations relating to the requirements and conditions for registration of a speciality in forensic social work (Department of Social Development, 2020). In May 2020, these regulations were published in the Government Gazette. Substantiated comments regarding the proposed guidelines could be sent to the Minister of Social Development. These regulations will come into operation after publication as government notice. At the time of writing this study, the proposal was still pending.

2.7.3 Scope of practice for specialised forensic social workers

The Regulations relating to the requirements and conditions for registration of a speciality in forensic social work, defines the tasks of a forensic social worker in South Africa as follows (Department of Social Development, 2020, p. 101):

a) conducting forensic social work investigations of all cases that require forensic assessment using scientifically validated protocols and techniques in relation to forensic social work;
b) applying relevant legislation;
c) applying forensic social work techniques to obtain and interpret data used in the compilation of the forensic social work report;
d) compiling and submitting evidence based forensic social work reports to primary clients;
e) providing expert testimony on relevant matters in a court of law;
f) engaging in research and developing the field of forensic social work.

All of the abovementioned tasks of an FSW are of utmost importance, but as this research study intends to formulate trauma-sensitive guidelines for forensic assessments, the task of investigating and specifically interviewing the sexually abused child, need to be defined in more detail. Therefore, forensic assessments will be contextualised in the next section.

2.8 Contextualising *forensic social work assessments*

Single child witness is approached with caution in South Africa due to a common perception that children are suggestible and unreliable witnesses (Fouché & Fouché, 2015). Therefore, during the investigation phase, cases of CSA are often referred to helping professionals, mostly FSWs, with specialised knowledge and skills in conducting forensic assessments. Very specific protocols and interviewing techniques are followed in order to maintain objectivity and not influence the child (Faller, 2015; Lamb et al., 2018). The purpose of a forensic assessment is to facilitate an evidence-based disclosure and to test the veracity of the child's claim(s) of CSA. Lastly, the FSW must compile a report with accurate information to establish the facts or evidence that can be used in courts of law (Fouché & Fouché, 2015).

2.8.1 Defining the forensic assessment

The forensic assessment of the child forms part of the broader forensic investigation process from accepting the referral of the child through to writing the forensic social work report that can be used in courts of law (Barker & Branson, 2014). A forensic social work assessment is defined

according to the Regulations relating to the requirements and conditions for registration of a speciality in forensic social work (Department of Social Development, 2020, p.99) as "an investigation of a specific matter by application of scientific assessment methods or processes designed to answer a question or a set of questions to establish the facts of the matter within the court of law". An assessment can thus be described as the process of determining the nature, cause, progression and prognosis of a situation, the people involved, the understanding of the problem, what caused the problem, and how it can be resolved (Smith, 2014). Furthermore, sexual abuse assessments are differentiated from other assessments as the process followed must be legally defensible. During the assessment, the forensic social worker will conduct forensic interviews with the child. The aim of the forensic interview is to obtain reliable information from the child in such a way that will respect the interests of the child but will still be legally acceptable. (Muller, 2001). Newlin et al. (2015) further explain that the forensic interview of the child must be developmentally appropriate and legally accountable whilst obtaining factual information regarding allegations of sexual abuse.

2.8.2 Interviewing protocols

Many different interviewing protocols are widely used globally, mostly based on a combination of practice experience and research. It is broadly documented that it is possible, though difficult, to obtain reliable information regarding sexual abuse experiences from children (Faller, 2015; Kenny, 2018; Lamb et al., 2011).The aim of protocols is, according to Kuehnle and Connell (2009), to assist forensic interviewers to guide the allegedly abused child to recall and report their sexual abuse experiences. Research has proven that when a forensic interviewer uses recommended interview protocols, the reliability and quality of the information elicited from alleged victims of sexual abuse is enhanced (Kuehnle & Connell, 2012; Lamb et al., 2018). Professionals questioning children regarding sexual abuse are often criticised for the method that was used to obtain the information, and this is often debated when an FSW gives evidence in court. As such, this unstructured interviewing methods, led to the development of sequencing the stages in forensic interviews, also known as the interview structure or protocol (Faller, 2007). Although the interview phases between different protocols may slightly differ, Faller (2007) defines the phases in existing protocols and guidelines as follows: 1) documenting people, time and place for the video; 2) informing the child about the interview; 3) competency assessment; 4) rapport building; (5) developmental assessment; 6) assessing overall functioning; 7) explaining the rules;

8) practise interviewing; 9) introduction of topic of concern; 10) obtaining a narrative from the child; 11) obtaining additional details; 12) the cognitive interview; and 13) closure.

Globally, various different evidence-based protocols are available for the purpose of interviewing sexually abused children. The most well-known protocols used by forensic social workers, are the following:

- The National Institute of Child Health and Human Development Investigative Protocol (NICHD): This protocol was designed by Lamb and his colleagues with the aim of providing much more precise examples of detailed questions that can be used during specific stages of the forensic interview (Lamb et al., 2018). These researchers note that this protocol focuses on open-ended questions and the flexible structure provides for a semi-structured way that allows interviewers to address all important issues of the incident but still in an appropriate sequence. Kenny (2018) and Kuehnle and Connell (2010) are of the opinion that this protocol is best designed to conduct developmentally appropriate interviews whilst catering for the characteristics of the child's memory and ensuring that the richest and most accurate statement of the sexual abuse experience will be given. The NICHD protocol, as protocol of preference, is utilised in the South African context by many forensic social workers and post-graduate students who are also trained in this protocol. A "Revised Investigative Interview Protocol: Version 2018" (Lamb et al., 2018) has recently been developed after extensive research. This revised version focuses more on the behaviour of the interviewer in order to support the child's emotional and social needs during the interview while simultaneously giving attention to the child's cognitive processes (Lamb et al., 2018). These researchers state that they will continue developing this protocol to improve better forensic investigative interviewing.
- The American Professional Society on the Abuse of Children (APSAC): APSAC is of the opinion that there is no single, correct way to interview a suspected CSA victim and only provides a framework for professionals to conduct forensic interviews. A criticism of this protocol is the fact that it is not an all-inclusive guide (APSAC, 2012) and according to Smith (2014) it is recommended that formalised protocols make use of generalised guidelines.
- Step-Wise Interview Protocol: This interview was developed by Yuille (2002) and was designed mainly to: 1) increase interviewer skills thus reducing multiple interviews; 2) the use of non-suggestive questions to avoid contaminating children's reports and maximise

the amount of information that is gathered; 3) the use of interview aids or techniques to enhance recall; and 4) a flexible approach for the interviewer to adapt depending on the purpose of the interview (Deeb, 2016; Yuille, 2002). A criticism of this protocol according to Smith (2014) is that this protocol only guides forensic investigators regarding the interview with the child and does not assist with the investigation of CSA cases.

- Michigan Interviewing Protocol: This protocol was developed by Michigan (2005) and suggests the gathering of background information before the interview commences and can include any information, for example: family composition, family habits, and family names for body parts (State of Michigan, 2016) thus the interview with the child will not be a blind assessment. Advantages of this protocol is that it does provide valuable guidelines for the interviewing environment, in terms of how to conduct the competency test in addition to the types of questions and interviewing techniques.
- In South Africa, FSWs also make use of inter-developed protocols, or others use protocols by Fouché (2008) or Smith (2014) that were developed to be utilised in the uniquely South African context. Rapholo and Makhubele (2019) argue that since most protocols have been adopted from the context of the United States of America, more protocols should be developed in South Africa, incorporating the wide variety of cultural systems that may influence disclosure, into consideration.

In summary, it appears that the use of structured and semi-structured interviewing protocols in forensic assessments may improve the quality and accuracy of the information obtained as well as possibly enhance the informativeness of such investigative interviews with children.

2.8.3 Alternative hypotheses

Another important factor during forensic assessments that needs to be mentioned is that multiple hypotheses need to be investigated in order to consider all possible explanations for the behaviour and reliability of the information obtained (Cronch et al., 2006; Fanetti & Boles, 2004). The following factors should be investigated in order to determine possible alternative explanations that may have led to the sexual behaviour of the child.

Table 11: Factors to be investigated regarding alternative hypotheses

FACTORS TO BE INVESTIGATED REGARDING ALTERNATIVE HYPOTHESES
• The original motivation that directed the sexual behaviour.
• The presence of others when the sexual behaviour occurred.
• The child's feelings towards, response to, and description of the sexual activity.
• The child's relationships with the other persons involved in the sexual activity.
• Family norms and values regarding sexuality.
• Family history of physical, emotional or sexual abuse.
• The influence of bribery or coercion.
• The child's level of developmental functioning.
• If the child was exposed to adult sexual activity or pornography.
• If there are any concerns about possible sexual abuse.
• If the child's behaviour is learned behaviour, for example, masturbation.

Table summarised from: Kenny, 2018; Kuehnle & Connell, 2009; and Smith, 2014.

It is clear that different hypotheses need to be considered and assessed in order to examine that more than one probable explanation for the sexual behaviour of the child may exist. As such, when evaluating the information obtained during the interview, it is imperative that the FSW consistently remains neutral and objective when considering and interpreting all the evidence (Spies & Bezuidenhout, 2006).

2.8.4 Integrating trauma-sensitive interviewing principles

The forensic social work interview forms part of the whole forensic investigation process and may include other professionals such as medical personnel and police services. As such, the inclusion of a broader team of professionals may imply that when the child arrives for the forensic social work assessment, and is already displaying signs of trauma, the forensic process may potentially then add additional stress on the child (Newlin et al., 2015). Furthermore, it should be kept in mind that the forensic interview in itself will influence the trauma level the child experiences (Lamb et al., 2011). Not only is the interview situation unfamiliar, but it is also expected of the child to share painful and intimate information with a strange person. It is clear that it is of great importance that FSWs conduct the forensic assessment in a trauma-sensitive manner. Forensic

social workers need to ensure that they incorporate trauma-sensitive principles into their forensic assessments. This starts with the FSW being equipped with knowledge of the following topics (Balfe et al., 2019; Collin-Vézina et al., 2015; Hunter, 2011; Kenny, 2018): the meaning of trauma in the child's life; the short- and long-term effects of trauma exposure; the relationship between trauma exposure and the challenges that the child currently experiences, for example, the legal process; the impact the trauma has on the child's beliefs about themself and other significant people; the impact that these beliefs have on the child's willingness and ability to engage with the FSW in the assessment process; and lastly, the intervention techniques that incorporate trust, safety, choice, collaboration, and empowerment. In addition, the amount and reliability of information reported by children in forensic assessments is also influenced by several factors, for example, the characteristics of the event and the trauma that the child experienced as a result thereof (Lamb et al., 2018).

In order to employ trauma-sensitive techniques, the FSW must first and foremost be aware and recognise trauma symptoms that the child presents with or relays during the forensic interview. The following table illustrates some of the verbal, emotional, and physical symptoms that can be regarded as possible indicators of trauma. It must be clearly mentioned that these symptoms can also be as a result of other factors, for example, cognitive and emotional developmental levels.

Table 12: Trauma symptoms during and outside of the forensic interview

SYMPTOMS PRESENTING DURING THE INTERVIEW
• Rapport building problems with interviewer as a result of loss of trust in significant others.
• Child's non-verbal reactions offers a different interpretation to that of the child's answer.
• Verbalisations are sometimes disconfirmed.
• Child is unable to organise and categorise experiences in a coherent manner.
• Child does not answer questions in a full and accurate manner.
• Child's report is contaminated by coercion.
• Child gives distorted answers as a result of threats.
• Child answers in a certain way in an attempt to please an authority figure or significant adult.
• Child organises their answer around keeping a secret in order to protect the family.
• Aggression during the interview is verbalised and aimed at significant others.

• Distrust and suspiciousness towards the interviewer as a result of the child's experience of a loss of trust.
SYMPTOMS THAT MAY MANIFEST DURING THE INTERVIEW BUT THE CHILD RELAYS THAT THEY ALSO EXPERIENCE THE SYMPTOMS AT HOME
• Deficits in emotional self-regulation
• Low self-esteem
• Guilt and shame
• Feeling powerless and helpless
• Relationship problems
• Isolation
• Maladaptive behaviour, for example, self-harm
• Alterations of consciousness, for example, dissociation
• Depression
• Low school performance
• Child complies with defiant behaviour as a result of helplessness
• Sleeping problems and nightmares

Table summarised from: Balfe et al. (2019); Bucchianeri et al. (2014); Fanetti and Boles (2004); Penning and Collins (2014); Singh et al. (2014); Spies and Bezuidenhout (2006); and Van der Kolk (2017).

2.9 Conclusion and recommendations

This literature review offered a deep understanding of the multifaceted nature of CSA and provided rich evidence of the trauma-causing factors and negative outcomes in the context of childhood sexual abuse. The Traumagenic Dynamics Model of Finkelhor and Browne (1985) was discussed and was contextualised with the context-specific factors, namely the family-, abuse-, and child-specific factors contributing to trauma, into the conceptual framework for this study. The trauma-sensitive approach, which forms part of the conceptual framework and that was incorporated into the guidelines that were formulated later in this research, was also defined.

A research gap was identified in the literature review as very little research regarding forensic social work in general as well as trauma-causing factors as a result of CSA within the South African context could be found. Limited studies about conducting trauma-sensitive forensic social work assessments are obtainable. Inadequate information is apparent regarding doing forensic

social work assessments whilst acknowledging the cultures of different ethnic groups in South Africa.

As such, the next section (Step two) will discuss the empirical study, namely a qualitative secondary analysis in order to answer the second secondary research question:

> *What traumatic experiences and negative outcomes of childhood sexual abuse were reported by women survivors who participated in S2T group treatment intervention sessions can inform trauma-sensitive social work forensic assessments?*

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STEP TWO: EMPIRICAL STUDY - QUALITATIVE SECONDARY ANALYSIS

REPORTS OF TRAUMA-CAUSING FACTORS AND RESULTING NEGATIVE OUTCOMES IN A GROUP OF WOMEN WHO EXPERIENCED CHILDHOOD SEXUAL ABUSE

The following secondary research question motivated this part of the study:

> *What traumatic experiences and negative outcomes of childhood sexual abuse were reported by women survivors who participated in S2T group treatment intervention sessions can inform trauma-sensitive social work forensic assessments?*

THIS IS PREPARED FOR THE JOURNAL HEALTH AND SOCIAL CARE IN THE COMMUNITY. GUIDELINES ARE FOUND IN ADDENDUM 6.

PREFACE

This part of the research consists of an empirical study, namely a qualitative secondary analysis (QSA) with the aim of exploring the trauma-causing factors and negative outcomes reported by South African adult women survivors of CSA that participated in the Survivor to Thriver (S2T) collaborative strengths-based group intervention programme. The specific focus will be on the trauma that these women experienced as children. Findings concluded from this step of the study will then be incorporated into step three of this study: Guidelines aimed at conducting trauma-sensitive social work forensic assessments.

3.1 Introduction

The purpose of this part of the study was to identify reported traumatic experiences and negative outcomes of women survivors of Childhood Sexual Abuse (CSA). This was done by performing QSA on existing data sets of treatment sessions from the S2T collaborative strengths-based group intervention programme.

The prevalence and devastating long-term impact of CSA is well documented in literature. The global prevalence of CSA is found to be between 18-21.1% amongst girls and 7.6-13.8% amongst boys. According to Stoltenborg et al. (2015), CSA for girls is the highest in Australia at 21.5% and the highest for boys in Africa at 19.3%. The first national representative study conducted on the prevalence of CSA in South Africa was conducted by the Optimus Foundation and found that one in three children reported some form of sexual abuse by the age of 18 years. Boys reported higher lifetime prevalence rates of sexual abuse (36.8%) than girls (33.9%). Furthermore, in South Africa, black children had the highest risk of sexual abuse at 35.7%, than children of coloured[3] backgrounds at 35.4%, then white children at 27.1% and lastly Indian children at 25% (Artz et al., 2016).

A body of research found that the effect of CSA is very complex and may manifest in a wide range of negative outcomes experienced in childhood, which may well continue into adulthood, namely mental health problems, sexual challenges, intrapersonal and interpersonal difficulties, behaviour problems as well as physical complications (Dolan & Whitworth, 2013; Kenny, 2018; Singh et al., 2014; Spies & Bezuidenhout, 2006; Ullman et al., 2014). The relating trauma associated with CSA and its effect on a child or adult, is very unique and has received considerable attention from researchers as well as professional people working in the field. Earlier researchers, Finkelhor and Browne (1985), presented seminal work on the trauma associated with CSA and proposed a more systematic understanding of the effects of CSA and the unique trauma-causing factors experienced by the victim. In their Traumagenic Dynamics Model, they conceptualised that four traumagenic dynamics, namely: traumatic sexualisation, betrayal, stigmatisation, and powerlessness are the core of the psychological injury inflicted by abuse, culminating in a unique and complex trauma experience (Finkelhor & Browne, 1985). Traumatic sexualisation explains a child's sexuality with regards to their sexual thoughts and behaviour that are developmentally inappropriate and interpersonally dysfunctional as a result of the CSA (Revell et al., 2008). The behavioural impact

[3] Internationally referred to as mixed race ancestry

of traumatic sexualisation can present in young children as sexual preoccupations or inappropriate knowledge and interests in sex, whilst adults can display aversion to sex or hyper sexualised behaviour and have negative attitudes towards their bodies and sexuality (Hodges & Myers, 2010). Betrayal happens when a child does not feel protected during the CSA ordeal and/or is not believed by a trusted adult when the abuse is disclosed (Hunter, 2011). Betrayal manifestation constitutes an intense need to regain trust and security in search of a relationship that will hopefully give back the trust that was taken away by the childhood traumatic experience (Karakurt & Silver, 2014) or it can result in withdrawal from intimate relationships due to mistrust and suspicion of the partner's motives (Human, 2015). Powerlessness can be explained by a child's unsuccessful repeated attempts to avoid or halt the abuse whilst the child's personal body and mind space is repetitively invaded by the sexual abuser, against the child's will (Baker, 2015). A major effect of powerlessness is fear and anxiety, which can result in depression and even self-harm as the result of constantly feeling entrapped in an abusive environment (Valdez et al., 2013). Stigmatisation refers to the negative self-image that a child may develop as a result of the CSA, such as feelings of shame and guilt and being bad or damaged (Collin-Vézina et al., 2015). Stigmatisation can reinforce a child's sense of being different and a low self-esteem may develop (Baker, 2015). When the sexual abuse is known to others, negative labels such as having poor morals may be assigned to the child (Finkelhor & Browne, 1985). As a result of stigmatisation, certain losses are also experienced, such as the loss of childhood innocence and safety, which may result in long term consequences, namely not being able to interconnect and emotionally experience life to the fullest (Kays Ebrahim et al., 2018).

To date, much research has been conducted on exploring how these four trauma-causing factors of Finkelhor and Browne (1985) may impact on children. Recently, a scoping review conducted by Henning (2017), focusing on women survivors of CSA, found that the majority of published studies on this topic were conducted in minority countries such as the United States of America (Makhija, 2014), Australia (Dolan & Whitworth, 2013), and Europe (Revell et al., 2008). The term *minority* is used for wealthier regions of the world or otherwise known as developed countries and only constitutes a small percentage of the world population (Madrid Akpovo et el., 2018). To date, only three empirical studies were conducted exploring trauma-causing factors in female survivors of CSA in South Africa. The one study by Ramasar (1997) included 16 participants and found that betrayal and stigmatisation were the two main trauma-causing factors evident in this study. In the case of betrayal, women experienced that significant others did not provide support, they received negative responses upon disclosure, had an inability to trust men, and unable to form trusting

interpersonal relationships. With regards to stigmatisation, they internalised victim-blaming and their guilt over the abuse impaired their sense of self-worth. The other two studies (Fleming & Kruger, 2013; Human, 2015) included one participant each and found that traumatic sexualisation was the core feature of what these women struggled with due to the fact that they experienced feeling immature at the time of the abuse, or the physical responses created confusion and thus disrupted their perception of sexuality. The one participant also experienced stigmatisation; she experienced shame as a result of society's perception of females who had been raped; and experienced powerlessness and lacking assertiveness in her intimate relationships. Although some authors attempted to contribute towards a better understanding of these trauma-causing factors in the context of CSA, only the above three studies report on how these trauma dynamics presented in South African samples of women survivors of CSA. Another South African researcher, Van der Merwe (2009), suggest the value of knowledge of these traumagenic factors when conducting assessments and interventions, as they appear to contribute to fully understanding the victim's experience, and thereby promotes the need to work more actively and effectively with the vulnerabilities of sexually traumatised children. Little attention is, however, given to addressing these unique trauma-causing factors of CSA as most therapeutic interventions mainly focus on only treating the symptoms (Walker-Williams & Fouché, 2017).

The Traumagenic Dynamics Model of Finkelhor and Browne (1985), provides a useful framework to understanding the trauma experiences of child survivors of CSA and was included in a conceptual framework for this research study. This framework is already used widely among forensic social workers (FSWs) in South Africa to inform themselves about the understanding of the trauma experiences of child survivors of CSA; it is further utilised in court reports and expert testimony (Spies & Bezuidenhout, 2006). The effect and degree of trauma experienced by the individual child, which may subsequently result in negative outcomes, will be influenced by a range of different contributing factors — a single theory is not best in attempting to understand the trauma-causing factors in the context of CSA. Context-specific factors will be contextualised with the model of Finkelhor and Browne (1985) into the conceptual framework for this research. The context-specific factors include: 1) child-specific factors (any inherent characteristics specific to the child), for example, the exposure to sexual activities they are not developmentally or emotionally ready to cope with, previous internalisations regarding trauma as well as the child's temperament and personality (McGuiness, 2019: Van der Kolk, 2017; Ullman, et al.); 2) family specific-factors, for example, parents did not believe or protect the child, parentification, and physical violence (Alaggia, 2010; Hunter, 2011; Mayhall, 2012); and 3) perpetrator-specific

factors, for example, threats and duration of abuse (Cummings, 2018; Gonzalez & McCall, 2018; Singh et al., 2014),. For the purpose of this study, this framework will further be used to build on the current knowledge base so as to move FSWs towards utilising a trauma-sensitive approach so as to enhance their understanding of sexually victimised children, as well as to anticipate possible problems to which these children may subsequently be vulnerable. This framework also explains the resulting negative outcomes such as emotional, behavioural, and psychological difficulties that children present associated with the traumatic CSA experience(s), which are important factors to understand when working trauma-sensitively during forensic assessments.

In this manuscript, the findings of the QSA will be reported, which will be contextualised with literature in section B, step three of this study, to formulate guidelines for conducting trauma-sensitive social work forensic assessments.

3.2 Aim of the current study

The purpose of the study is to conduct QSA on data collected from two groups of treatment sessions of the S2T programme collaborative strengths-based group intervention programme. Although the primary research was conducted on adult women, a very rich source of data about their CSA experiences and negative outcomes were reported. The researcher will analyse the datasets about their traumatic childhood experiences in order to investigate the second secondary research question, namely:

> *What traumatic experiences and negative outcomes of childhood sexual abuse were reported by women survivors who participated in S2T group treatment intervention sessions can inform trauma-sensitive social work forensic assessments?*

3.3 Methodology

This study employed qualitative secondary analysis (QSA) on two pre-existing data sets of treatment sessions of adult women survivors of CSA participating in the S2T collaborative strengths-based group intervention programme. Qualitative secondary analysis is the re-use of pre-existing qualitative data collected from previous studies with the purpose of studying new research questions (Heaton, 2008; Irwin & Winterton, 2011). This study employed the use of available transcripts from 16 sessions of two groups of treatment sessions of the S2T collaborative strengths-based group intervention programme. Written consent was obtained from the S2T participants to use the data for the purpose of this study. According to Heaton (2008) there are five potential ways

in which existing qualitative data can be re-used in QSA, namely: supplementary analysis (this is to get a more in-depth understanding of aspects of the data that was not explored in the primary study); supra-analysis (where the focus and aim of the secondary study exceeds those of the original study); re-analysis (re-examining the data to validate or confirm findings of a primary study); amplified analysis (when two or more data sets are combined or compared for purposes of a secondary analysis); and assorted analysis (re-using existing data in conjunction with the collection and analysis of primary qualitative data for the same study).

During this research study, the researcher followed the supra-analysis approach. The primary study focused on the efficacy of the S2T collaborative strengths-based group intervention programme. This study aims to conduct QSA on two groups of data sets of treatment sessions of the S2T collaborative strengths-based group intervention programme, in order to address a research question not previously explored, and exceeds the original primary study, by answering a new empirical and conceptual question. Therefore, the traumatic experiences and negative outcomes of childhood sexual abuse that were reported by women survivors who participated in the S2T group treatment intervention sessions will be explored in order to inform trauma-sensitive forensic assessments.

Although QSA allows for answering new research questions from existing data, the effectiveness of QSA as a research method sometimes poses challenges and/or a threat of a conflict of interest(s) (Irwin & Winterton, 2011). The semi-structured ways in which data is collected can result in data sets with variable depth, which may not always be suitable for a secondary study (Heaton, 2008). The researcher must interpret and analyse data that was collected by other researchers (Heaton, 2008). A further issue is that of informed consent from the research participants and how the re-use of their data is going to be kept confidential while being re-used by a new researcher (Heaton, 2008).

Irwin and Winterton (2011) are of the opinion that there are substantial reasons why QSA can be used to find fresh insights from already existing data. They indicate that the researcher can engage with the data without preconceptions; they can provide rich, descriptive information, which can conclude new findings from old data; and these new findings can reach sensitive and vulnerable populations. According to Sherif (2018), QSA can reveal additional detail on the same research topic, the research can be analysed with a new theoretical framework not applied in the primary study, and the research questions can be answered more thoroughly than in the primary study.

3.3.1 Sampling and data collection

This research conducted QSA and used two secondary data sets of treatment sessions from the primary S2T collaborative strengths-based group intervention programme study. The sampling of the primary study was done by Professor Fouché and Professor Walker-Williams. Ethical clearance was obtained for the primary study (ethics number: NWU 0041-08-A1 [Group 1-3, 2013-2018], Addendum 2). Consent from participants for the re-use of data for future secondary analysis was obtained. Due to the secrecy and sensitive nature of CSA, it was impossible to randomly select women. Therefore, purposive sampling was used. The previous researchers approached various professionals like social workers and psychologists in the Vaal Triangle area as gatekeepers. The gatekeepers screened for possible participants according to the inclusion and exclusion assessment criteria. The gatekeepers obtained informed consent from the participants to disclose their details to the primary researchers. As QSA was conducted, this research study was not required to do participant sampling. The researcher was provided with the anonymised transcriptions of one data set of S2T treatment sessions, which had already been professionally and ethically transcribed, as well as the audiotaped sessions of the other data set of S2T treatment sessions, which was then referred for professional transcribing and checked for accuracy by the primary researchers. A confidentiality agreement was signed between the primary researchers, the current researcher, a student, and the professional transcriber. The data was then stored on a password-protected computer in a secure location. The researcher was informed to permanently delete these data files after research completion.

3.3.2 Data analysis

Braun and Clarke (2006) employ the following six phases when analysing the data during thematic analysis: 1) familiarising yourself with the data through the transcription of the verbal data and reading the data while making notes and re-reading of the data; 2) generating initial codes to identify a feature of the data that appears interesting to analyse and that can be assessed in a meaningful way regarding the phenomenon; 3) searching for themes and sorting the initial code list into potential themes; 4) reviewing themes and refining them against the entire data set; 5) defining and naming themes and further refining the themes, as well as writing a detailed analysis that describes the true meaning of each theme; and 6) the final analysis and writing of the report to tell the complicated story of the data in a logical and interesting way focusing on the prevalence of the theme. The same thematic analysis phases were employed to analyse the two data sets of S2T treatment sessions for this research study as it is a useful and flexible analytic method to

analyse qualitative data, search for themes or patterns, analyse them, and then report on them (Braun & Clarke, 2006). Themes and sub-themes were finalised after consensus discussions between the primary researchers, independent coder, and the research student. Unique abstracts from the data were quoted as evidence of the trauma-causing factors of CSA. This evidence was analysed in a practical way for forensic social workers to implement in the assessments with children. Consultations with the researchers who conducted the primary study took place on a regular basis to ensure that the findings are representative and are a true reflection of what happened during the group sessions.

3.3.3 Trustworthiness

The following figure illustrates the trustworthiness of this study:

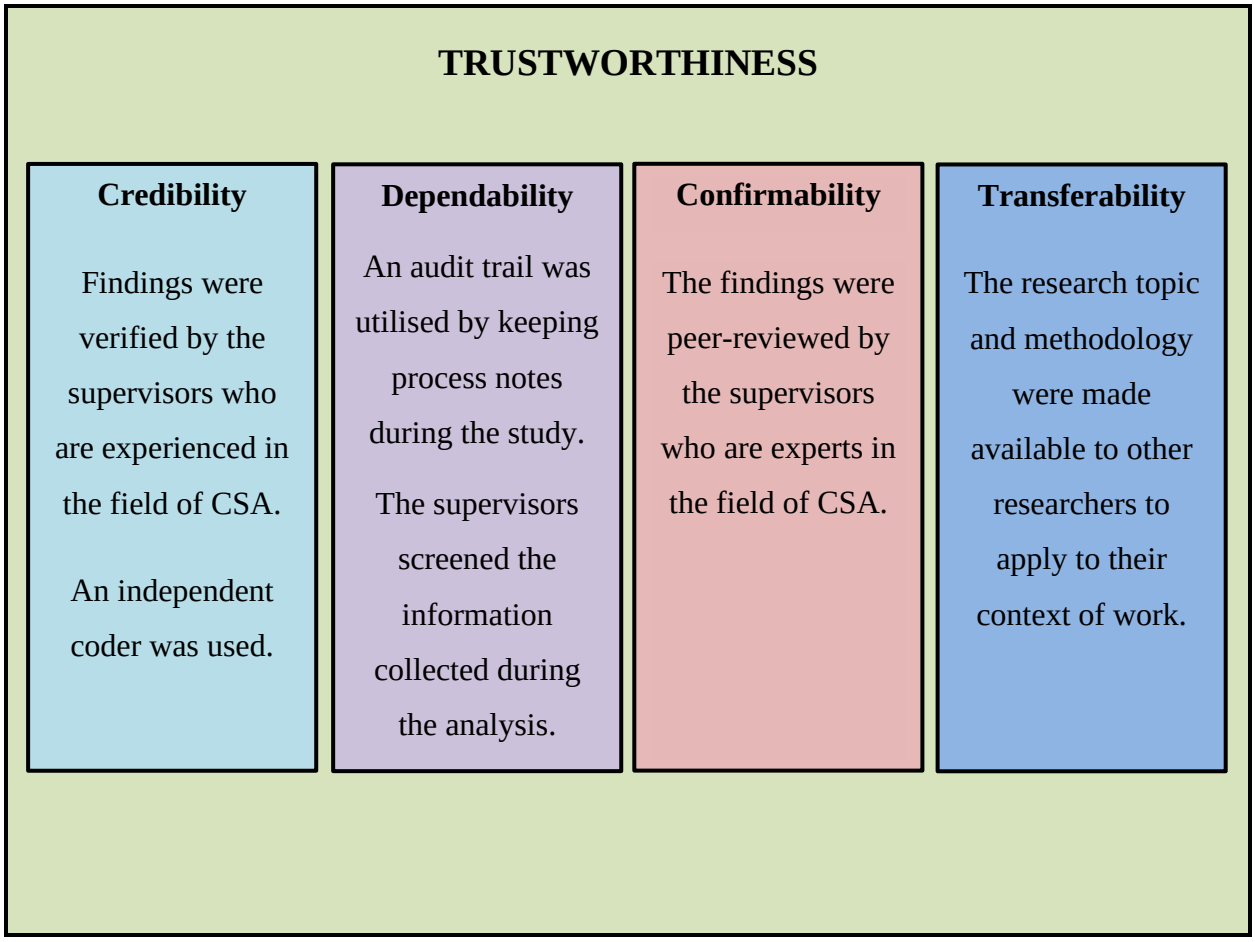

Figure 2: Trustworthiness

According to Connelly (2016, p. 435) "trustworthiness of a study refers to the degree of confidence in data, interpretation and methods used to ensure the quality of a study." Thus, if research can be regarded as trustworthy, it will contribute to the field of research. The trustworthiness of research

is judged according to its credibility, dependability, confirmability, and transferability (Anney, 2014; Connelly, 2016). Credibility is the most important criteria in trustworthiness and it can be defined as the confidence in the truth of the study and the research findings (Connelly, 2016). The credibility of this study was ensured by allowing the findings to be verified by the study leaders who are experienced in the field of CSA. In addition, a co-coder, who is also experienced in qualitative research, coded the data after receiving training in thematic analysis by the supervisors. According to Connelly (2016) the dependability refers to the stability of the data over time and over the conditions of the study. The dependability in this research was ensured by utilising an audit trail by keeping process notes during the study. The two study leaders further screened the information collected during the analysis. Confirmability refers to the degree to which the results of an inquiry could be confirmed by other researchers (Connelly, 2016). For confirmability in this research, the findings were peer-reviewed by the study leaders who are experts in the field of CSA. Transferability describes the extent to which qualitative research results can be transferred to other contexts with other respondents (Anney, 2014). In this study, this was done by making the research topic and methodology available to other researchers to apply to their context of work.

This study employed QSA and makes use of existing data that was obtained through ethically accepted and approved standards. The researcher aimed to stay empathetic and neutral towards the evidence and data, and was non-judgemental in approaching the data. A systematic approach was followed in reading and understanding the data and it was done consecutively to make sure that the data was correctly interpreted. Participant quotes were used verbatim in the study to indicate the specific trauma-causing factors that were discussed. The researcher made use of regular consultation sessions with her study leaders who were also the facilitators in the primary S2T study in order to ensure that the interpretations were clear and credible. An independent coder was further employed. All the above contributed to the trustworthiness of the study.

3.3.4 Background of the data sets

The S2T collaborative strengths-based group intervention programme follows a strengths-based and supportive approach and focuses on women survivors of CSA's strengths in order to facilitate resilience processes and post-traumatic growth enabling outcomes from their traumatic CSA experiences (Fouché & Walker-Williams, 2016). This intervention covers four treatment outcomes (Walker-Williams & Fouché, 2017):

1. Providing a supportive space for sharing the trauma story, experiencing heightened emotional awareness, and validating the group members' experiences (drawing

on cognitive behavioural therapy and cognitive processing therapy principles of cognitive processing).

2. Normalizing symptoms (emerging from the psychodynamic approach) and reframing trauma messages (cognitive behavioural therapy and post-traumatic growth model).
3. Active adaptive coping drawing on psychological inner strengths (psychodynamic and post-traumatic growth model).
4. Transforming from meaning making to personal growth by re-sharing the trauma story "for a change" from a new perspective (post-traumatic growth model).

The sample in both groups included adult women that were exposed to CSA. They all experienced contact sexual abuse as children and the perpetrator was known to them. They were all residing in the Vaal Triangle within the larger Gauteng Province in South Africa. A quasi-experimental design was used during a pilot study conducted in 2013/2014 (Walker-Williams & Fouché, 2017). The benefits of this collaborative strengths-based group intervention programme were further tested by the researchers over a four-year period and included two more groups, Group 2 (2014-2015) and Group 3 (2017-2018). The sample inclusion criteria for the groups were: 1) CSA before the age of 18 years old; 2) disclosure of the CSA; 3) had received some form of crisis intervention as a child; 4) could function reasonably well in day to day life; and 5) were willing to participate voluntarily in the S2T intervention programme at a community location (Walker-Williams & Fouché, 2017). The group sessions ranged from six to nine sessions and the duration of these sessions where approximately two hours. Follow-up sessions were also held after a period of time. The group sessions were held at a central and private community location. The sessions were facilitated by two group facilitators (a social worker and a clinical psychologist). After the group sessions, the data was professionally transcribed (Walker-Williams & Fouché, 2017). For the purpose of this study, only the data of treatment sessions from Group 2 and Group 3 were analysed.

The following table illustrates the demographical data of the S2T group participants:

Table 13: Demographic characteristics of participants (N=15)

Characteristic	No.
Age group	
18-25	7
26-30	2
31-45	4
46-50	0
51-60	2
Nationality	
South African	15
Foreign	0
Race	
White	8
African	7
Higher	11
Secondary	4
Occupation	
Employed	8
Student	6
Unemployed	1
Relationship status	
Single	8
Married	6
Cohabitating	1

Characteristic	No.
Children	
No	12
Yes	3
Type of abuse	
Contact	15
Noncontact	0
Perpetrator	
Known	15
Unknown	0
Age of CSA onset in years	
3	1
5	3
6	4
8	2
9	2
10	2
13	1
Duration of abuse in years	
1 - 2	2
3 - 4	7
5 - 6	4
7 - 10	2

3.3.5 Research integrity of the primary study

The participants of the primary study were recruited as follows: The researchers approached clinical, counselling, and educational psychologists working in private practice as well as social workers employed at organisations as gatekeepers. These gatekeepers had to qualify by having experience in working with women who had experienced CSA. The gatekeepers screened for and identified possible candidates according to the primary study's inclusion criteria. The gatekeepers were requested to obtain informed consent from the participants in order to disclose their personal details to the primary researchers. After the consent was obtained, the researchers telephonically contacted the prospective participants. The research programme and their participation were explained to participants and they were invited to attend an information session. During this information session, the nature and purpose of the programme was explained. The participants also completed an informed consent form stipulating their voluntary participation in the programme.

The consent form also included giving consent that the transcriptions of the recorded group sessions may be used for qualitative secondary analysis. The participants were also given the opportunity to withdraw from the programme at any time without reprisal.

The group participants were encouraged to treat all the personal information that was discussed during the group sessions as confidential. The confidentiality of the voice recordings was also treated as high priority. After each session, the voice recording was transferred from the recording device to the primary researcher's computer. These audio files were then ethically transcribed by a post-graduate student and professional transcriber who had signed confidentiality agreements. All transcriptions were anonymised, and no names of participants were used in the transcriptions. The transcriptions were checked for accuracy by the primary researchers and the audio files were then deleted from all computers. The transcriptions were stored in securely locked cabinets in the Social Work building of the North-West University, Vaal Triangle Campus.

Risks to the participants were reduced by only selecting women who had already disclosed their CSA experiences and who had received some form of therapeutic intervention. Besides having received previous therapy, participating in the S2T could still elicit strong emotional reactions. Both primary researchers, being a social worker and a clinical psychologist, were adequately qualified to deal with and handle these reactions, if and when they arose. To be fully prepared for any unforeseen circumstances, additional, external psychological counselling services were also made available for any participant should the need have arisen. The primary researchers also offered extra support outside the group context. Group members also received their telephone numbers in the event that the need for support or counselling arose before the next group session. Participants were also given access to a support WhatsApp group where communal support discussions took place between sessions. This WhatsApp group was administrated by the primary researchers and group facilitators.

Two articles were published to date confirming the positive resilience and post-traumatic growth of the participants from Group 1 (Walker-Williams & Fouché, 2017, 2018). This research found similar positive outcomes after analysing the data from Group 2 and Group 3.

3.4 Ethical considerations

Prior to the commencement of this research, ethical approval was obtained from the Health Research Ethics Committee (HREC) of the North-West University (NWU) to obtain permission and ethical clearance to conduct this study (ethics number: NWU-00304-20-S1, Addendum 1).

The two researchers of the primary study obtained ethical approval from HREC of the NWU (ethics number: NWU-00041-08-A1, Addendum 2) to conduct the primary S2T collaborative strengths-based group intervention programme study. Regarding this QSA, consent from all the participants in the S2T groups (2013-2018) were obtained to use the data for further research. This researcher also obtained written consent from the primary researchers to use the existing data sets for the purpose of conducting QSA in this research study (Addendum 3).

3.5 Findings

The findings section was compiled by analysing the quotes of women who participated in the S2T collaborative strengths-based group intervention programme for women survivors of CSA. They reported their trauma-causing experiences, and the following three themes were identified: 1) family-specific factors (non-supportive response of parents and significant caregivers); 2) abuse-specific factors (emotional manipulation, or threats by the perpetrator); and 3) child-specific factors (child exposed to sexual activities she was not developmentally, emotionally or physically ready to cope with). An example of theme development is depicted in the audit trail (Addendum 5).

Figure 3 illustrates the three different themes, with their subsequent subthemes.

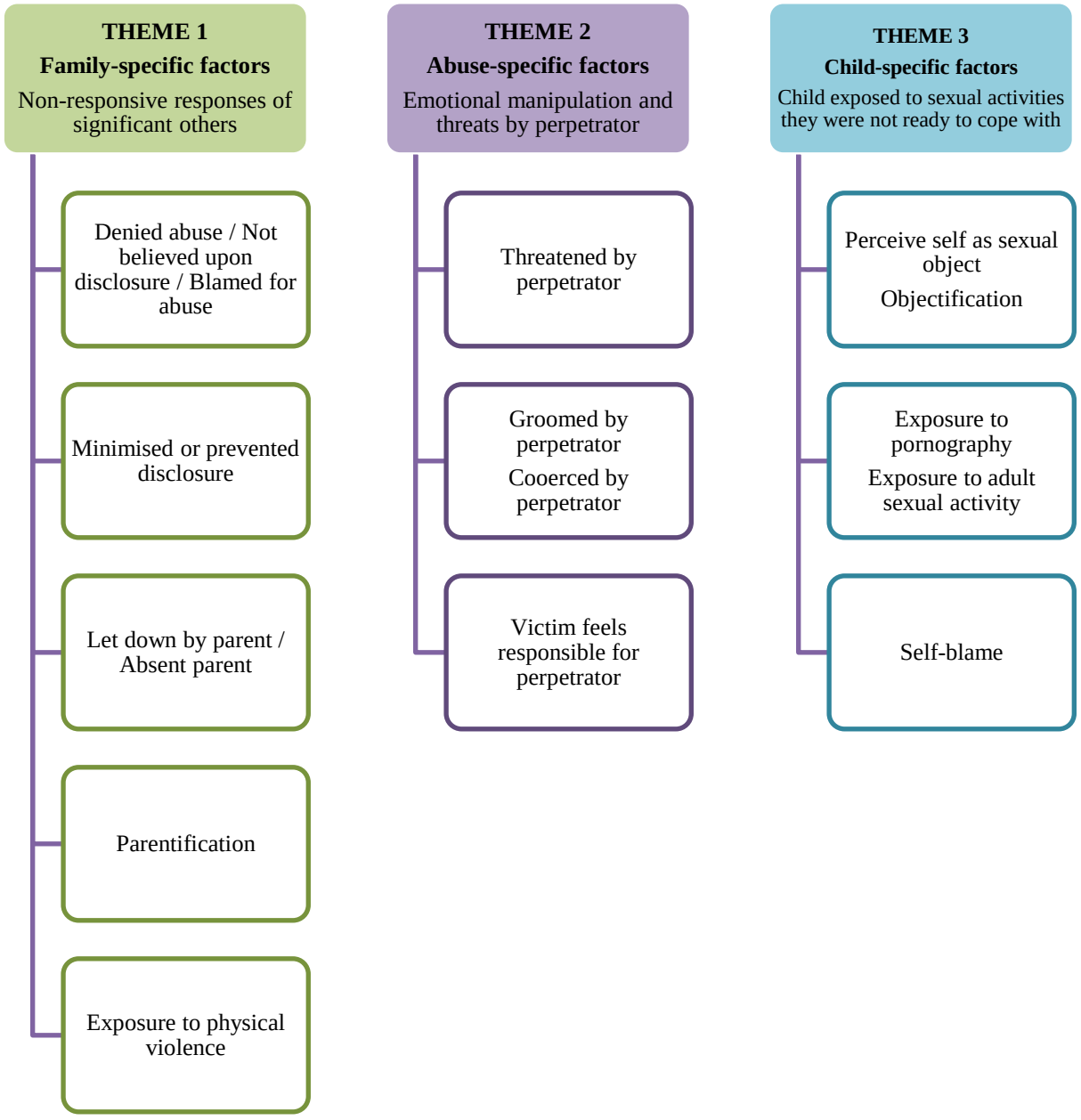

Figure 3: Themes and subthemes

3.5.1 Theme one: Family-specific factors

As depicted in Figure 4, family-specific factors became evident from this research that significant and sometimes insignificant caregivers responded in an unsupportive way to the child's disclosure by not believing the child or not reacting in a way to help or support the child. This appeared to result in further disclosure being inhibited and/or in the child's emotional and physical needs being unmet. These unsupportive reactions from the parents appeared to lead to various feelings, for example, betrayal and helplessness, which contributed to the level of stress experienced by the child.

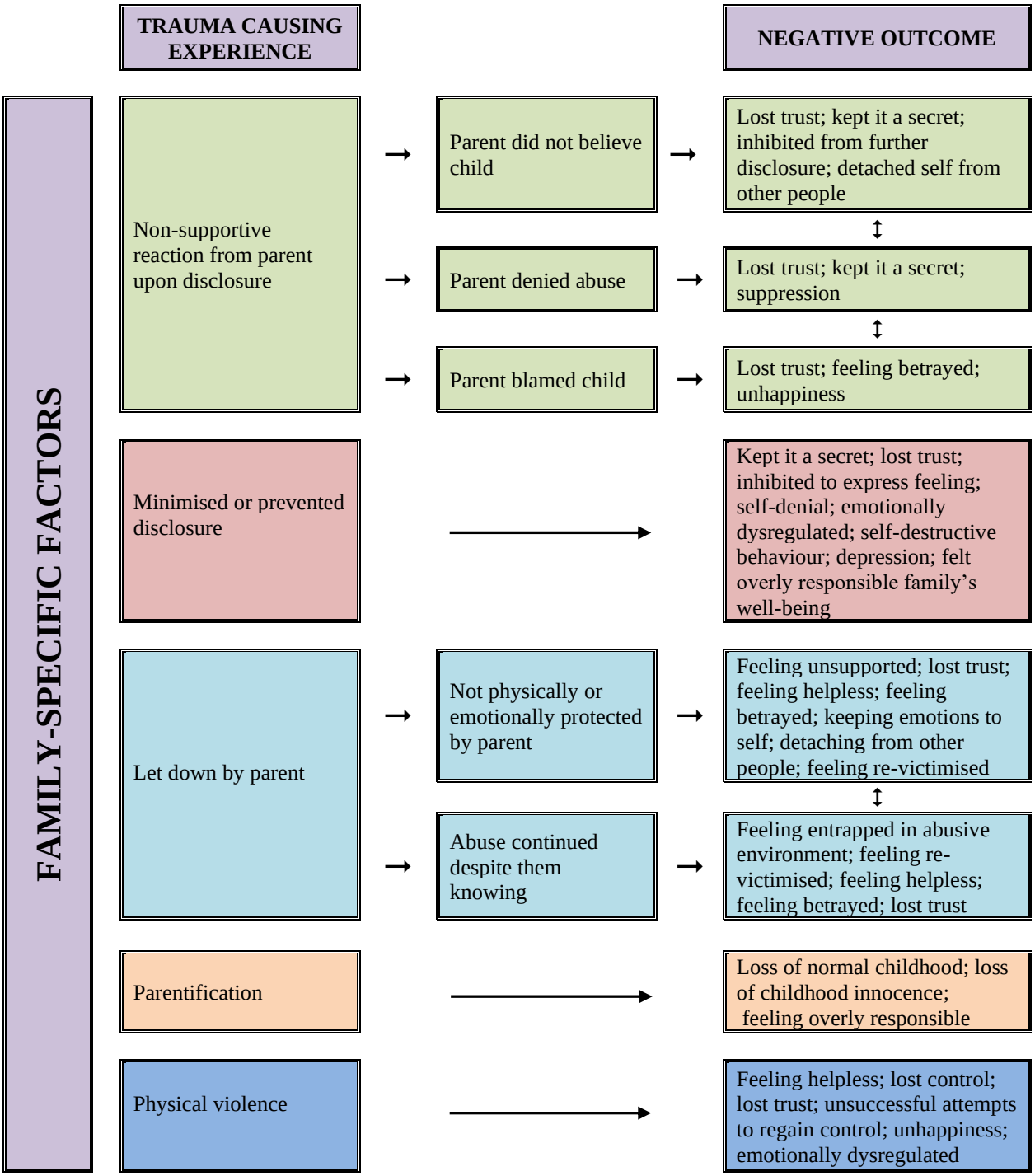

Figure 4: Family-specific factors

The family-specific factors that became evident in this research, will now be illustrated by referring to participant quotes.

- **Denied abuse / Not believed or blamed for the abuse**

Participants described that they were not believed when they told significant or even insignificant adults about their abuse or that the adult even blamed them for the abuse, which resulted in them feeling angry or inhibited them from further disclosure.

Participant 5 (Group 2) described how not being believed and blamed for the abuse inhibited her from further disclosing. The following quote illustrates how this participant was manipulated into keeping a secret, as she felt overly responsible for her family's well-being.

> *And now I think maybe she [mother] realised what was happening, but she didn't do anything about it. And that kind of made me so angry, because instead of doing something, she said I should move in with my grandmother … I told my teacher, told my grandmother and I told her about it but she didn't believe me … I told them and they still didn't believe me … So, I tell my grandmother about it and then she said that I am having an affair with him [abuser] … and like the message my grandma gave me was that if word came out, I would actually be destroying my family. So, if I did something about it … or the family knew about it … it would be on my shoulders … I don't want to repeat myself … I don't want to talk about it a lot…*

Some participants shared that after not being believed upon disclosure, they lost trust in both significant (mother) and insignificant (priest) adults resulting in inhibited disclosure.

> *At first, I spoke out and nobody believed me. … when I was thirteen and ran away from home the first time and I told a priest and they did nothing about it* (Participant 4, Group 3).

> *Then my mom, it wasn't that she didn't believe me, she was convinced by one of her friends it wasn't true. But she just didn't acknowledge it, we never spoke about it, it was like taboo* (Participant 2, Group 3).

> *Like in a time when I grew up that was a total taboo. You never spoke about it … Nobody actually knew about it except my mom and she didn't believe me … my mom told me I was talking nonsense … and I decided I wasn't going to talk to anybody else because my mom*

said its part of my imagination … and after that I thought but why must I ever talk to you again about anything. So, I kept to myself tor the rest of my life … (Participant 3, Group 3).

Participant 3 (Group 3) further indicated that she, after not being believed upon disclosure, lost trust in her primary caretaker (mother), and thus suffered the long-term consequence of detaching herself from other people.

I think the best way I survived when I was young was to lock myself away from everyone else. I think the reason for that is when the situation first started, my mom was the first person I talked to and the first time was the first night it happened … and she didn't believe me.

The following participant relayed how she was groomed by the abuser, and not only experienced blame for that from her primary caretaker (grandmother), but was also threatened not to disclose. Living with this burden in addition to the sexual abuse trauma, lead her to experience lifelong feelings of unhappiness and being emotionally deprived.

So I tell my grandmother about it and then she said that I am having an affair with him [abuser] … and like the message my grandma gave me was that if word came out, I would actually be destroying my family. So, if I did something about it … or the family knew about it … it would be on my shoulders … this experience is like disability. …It's not like a physical disability but it's like an emotional wheelchair … So, I actually referred to myself as the little girl who lost her smile. Because I always looked so sad and so angry…… because I won't say I was a happy child, I was not a happy child (Participant 5, Group 2).

The above quotes from participants indicated that they were not believed upon disclosure, or they were blamed for the abuse or their parents denied the abuse. These unsupported reactions from significant adults resulted in participants being inhibited to further disclosure, as will be illustrated in the next sub-theme.

- **Minimised or prevented disclosure / Denying the abuse or keeping it a secret**

The following two participants emphasised that they felt responsible for their family's well-being and wanted to protect them from emotional trauma, which inhibited them from disclosing the abuse. Furthermore, it appeared that in order to live with the secret of the CSA, survivors engaged

in negative coping behaviours, such as denial, and these behaviours appear to have resulted in emotional dysregulation such as depression.

> *I will not disclose this [abuse] to my family because I do not know what their reactions will be … I think their world will be torn apart inside and I don't want that to happen. They do not need to go through those emotions that I had been through already… Keeping it from my parents, to me it doesn't feel like I am keeping a secret from them it is more like protecting them…I don't want them to go through those emotions and everything…* (Participant 2, Group 2).

> *… because I also haven't told my mother … I feel like I am protecting her because my mother has also been through a lot herself … but I don't want her to go through all of that … So, from that time I just tried to ignore it. I was even in denial. Sometimes I think that I am making it up because someone else is going through it but I was just in denial after I realised that this really happened to me I just try to ignore it … so I just thought if I could ignore it I could tell that it hasn't happened but since it was now in my mind I … kept thinking of it and then I would be angry, feel sad and then that is when I started having depression* (Participant 8, Group 2).

Participant 1 (Group 2) reported on the lack of understanding from her parents, as expressed in the following extract. This participant explained how a lack of emotional support inhibited her from disclosing and that it appears to have led to long-time negative outcomes, for example, self-harm and attempted suicide.

> *I can see now looking back that my relationship with my mom, actually my parents … they didn't understand and because I didn't tell them the things that happened in my life … I never shared any emotional thing with them, never…So, they couldn't understand me … I am not telling them and by keeping it to myself I revert to other things, self-harm, suicide attempts….*

In the above quotes, participants report reasons as to why they were so inhibited to disclose, for example, that they felt responsible for their family's well-being or they wanted to protect their family. Living with this secret appears to have resulted in negative coping mechanisms and dysregulated feelings like depression. The next theme will demonstrate how feeling let down by a parent may lead to the loss of trust and parental betrayal.

- **Let down by parent or absent parent**

Accounts where victims have been exposed to the physical or emotional absence and/or not being protected by their parents, were reported as contributing to being vulnerable to the trauma and occurrence of the CSA. Parental betrayal was experienced by these participants as they reported non-supportive behaviour from the significant family members in their lives when they needed it most, resulting in the loss of trust in significant adults.

The following three quotes illustrate such incidents:

> *So most of the time when my mom was working … Because in my childhood I spend most of my time by myself, my mom was at work, by age seven I had learnt to open for myself, at night I had to close the curtains and lock and not let strangers in, I was always alone because my mom had to work and come back late. … I have been playing around with other kids and that is where it [abuse] sort of happened* (Participant 4, Group 2).

> *… but we could play out on the streets [unsupervised by parent] … We played on the streets on Wednesdays and my friend's brothers would beat me up [referring to sexual abuse]* (Participant 2, Group 2).

> *My first attempt … I attempted suicide at the age of fourteen. I took all the tablets in the house, I swallowed all of them. I remember it was about 7 o'clock in the morning, I woke up at about 6 … I didn't know what was happening there, but they were making me vomit all these tablets that I have taken. They didn't even take me to hospital* (Participant 5, Group 3).

Two participants pointed out that regular exposure to their abusers and being re-victimised left them feeling entrapped in the abusive environment whilst their parents were physically present but remained indifferent about or were unaware of the abuse.

> *Age ten, it [sexual abuse] was of five different people. Close family friends, neighbours basically … it was basically, my best friend's brothers and friends of theirs … I saw them [teenage abusers] every day, we lived across the road from each other. So, and we as friends, the two girls, were constantly at each other's houses. So, it did make it very difficult. And you know our parents were friends, we would go to the country clubs and this*

and to that function together … I was afraid to go and sleep over at her [friend's] house if they [abusers] were around (Participant 2, Group 2).

My mom and dad visited their [his] parents [parents of sexual abuser] quite a lot and we went there almost every weekend. And it didn't stop there, because when we were in the swimming pool, he would always try me …and at that stage I decided I wasn't going to be part of this anymore but for four years after that, it [abuse] still carried on (Participant 3, Group 3).

Participant 5 (Group 2) perceived her mother's death as abandonment, she appeared to long for her mother to rescue her and thus the loss of her mother lead to her feeling unsupported and helplessness.

I was nine when she [mother] passed away … you were just in that [abuse] situation, you wanted to be rescued and your mom was not there to rescue you.

Participant 2 (Group 2) relayed her loss in trust in significant adults as a result of adults that were in the position to physically or emotionally protect her, but failed to do so, leaving her in a position of helplessness.

So I think that's what I can relate … people who are supposed to be looking after you or being in leadership, fault. So that you're aware that as a child you were helpless and your parents who had all the authority should have been able to serve the purpose of protecting you.

You know with us black people, there's this stigma about rape, especially when it comes from the family. No one would believe you, I mean how would your own dad do that to you? … I was seven, I told my granny and she didn't believe me…. Every time he [abuser] tried to do whatever, I tried to fight back, but it didn't really help (Participant 6, Group 3).

It further appears that victims also felt let down by their parents through the emotional absence of their parents. Participant 7 (Group 3) relayed how she had no one to trust, which resulted in her keeping her emotions to herself and detaching from other people. Parental rejection was also illustrated as a reason for the loss of trust in significant caregivers, as seen by her quote:

I've been on my own since I was little, I never had anyone I can trust so I've learned to just keep to myself. My coping is I just cut off my emotions and go on … I also locked myself

from anyone else. Stayed in my bubble, no -one could get through. The first time when I finally got the courage to tell my mother to ask for help, she told me: "go play, I don't want to hear stories" ... I was made out to be a lair, trying to get attention.

Parent or significant others appeared to be complicit in the sexual abuse. Some participants reported that adults who were in a position to protect them instead ignored or never acted in a way to aid in stopping the abuse and as a result they lost trust in the adult figure and experienced a sense of betrayal.

I kind of realised that I was in this alone and that it was up to me to sort it out and fix it, because nobody really cared. ...so, I was lying in bed and the man [abuser] told my mother what had happened, my mother stood at the door ... and she threw a lollipop at me and said shut up and stop crying. So that was the extend of her involvement, it was never discussed after that ... I hid myself ... because that's also what I kind of did ...lock myself away with books and stories in my head (Participant 4, Group 3).

Her husband decided he liked me a lot, so that was from nine through to sixteen, uhm ... I use to have to play wife to him while my aunt was lying in the next bedroom smoking her Van Rijn cigarettes and reading Mill's and Boon (Participant 4, Group 3).

The stepfather tried to rape me, they would go out, come in early hours of the night, then he would come into my bedroom, 2 o'clock a.m. My mother would go straight to her bedroom. I don't know what she was thinking. I don't remember her being there ... my mom was never there ... She never protected me from the rapist. She never protected me from my father, she was never there for me ... But I feel like with my mom, she was supposed to be there. She didn't do enough ... she wasn't protecting us with this man that she had (Participant 5, Group 3).

The following two quotes illustrate that the loss of trust and anger is not always felt towards significant adults in a child's life, but towards any significant other or higher power that was trusted and then deceived them, in this case, God.

I was angry with God when I was a kid. Like "how could you make this happen?" I believed in him. But I was angry with him (Participant 2, Group 3).

I was a very religious person and as a young child, I remember giving my life to God at the age of seven, which is very young. And a lot of children don't know the difference at that age, and I did. And this [abuse] occurred when I was ten and I couldn't understand why God had let it happen (Participant 2, Group 2).

It thus appears from the above quotes that the physical and/or emotional absence or not being protected by parents or significant others led these participants to being re-victimised by the perpetrators. Furthermore, parental betrayal was caused by not being supported by their parents when they needed them most. A different form of absence of the parent, namely parentification, will be explained in the next sub-theme.

- **Parentification**

In this uniquely South African data sample, which included different ethnic groups, parentification, where the mother's role was transferred to the child as a result of the physical absence of the significant mother, was found to be very evident and will be illustrated in this sub-theme.

Accounts of parentification where the parental role was transferred to the child were reported by the next two participants, by them indicating how responsibilities above their age were assigned to them, which left them with the feeling of losing their normal childhood and childhood innocence.

Since childhood … I was the one who was busy with my siblings, I mean at the age of nine years I was doing laundry, doing the cooking, my mom was never there … I was taking care of my brother and sister at a very young age. When my mother was out gallivanting, my father was also out there, they were doing their thing. I had to be the responsible one, I had to be the strong one. I had to make sure that my siblings are fed, my siblings have something. I was a mother; I was a father to them (Participant 5, Group 3).

I was always protecting myself more than playing, more than trying, more than growing up … And I did get a lot of responsibility at that age to my sister who would have been three, so it was all about responsibility (Participant 2, Group 2).

It was illustrated in this sub-theme that accepting responsibilities above a child's age by taking over the motherly role can result in feelings of added responsibility and, therefore, the loss of

normal childhood and childhood innocence. The next sub-theme will demonstrate how exposure to physical violence may have contributed to the severity of CSA trauma for the child.

- **Exposure to physical violence**

This research indicated that physical violence is often also present in the family lives of sexually abused children, contributing to additional stress, over and above the trauma of the sexual abuse. Participants described how this leads to intense feelings of helplessness, as well as to feeling entrapped in the abusive environment. Some participants relayed their coping mechanisms as isolation and suppression.

In the following quotes, two participants highlighted how they were exposed to physical violence from their primary caretakers and felt out of control in their entrapped abusive environments. Both also described how they longed for the violence to stop and even tried to fight back, with Participant 5 (Group 3), also relaying how she lost trust in her mother during this process.

> *He [father] was a bit of an alcoholic, badly, drank himself to death. He literally got into a fight with the fridge because the fridge was in the way. He was bad, always abused my mother, one time he tried hitting her and she beat him up to a pulp … He would walk through the house and look for something to fight about. If he was in the house, you'd literally tense up … And then the abuse afterwards, look the sexual abuse … but after that it was so much violence and control … many a times, he would strangle me, hit me, try and drown me, so many different … kick me … well one time he tried breaking my foot, but I pushed it against the wall, I always fight back* (Participant 2, Group 3).

> *When it [abuse] happened, at nine years, it was also physical abuse from my father … and then she [mother] gave me this scar when I told her, she poured me with hot water … I don't trust my mother, don't want her name, at one stage I just wanted her to die … I thought the physical abuse … I'm done … but then, it went on …* (Participant 5, Group 3).

The following participant indicated how she was blamed for the abuse, was threatened as result thereof, and was physically beaten. These actions resulted in the participant feeling betrayed and worthless.

> *I lied because I already being hit and so that it wouldn't leave a mark because they sort of hit me places like, like not my arms or legs where you could see. So it would be in the*

stomach and kick me in the back and that sort of things …So it was like them having their guilt projected onto me and saying well you know, you deserved it, you looked for it, but I didn't… and saying if you tell, or if you say that, do you know that you are dirty, you did this, you know? … So as many times afterwards I was beaten and told it's my fault ... like it was drawn, physically beaten into me …. is that you feel like you're not worthy. I interpreted it as not being accepted because everything I did was unacceptable and everything I was, was unacceptable… (Participant 2, Group 2).

Participant 6 (Group 3) elaborated on how she was exposed to severe emotional trauma above her developmental readiness through exposure to physical violence. The following quote defines her coping mechanisms as not effective, resulting in her isolation.

I went to my granny's house again and he [father] tried doing it [abuse] and my mother walked in … that is the night that I lost my dad. Because then, they were fighting and that's when my mother started beating him up and that's when she stabbed him and that was on my birthday. My 12th birthday, when I should have been celebrating, I lost my dad the very same day. And then, it hasn't been easy, I don't know … but it was hard cause I struggled so much that I had so many problems … I think it was my coping mechanism yes … I isolated myself from everything, almost everything I could.

Emotional manipulation through using physical violence was illustrated in the next excerpt with this participant forced to supress her emotions with the result of living an emotionally-deprived life.

Even when I was forced to see sperm donor [abuser], if I would get hurt when I was young, he would tell me I wasn't allowed to cry. I wasn't allowed to show emotion. If I start crying because I got hurt, he would beat me, so ja, I was never allowed to show emotion (Participant 7, Group 3).

Participant 5 (Group 3) shared how she felt stigmatised, exposed and humiliated as a result of her father's physical maltreatment in the following quote:

My father used to strip me naked while my mother was at work and say, run from this street to that street. I'm fourteen years old, I'm naked, the whole street is looking at me.

The following excerpt illustrates how this participant was rendered helpless by the physical violence of a significant adult:

> *… he [abuser] got his gun and said he will shoot me. So, to stand in front of a person with a gun in your face …* (Participant 2, Group 3).

It is illustrated in the above sub-theme that the presence of physical violence over and above the sexual abuse, can add to the severity of the emotional trauma for the child. Emotional dysregulation often results as well as feelings of helplessness and fear. Findings from the next theme, namely the abuse-specific factors, will now be discussed.

3.5.2 Theme two: Abuse-specific factors

In figure 5, the abuse-specific factors are depicted. Findings in this theme will demonstrate the significant impact that the emotional manipulation by the perpetrator may have had on the trauma level of the child. It will be discussed by referring to the threats made by the perpetrator, the grooming by the perpetrator and even how the perpetrator made a victim feel responsible for his well-being by blaming her.

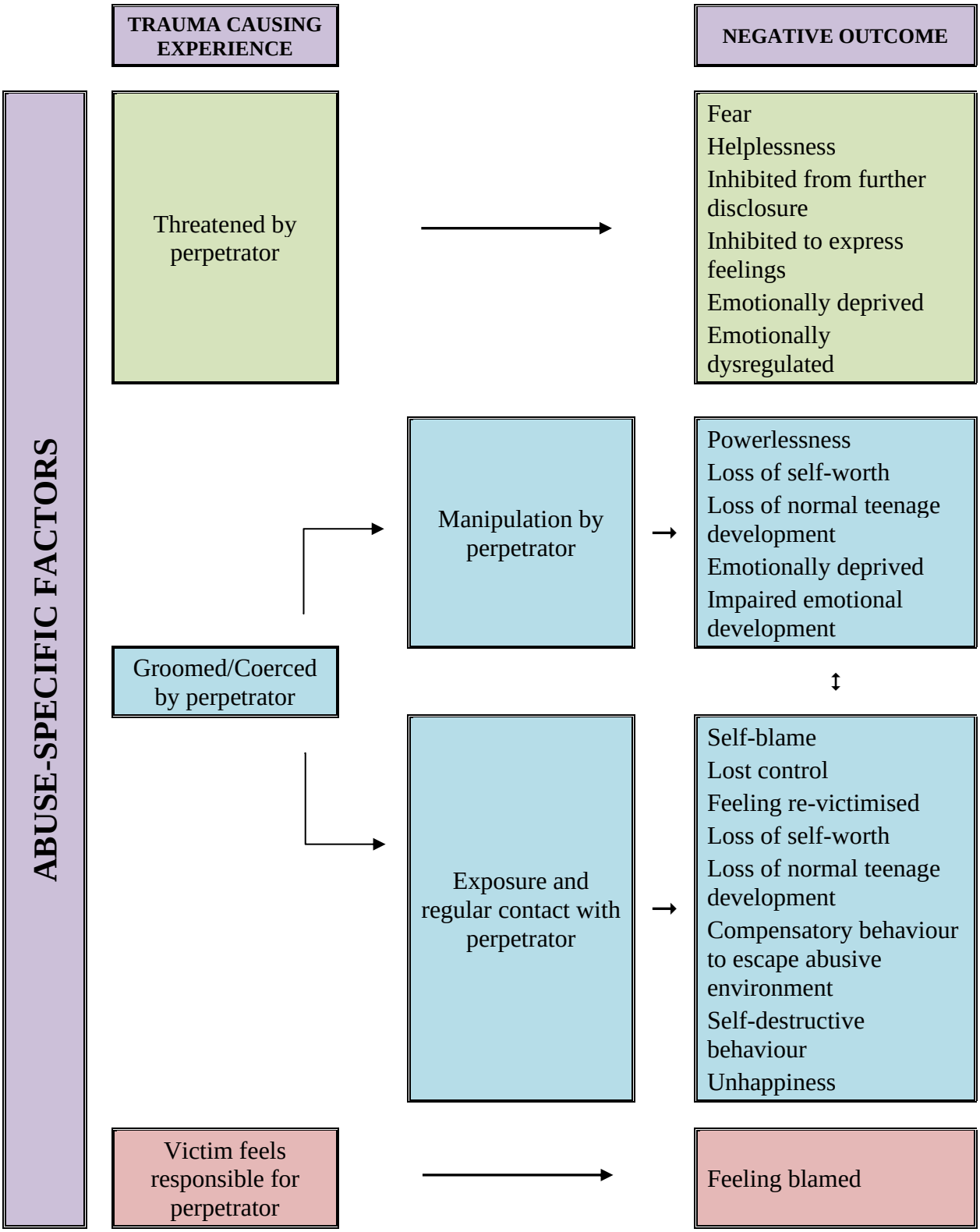

Figure 5: Abuse-specific factors

- **Threatened by perpetrator**

Perpetrators often use threats as power mechanisms to ensure that a child does not speak up about the sexual abuse. It can have a mammoth impact on a child, especially when it is aimed at somebody that plays a significant role in the child's life.

In the following extract, it was demonstrated by Participant 2 (Group 3) how threats and manipulation from the abuser, especially when aimed at somebody very important (mother) to the victim, can inhibit a child from expressing feelings and thus prevent disclosure.

> *When I was a kid, I couldn't express, wasn't allowed to say how I feel … We never spoke about it, it was like taboo … And he told me that if I told her [mother], I'd never see her again. And my mother was my life, I mean my dad just passed away … Yes, he used that so often, threatening to hurt my mother to control us and threatening to hurt us. You know, you're small, you don't know anything else. So ja, he manipulated and it was bad, very, very bad.*

The powerful mechanisms that perpetrators may use, are not only limited to threats as was illustrated above, but can also be used in the grooming process, as illustrated in the next sub-theme.

- **Groomed / Coerced by perpetrator**

Grooming is often used by perpetrators to win a child's trust as part of their plan to later sexually abuse the child. Grooming is aimed at making a child feel special, often satisfying emotional and physical needs, that may not otherwise be met, as will be described in this sub-theme.

Evidence of the abuser grooming the victim and making her feel special can be found in the next excerpt. This participant reacted to the abuser's manipulation and then found herself in a situation where she lost control and was helpless and was consequently exposed to sexual abuse.

> *Somebody called me and said he [abuser] is going to give us a ride on his bicycle and when I got there he said I must stand right at the back and then I will be able to have a long ride and it was exciting, bicycles in the coloured community was a big deal and made me feel special because he wanted to give me an extra-long ride … He took me down to the river with his bicycle and said that I had to come look at his snake. Was actual small, I was expecting a long snake. So eventually the neighbour [abuser] raped me* (Participant 4, Group 3).

The following quote elaborates on how a non-supportive significant adult can conspire with the abuser by indirectly participating in the abuse. This participant reflected on how her father's girlfriend groomed her for the abuse and made her look pretty after which she was sexually abused by her father. This participant further relayed how she lost trust in her father, was confused and felt powerless as a result of being exposed to a sexual activity beyond her developmental age.

> *So, since my mother was working, she would always leave me at my grandmother's house … So eventually my dad met this other woman and they were living at the back of my granny's house and I would be there like every day … and then I don't know, I don't know what happened but there was a night where my dad wasn't around, he went to work and I was left with the lady, the girlfriend. And then she started [conspiring with the perpetrator in grooming the victim for abuse] putting make-up on my face you know, dressing me up. And I think I looked really pretty, I though she wanted me to look pretty … I don't know about what, in the middle of the night the very same night he [father/abuser] came and he started touching me. And because it's my dad I wouldn't say, ok papa what are you doing? … He started undressing me and then he did whatever, but the only thing I remember was the one thing that of course that time I didn't know what was happening, but I remember the white fluid on my thighs and … I just didn't understand what was going on. Every time he [abuser] tried to do whatever, I tried to fight back, but it didn't really help … And from there on it happened, I was fine with it, I didn't complain, I didn't say anything to anyone* (Participant 6, Group 3).

Participant 4 (Group 2) explained in the following quote how she was blamed and coerced by the perpetrator to follow his instructions. Her inability to act upon the abuse from happening, left her feeling vulnerable and helpless.

> *I remember the words that the man said to me … he said because you talk too much and because you are naughty, you did this, and when you get into the house you must go straight to the bedroom, I can't remember anything I said, I can't remember what was happening, I didn't even know the man … But the next thing I remembered, he was on top of me, he was touching me inappropriately and all these things, it was very painful. It was painful, I didn't know what to think, I didn't know what to do … I felt so vulnerable, I felt helpless.*

In summary, it is explained in the above sub-theme how grooming and being coerced by a perpetrator can lead to the sexual abuse of a child victim. This often results in the victim feeling

helpless and powerless. Coercion can be used on different levels, also to make the victim feel responsible for the perpetrator, as will be illustrated in the next sub-theme.

- **Victim feels responsible for perpetrator**

A child victim can be manipulated by the perpetrator into blaming herself and making her feel responsible for the abuse. The victim can further be manipulated into feeling responsible for the perpetrator's satisfaction, as will be explained in this sub-theme.

Participant 4 (Group 3) reflected on how the abuser blamed her and made her feel responsible for keeping him sexually satisfied.

> *My message to myself was, it was my responsibility, cause to satisfy him [abuser] … because he had sexual problems with himself, he had premature ejaculation or something like that, so he had to teach me how to do it properly so that he doesn't come too quickly and stuff like that. So, I had to learn how to satisfy him properly and I felt responsible to keep him happy and that's what he used to tell me … and that it was my fault … it's your fault because you're so pretty*.

The above theme thus demonstrates the significant impact that a perpetrator can have on the trauma level of a child during sexual abuse. The power of the perpetrator can be used to threaten a child leaving the child feeling helpless and vulnerable. Grooming and manipulation, in order to win a child's trust, can also be used in the process that leads to sexual abuse.

3.5.3 Theme three: Child-specific factors

Figure 6 depicts the child-specific factors, which is the last theme that was identified in this research. This theme refers to the child that was exposed to sexual activities they were not ready to cope with and the excerpts will illustrate the effectiveness of how each individual child handled the trauma of the abuse. The child-specific factors will be divided into the following sub-themes: perceive self as a sexual object, exposure to pornography and adult sexual activities, and self-blame.

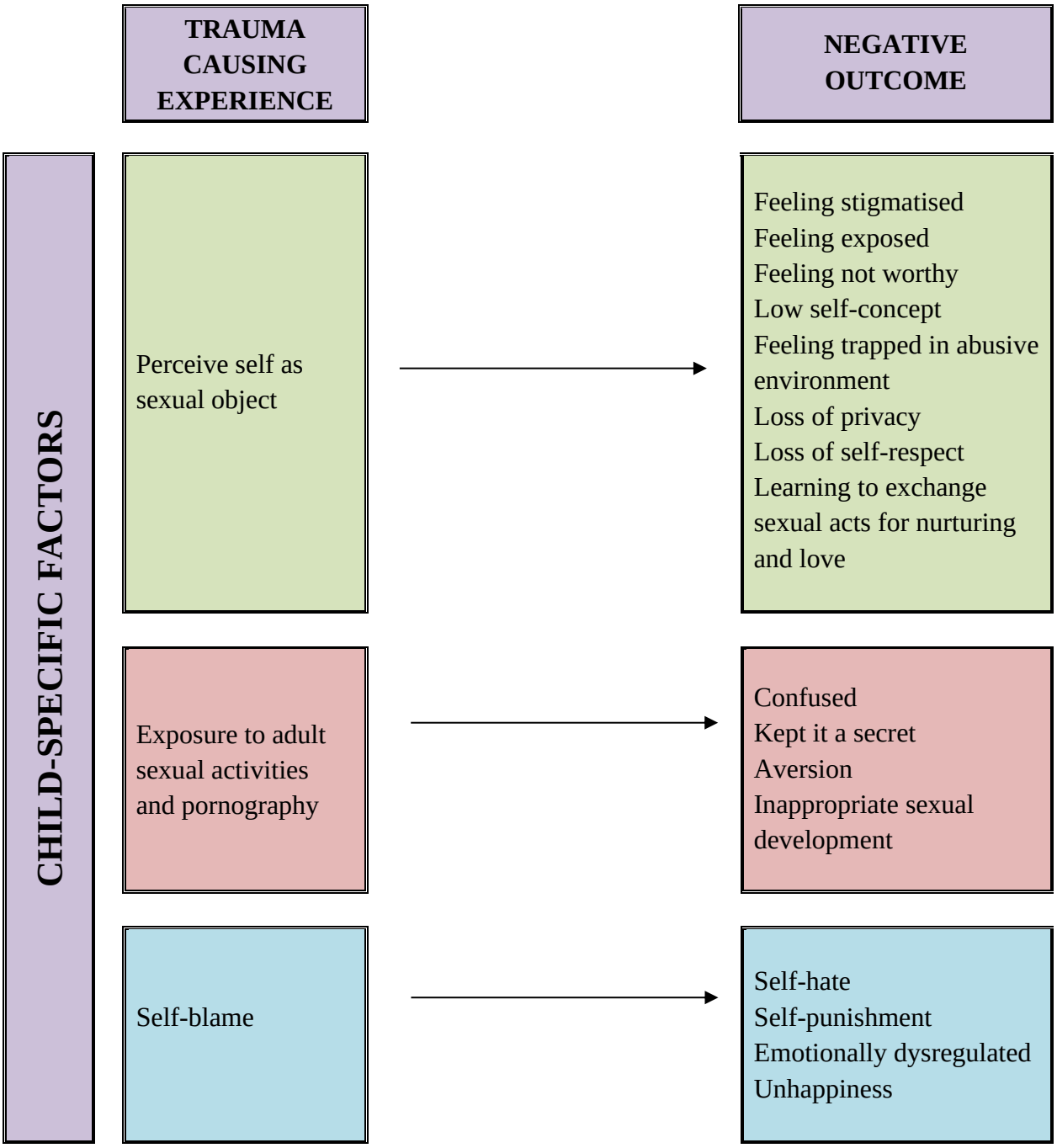

Figure 6: Child-specific factors

- **Perceive self as a sexual object / objectification**

This sub-theme will explain how sexual objectification was evident where a child's body is used by the perpetrator for no other reason than satisfying his own sexual needs. Objectification further includes the emotional and physical boundary violations where the perpetrator disrespects the

victim's personal space and privacy. This can leave the child feeling stigmatised, out of control, and confused.

Objectification was evident in the following extract of this participant's perception of her objectified body, which left her feeling exposed and stigmatised, eventually blunted from the situation.

> *I was like nine years old and he [abuser] saw me as a sexual object, even in high school, I would clothe my body, I would like clothe it, knowing that guys always treated me, they were so sexual towards me like I found it as the norm, I eventually got used to it …* (Participant 5, Group 2).

It is clearly defined by the words of Participant 2 (Group 3) how a child's body can be objectified by an abuser and be used for no other reason than his sexual self-gratification. These actions left the victim feeling out of control and confused.

> *My story about what the sexual abuse is, is my stepfather, so-called father … But yes, every night he would visit me in my room … for five years, I was five years old until I was ten … I always had to be ready for when he wanted it … It was very confusing because he [abuser] would pull me close and push me away, pull me close and push me away … it was very confusing*.

The following quote provided some insight into boundary violation where the child's personal space and privacy was disrespected. In order to escape the situation, this participant's coping mechanism was to overcompensate by throwing herself in her studies and books.

> *He [abuser] would spy on me like through the keyhole of the bathroom, or he would be in the bathroom with me. He would always be everywhere. It was, I don't know how to explain it. I wasn't allowed to draw my curtains when I was dressing or things like that, so he took my sense of self away at that stage … And the little girl won't smile because she doesn't have coping mechanisms … how I dealt with or coping mechanisms when I was small was reading and learning because it was a whole other world that I could hide in … I could cut off … my studies, hiding behind books, love reading … but that was my hiding place, he [abuser]could take my body but not my mind* (Participant 2, Group 3).

Another example where a child's body was merely used as a sexual object, is evident in the following quote. Participant 5 (Group 3) elaborated how a child's beliefs and behaviour can be inappropriately conditioned by the abuser in order to purely satisfy his own needs. For this participant, it resulted in distorted meanings about sexual morality where she traded sex for affection, which led to her promiscuous behaviour.

> *The abuser betrays the child's trust. He robs her of any resemblance of safety, privacy or self-respect and uses her as a mere object. That's how I felt … So small children, I was eight years at the time, do not understand the significance of the immoral act that is forced upon them. But universally they find the experience frightening, humiliating, that's how I felt. Childhood sexual abuse has thus been called the ultimate betrayal. What if a child is trained that she is powerless to prevent sexual intrusion? Trained to view herself as useless, dirty, trained to perform perversions in exchange for love. Dirty. Trained to perform … could that not lead to a lifetime of destructive behaviour? … I was also into boys … the feeling arose, I develop compulsive and immoral desires, I was into boys*.

Participant 2 (Group 3) indicated how her body was seen as a sexual object by her abuser and was only assigned to himself. Control over her was further taken by not allowing her to have normal teenage relationships or dress and nurture herself appropriately. This resulted in her loss of self-worth and inappropriate teenage social development.

> *… not having any boy in my life because I belonged to him [abuser] kind of thing … so it was hard to understand. I couldn't even wear v neck tops, I had to be closed up and I couldn't wear my hair like I wanted… when I started shaving, he hid my razor… he had an issue with me wearing make-up … it was this … it was hellish*.

The above-mentioned participant further explained in the following extract how the only way she thought she could regain control over the abusive situation, was to change her physical appearance to look different to the abuser's physical preference of his sexual object. This resulted in a self-destructive relationship with food.

> *I had to look totally different than what he wanted, I had to put on weight, cut my hair … He [abuser] doesn't really like people who are fat, so I put on weight … but it's tough for a kid to understand … in my mind that was the only thing I could control … he literally trapped me in such a way I couldn't control anything but the food. And I refused to eat at a stage, and he would make me sit at 12 at night until I started pushing the food into my*

mouth … so it was a big thing with food, so he gave me chocolates, saying sorry … (Participant 2, Group 3).

The following participant described how she was seen as a sexual object by the community as a result of incorrect information that was relayed. This resulted in her feeling stigmatised and judged, leading to her low self-concept.

I feel judged, like they know my secret and they think you are a skank or something and I think that's mostly because of what happened with the youth pastor, was he told other people that we had sex and not that he raped me, so rumours spread around. So, a lot of people that know me think I'm like that because they don't know my story. And because of what happened I don't feel beautiful, I feel dirty and disgusting. I mean I can't look at myself naked without having disgust within me (Participant 3, Group 2).

Being entrapped in an abusive environment over time, can lead to the victim's negative evaluation of their physical attractiveness and thus contributes to a distorted self-concept, as illustrated in the following quote:

You know, people would tell me, participant 6, you look so beautiful, participant 6, you this … but I didn't feel beautiful, I felt so ugly, I didn't appreciate myself. I felt like I was trapped in this body and I was drowning and nobody was even realising … (Participant 6, Group 3).

The above sub-theme demonstrated how victims of CSA can, over a period of time, start perceiving themselves as a sexual object. This can be the result of the child being coerced and inappropriately conditioned by the perpetrator to purely satisfy his own sexual needs. This may eventually lead to a child's distorted meaning of sexuality. The effect of exposure to pornography and adult sexual activities will be discussed next.

- **Exposure to pornography and adult sexual activities**

This sub-theme will show the effects of a cognitively and emotionally immature child being exposed to pornography or adult sexual activities that the child is developmentally not ready for. Negative responses and anxiety were found in this research, as well as a victim experiencing the re-traumatising feelings of her own rape.

Pornography, as inappropriate exposure to sexual knowledge above age, is described by Participant 2 (Group 3) in the following excerpt, explaining how her continuous exposure to pornography as a child, resulted in her long-term aversion of any sexual images.

> *It's always sex, its sex everywhere, he would have porn on the TV … and until today I can't stomach that, I can't stomach anything of that sort*.

Participant 5 (Group 3) shared how her inappropriate exposure to adult sexual activities beyond her developmental age, resulted in her experiencing the re-traumatising feelings of her own rape ordeal.

> *By then my mother was married to my father, but she was sleeping around with all the men in the house and I had to see that. It was more than ten men. It was like being raped all over again, seeing that*.

The following quote illustrates how Participant 6's (Group 3) exposure to inappropriate adult sexual activities resulted in her feeling responsible for her mother's emotional well-being.

> *I went to stand by the door of their [mother and girlfriend] room and then she [girlfriend] was busy on my mother and then I thought about it … but I thought it's like old people stuff, let your parents do whatever, its ok. But only then I realised it wasn't ok because my mother didn't look happy, she didn't look like she wanted to do it although they were together, although they were a couple*.

Therefore, it is apparent from the above quotes, that exposure to pornography and adult sexual activities at an inappropriate developmental age may lead to negative responses by the victims. As such, because these victims were not developmentally mature enough for these sexual images, they were not capable of organising these experiences in a comprehensible way. This consequently led to re-traumatising feelings, confusion, and long-term aversion to sexual images. The last sub-theme, namely self-blame, will now be discussed.

- **Self-blame**

This research indicated that being exposed to sexual abuse over a period of time cognitively engaged victims in trying to work out why the abuse had occurred, which appeared to lead to feelings of self-blame being internalised. This sub-theme will explain how victims blamed

themselves for the abuse or their inability to stop the abuse, resulting in their self-punishment and self-hate.

Participant 2 (Group 2) described that as a result of her at a young age not understanding why the abused happened, the only possible explanation was that it was her fault. This resulted in self-blame and self-punishment as the long-term negative internalised effect.

> *And I couldn't understand why at the age of ten this [abuse] has happened. So I thought it was something I did…… Everything that happened wrong in my life … was my fault of what I had let happen to me. So if I fell off my bicycle, I deserved it because it was punishment of something I did … every little thing that went wrong in life I thought was an extra punishment or I deserved it … I think as a child I believed it*.

The following two participants also provided valuable insight into their feelings of self-blame. They both stated that they felt responsible for the abuse that took place or felt responsible for their inability to stop the abuse, leaving them with feelings of self-blame and even self-hate.

> *He [abuser] used to force himself, kiss with his tongue … and by that time he was drunk. I was sexually abused, it started when I was six years old. It went on for about three years … I just hate myself, I keep thinking there's something I should have done, should have said to stop it* (Participant 5, Group 3).

> *First of all, with the molestation, I thought like maybe it's my fault in a way because living with him [abuser], he was the person I was used to, because he was my uncle. And so, I wasn't close to my aunt. So, whenever I needed something, I use to tell him, you see? … I wasn't close to her; I was close to him … I would say I was at fault* (Participant 5, Group 2).

Participant 6 (Group 2) reflected that she regarded her own actions as the reason why she was exposed to the sexual abuse. The consequences of her actions left her with feelings of self-blame and unhappiness.

> *Because I believe that if I wasn't exposed to that person [abuser], if I didn't visit my aunt, he wouldn't have done that [abuse] to me. If I just would have stayed home with my grandmother, he wouldn't have access to me … so I believe that if I just stayed home, none of this would have happened to me I would be a happy person*.

Therefore, self-blame as an internalised feeling was found in this research as a common feeling, experienced by most participants. Victims cognitively tried to work out why the abuse occurred and due to a lack of explanation, blamed themselves. This consequently resulted in self-hate and self-punishment.

The discussion of this QSA will now follow, whereafter the limitations, conclusion and recommendations will be highlighted.

3.6 Discussion

The objective of this study was to explore the traumatic childhood sexual abuse experiences of women survivors who participated in the S2T collaborative strengths-based group intervention programme in order to inform guidelines for conducting trauma-sensitive social work forensic assessments.

The conceptual framework for this study was based on the Traumagenic Dynamics Model as proposed by earlier researchers, Finkelhor and Browne (1985), which offers a systematic understanding of the unique trauma-causing factors as experienced by victims of CSA. These researchers conceptualised four traumagenic dynamics, namely: traumatic sexualisation, betrayal, stigmatisation, and powerlessness (Finkelhor & Browne, 1985). The findings from this study appear to correspond with the theory of these international researchers as the data extensively described the trauma-causing factors of the victim's challenges regarding their sexual thoughts and behaviour, which appeared to be developmentally inappropriate or interpersonally dysfunctional and so resulted in victims feeling sexualised, betrayed, stigmatised, and powerless or helpless.

Although the above-mentioned four traumagenic dynamics were clearly identified in this research, this unique South African data sample indicated that the trauma-causing factors and negative outcomes can also be contextualised within three context-specific themes that influenced the effect and degree or dose of the trauma that the participants reported, namely: family-specific factors (focusing on the non-supportive response of parents and significant caregivers or others to disclosure); abuse-specific factors (focusing on emotional manipulation and threats by the perpetrator); and child-specific factors (focusing on the child that is exposed to sexual activities they are not developmentally, emotionally or physically ready to cope with). These themes identified in this research demonstrate a correlation between previous research done in South Africa (Spies & Bezuidenhout, 2006) as well as research from the USA (Yancey & Hansen, 2010).

In addition, this study indicated that betrayal as a result of loss of trust, was experienced by the participants as the most predominant trauma-causing factor in this specific data sample. The data suggests that the loss of trust was not only restricted to significant adults (parents and close family members), but also to insignificant adults (priest) as well as a significant other or higher power (God). Trust was betrayed by not being believed upon disclosure, being blamed for the abuse, not being protected by parents, abuse continuing despite parents knowing, and the presence of physical abuse. Loss of trust as a trauma-causing experience leading to betrayal was not only indicated in this South African study, but is widely supported by international literature in the USA (Makhija, 2014), Canada (Godbout et al., 2014), Australia (Hunter, 2015), and the UK (Macdonald et al., 2012).

An unexpected discovery in this study was parentification as a contributing factor to additional trauma-related symptoms and a further increase in the severity of the trauma experienced by the child is apparent. Parentification is described in literature as the absence of a strong mother figure where the child is forced to take the mother role upon themself (Mayhall, 2012). This finding is of great significance in the unique South African context, as cultural influences play a significant role and it is widely regarded acceptable in certain ethnic groups for a young child to take on the caring and nurturing role for her younger siblings.

The findings from this study indicate that the most predominant trauma symptoms that were experienced by the participants during their CSA are: loss of trust, feeling betrayed, experiencing negative responses upon disclosure, feeling powerless and helpless, detaching from other people, feeling worthless, being emotionally dysregulated, having a low self-concept, engaging in self-destructive behaviour, self-blaming, feeling re-victimised and stigmatised, and perceiving themselves as a sexual object. These findings correlate with previous studies done in South Africa (Fleming & Kruger, 2013; Human, 2015; Van der Merwe, 2009) that indicate similar findings. The presenting findings from this research were utilised to compile guidelines for conducting trauma-sensitive social work forensic assessments and will be discussed in Section B, step three, of this research study.

3.7 Limitations

The data sample is small. Furthermore, the researcher was not involved in the data collection and was thus not able to ask relevant questions or make observations. The fact that secondary data is used in QSA can be regarded as another limitation as the data was not gathered to answer the

research question for this study. Data may thus not include comprehensive information and experiences relating to the specific research question. The data was gathered in a group intervention context, and the participants may not have been truly open and honest due to concerns about confidentiality and possible distrust of other group members. The data sample only included female participants and therefore possible valuable contributions from a male perspective were not accounted for. Lastly, the data was obtained from adult women, and therefore their reflection on the trauma as a result of CSA that they experienced as small children may have, over time, lost certain aspects and intensity.

3.8 Conclusions

The purpose of this part of the study was to explore reported traumatic experiences and negative outcomes of women CSA survivors. The trauma-causing factors that were recognised are in line with the seminal Traumagenic Dynamics Model of Finkelhor and Browne (1985). While these earlier researchers identified traumatic sexualisation, betrayal, stigmatisation, and powerlessness, the findings of this research demonstrated that the trauma-causing factors can further be categorised differently in context-specific factors, namely family-specific factors, abuse-specific factors, and child-specific factors. Family-specific factors depicted in this study included not being believed upon disclosure or parents denying the abuse; parents minimising or preventing the disclosure; the child was let down by the parent or the parent was absent; and/or there was exposure to physical violence. Abuse-specific factors included threats by the perpetrator or the victim felt responsible for the perpetrator. Child-specific factors that were identified were perceiving self as a sexual object; exposure to adult sexual activities or pornography; and self-blame. The increased knowledge relating to the trauma-causing factors from this South African sample will be used to develop guidelines with the intent to give forensic social workers a better understanding of the child's behaviour when conducting forensic assessment using a trauma-sensitive approach. These guidelines are discussed in Section B, step three, of this research.

3.9 Recommendations

The findings of this manuscript need to be contextualised with literature in Section B, step one of this study to inform the formulation of guidelines for conducting trauma-sensitive social work forensic assessments.

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STEP THREE: GUIDELINES TO DO TRAUMA-SENSITIVE SOCIAL WORK FORENSIC ASSESSMENTS

THIS IS PREPARED FOR THE JOURNAL OF CHILD SEXUAL ABUSE. GUIDELINES ARE FOUND IN ADDENDUM 7.

PREFACE

This part of the study will formulate guidelines to conduct trauma-sensitive social work forensic assessments. Research from the literature review (step one) and findings from the QSA (step two) of this study will be combined to propose these guidelines.

The secondary research question that drove this part of the study is as follows:

> *How can guidelines be formulated from the empirical findings and the literature review, so as to reflect a trauma-sensitive approach and integrate and acknowledge the role and duty of the forensic social worker in South Africa?*

4.1 Introduction

These guidelines were formulated with the aim of providing forensic social workers (FSWs) with an enhanced understanding of the unique trauma-causing factors and negative outcomes related to CSA, in order to guide these FSWs to conduct forensic assessments in a trauma-sensitive manner. The concept of *trauma-sensitive* means that the adverse consequences of sexual abuse of a child must be conceptualised into the negative outcomes of trauma and must then be used as such and be reflected in the structure and content of the interview or assessment process of the child (Macdonald et al., 2012). The FSW must thus account for the possibility that the child in the forensic interview may have experienced some form of previous trauma as a result of CSA. The FSW must understand and be sensitive to the child's emotional and behavioural reactions during the interview. Furthermore, it should be kept in mind that the forensic interview in itself will influence the trauma level of the child as the interview situation is unfamiliar and it is also expected of them to share painful and intimate information with a strange person (Lamb et al, 2011).

4.2 Definitions

4.2.1 Definition of guidelines

Rosen and Proctor (2003) define guidelines as a set of methodically compiled statements that consist of empirically-tested knowledge and procedures to help professionals select and implement the most appropriate and effective interventions for the most desired outcome. Guidelines can further be described as a series of steps to be followed towards the appropriate challenge, using professional expertise based on evidence-based research findings, whilst considering the client's unique circumstances and characteristics (Lucio & Nelson, 2016).

4.2.2 Definition of social work guidelines

In the social work context, Kirk (1999) refers to guidelines as the use of specific treatment recommendations, applying evidence-based social work treatment methods within the background of organisational processes and procedures to support therapy and recovery whilst addressing the client's symptoms and challenges directly. Rosen et al. (2002) refer to social work guidelines as set of knowledge statements to assist practitioners and clients in finding, selecting, and using the most appropriate therapy or intervention for client-specific circumstances.

As the literature review of this study revealed that very limited guidelines in forensic social work is available, the purpose of developing guidelines can be regarded as managing basic challenges of social work practice, namely encouraging FSWs to use evidence-based and appropriate knowledge in the form of guidelines to successfully conduct forensic assessments and to further inspire knowledge development that can be utilised in forensic social work practice. Literature (Rosen & Proctor, 2003) distinguishes between *practice standards* and *practice guidelines*; guidelines allow for greater flexibility, as the FSW can implement these guidelines according to her own knowledge as well as the child's specific circumstances.

4.3 Research question

The third secondary research question will be answered in this part of the study, namely:

> *How can guidelines be formulated from the empirical findings and the literature review, so as to reflect a trauma-sensitive approach and integrate and acknowledge the role and duty of the forensic social worker in South Africa?*

4.4 Formulation of guidelines

The guidelines were formulated so as to inform trauma-sensitive social work forensic assessments, which were deduced from the empirical findings and the literature review, using three principles (3-R: recognise, respond, and report) which reflect a trauma-sensitive approach and integrates and acknowledges the role a of the forensic social worker in South Africa.

The intent of these guideline is to equip FSWs with trauma-sensitive knowledge in order to *recognise* the signs and symptoms of CSA trauma on the child victim, to *respond* with trauma-sensitive skills when handling the situation and to *report* the incident(s) through process notes during the forensic interview in order to finalise court reports. The guidelines will hence be formulated using the 3-R approach, namely recognising, responding to, and reporting the trauma symptoms and negative outcomes that the child present with.

First, a framework within which the guidelines could be rooted was identified. The trauma-sensitive approach and the nature of forensic social work informed a framework. In terms of the trauma-sensitive approach, the FSW must be mindful and sensitive that the child can relay or present with emotional and behavioural reactions during the interview as a result of trauma experienced due to CSA. Therefore, such signs and symptoms of trauma must be dealt with in a trauma-sensitive manner and must be acknowledged and be understood by the FSW. Lastly, the information that became available during the interview must be reported in process notes to be utilised when compiling the court report.

The effects of the trauma that the participants experienced as a result of sexual abuse will be referred to in this guideline as the negative outcomes and can be seen as the symptoms that the child could present. These negative outcomes will be discussed as indicators of what possibly may have caused the outcome, by referring back to the trauma-causing experience or sub-themes identified in this research. It must be mentioned that this research indicated that the trauma factors are inter-related and are also child- and situation-specific.

The following table gives a summary of trauma symptoms, indicated in this study, that were contextualised into the guidelines that the child can present with as well as possible reasons that the forensic interviewer can consider that could have caused the trauma.

Table 14: Trauma symptoms

NEGATIVE OUTCOMES: **Trauma symptoms that the participants presented**	**TRAUMA-CAUSING EXPERIENCE:** **Possible reasons that caused the trauma symptoms**
DISTRUST	
Lost trust	Not believed upon disclosure Parent denied abuse Parent blamed child Minimised or prevented disclosure Not protected by parent Abuse continued despite them knowing Physical violence
Feeling betrayed	Parent blamed child Not protected by significant adult Abuse continued despite them knowing No emotional support from significant adult
Minimised or inhibited disclosure Kept a secret	Not believed upon disclosure Parent denied abuse Threatened Exposure to adult sexual activities Exposure to pornography
EMOTIONAL AND BEHAVIOURAL DYSREGULATION	
Keeping emotions to self Emotionally deprived	Parent denied abuse Threatened Not protected by significant adult Manipulation by perpetrator Inhibited to express feelings
Emotionally dysregulated	Self-blame Threatened Was inhibited upon disclosure
Self-destructive behaviour	Was inhibited upon disclosure Self-blame Exposure and regular contact with perpetrator
WORTHLESSNESS	
Feeling worthless Feeling helpless	Not protected by significant adult Abuse continued despite parent knowing

NEGATIVE OUTCOMES: **Trauma symptoms that the participants presented**	**TRAUMA-CAUSING EXPERIENCE:** **Possible reasons that caused the trauma symptoms**
Feeling powerless Lost control Feeling entrapped in abusive environment	Physical violence Threatened Manipulation by perpetrator Exposure and regular contact with perpetrator Perceived self as sexual object Not believed upon disclosure Not protected by significant adult
Low self-concept	Perceive self as sexual object Loss of self-respect
Self-blame	Exposure and regular contact with perpetrator
Detached self from other people	Perceive self as sexual object Manipulation by perpetrator Exposure and regular contact with perpetrator Groomed / Coerced by perpetrator Not believed upon disclosure
RE-TRAUMATISATION	
Loss of normal teenage development Loss of normal childhood	Manipulation by perpetrator Exposure and regular contact with perpetrator Parentification
Feeling re-victimised	Not protected by significant adult Abuse continued despite parent knowing Exposure and regular contact with perpetrator
SEXUAL REACTIVE BEHAVIOUR	
Exchanging sexual acts for nurturing and love	Perceive self as sexual object
Aversion towards sexual acts or images Confusion towards sexuality	Exposure to adult sexual activities Exposure to pornography

The guideline depicted in Figure 7 includes a schematic representation of the reported emotional and behavioural trauma messages or negative outcomes. Following the figure, these trauma message will be discussed separately, first contextualised within literature after which, the three core practice principles, (3-R) will be explained.

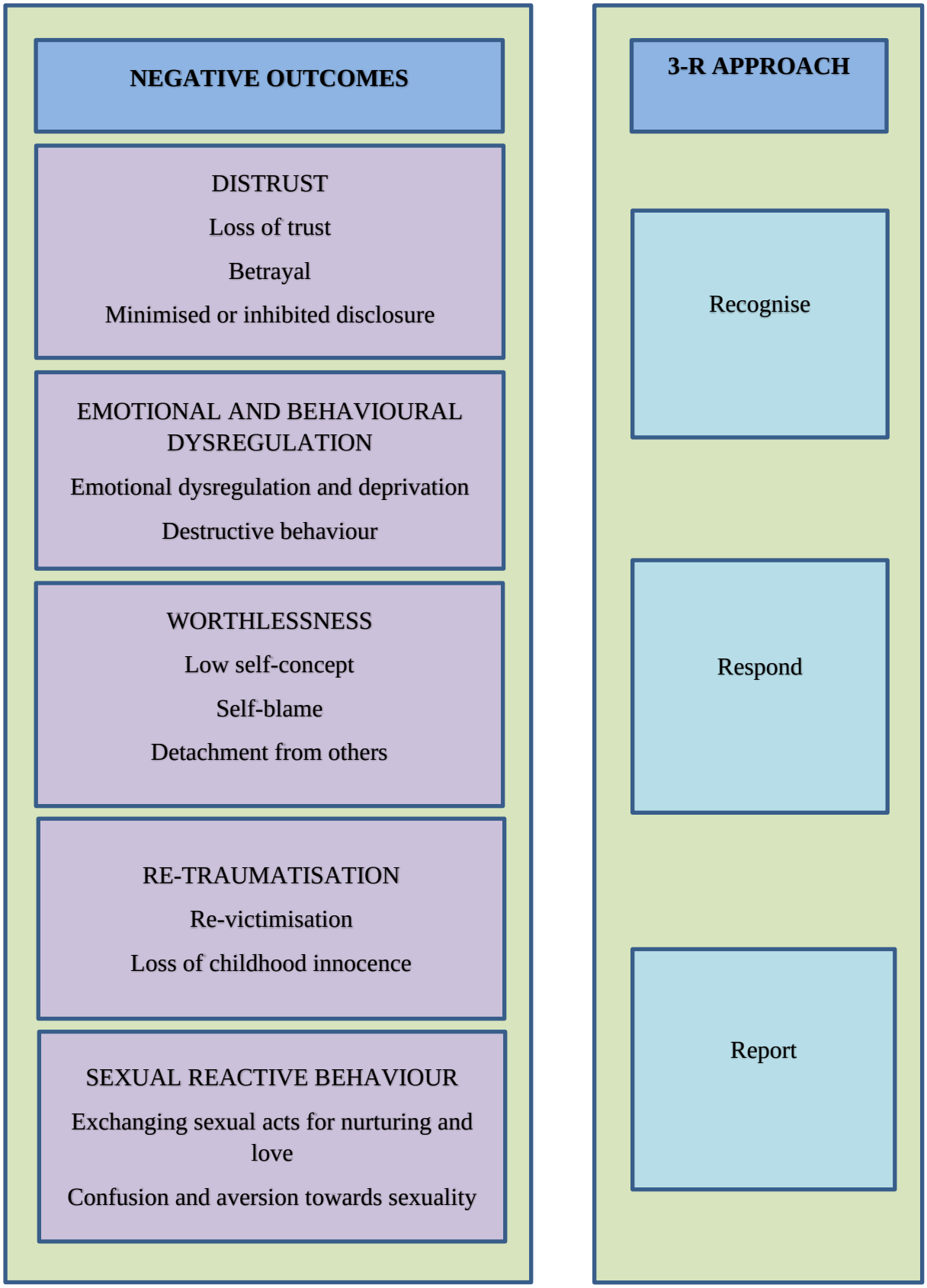

Figure 7: Summary of guidelines

The emotional and behavioural trauma messages will now be discussed, followed by the 3-R guidelines.

4.4.1 Distrust

Distrust in this study was indicated by loss of trust in significant others, betrayal, and minimised or inhibited disclosure as a result thereof. Distrust is one of the most profound losses that a sexually abused child can experience (Spies & Bezuidenhout, 2006). Forensic social workers should be aware that this loss of trust in significant others often results in a child feeling betrayed (Human, 2015; Van der Merwe, 2009). Feeling betrayed, specifically as a result of being blamed, can contribute to the devastating outcome of the child then blaming themselves, hence, self-blame (Zinzow et al., 2010). Karakurt and Silver (2014) report on the lack of protection during abuse, specifically from the victim's mothers, resulting in a deep feeling of betrayal. Apart from the protective adult being physically absent when protection is required, the belief that the adult knew about the ongoing abuse but failed to act upon it, further results in the child not feeling safe or protected (Hunter, 2015; Winnett, 2013). The lack of such protection from significant adults, often results in the child feeling betrayed (Hardy, 2017; Karakurt & Silver, 2014; Kenny, 2018). Additionally, the loss of trust in significant others often inhibits further disclosure, as researchers from Canada as well as South-Africa (Collin-Vézina et al., 2015; Spies & Bezuidenhout, 2006) agree that the parent's initial response to the child's disclosure will have a significant impact on whether or not and to what extent the child will further disclose. Distrust, as a result of threats, is also indicated in global literature to constrict a child's opportunity to disclose as a result of the fear of the negative outcome upon disclosing, for example, harming a family member or being taken away from their home (Alaggia, 2010; Allnock & Atkinson, 2019; Mayhall, 2012).

Forensic social workers should be cognisant and recognise how distrust in adults as a negative outcome of CSA can manifest in various symptoms and may be presented to the FSW during the forensic interview. As such, when a child relays their loss of trust during the assessment, the FSW should recognise the multiple causes contributing to this distrust. It was indicated in this research that there are various trauma-causing experiences for distrust, such as: the child was not believed upon disclosure; the child was not emotionally supported; parents denied the abuse; parents blamed the child; the child was prevented to disclose; the child was not protected; the abuse continued despite the parents knowing; and/or the presence of physical violence or threats. Literature supports these findings and negative outcomes which can be summarised as the loss of trust resulting in feelings of being betrayed or exploited by others (Karakurt & Silver, 2014;

Kenny, 2018; Knight, 2015; Miller & Cromer, 2015). It can further be mentioned that when a child expresses anger and blame towards the unprotecting parent during the assessment, it can be as a result of feeling betrayed by the parent (Mayhall, 2012; Zinzow et al., 2010).

During the trauma-sensitive assessment, the FSW worker must be mindful that when the child indicates that they experience distrust or feels betrayed that a wide range of possible causes could be contributing to this negative outcome. As such, the FSW must respond by acknowledging these feelings and actively engage and explore these factors in order to gain more in-depth, accurate information.

Lastly, the FSW must respond in a way that will make the child feel emotionally safe, as Van der Merwe (2009) further notes that a child's distrust is not only relevant to their primary relationships, but is also pertinent to the relationship with the FSW interviewing the child, and therefore, this further stresses the importance of the FSW working within a trauma-sensitive approach to be mindful of the child's sense of distrust.

Trauma-sensitive 3-R guidelines for responding to children who present with a feeling of distrust.

Recognise:

- The FSW must recognise that the loss of trust in significant adults can lead to the child feeling betrayed.
- Distrust may present as emotional and/or behavioural manifestations and may be communicated verbally or non-verbally, for example, the child may present with feelings of anxiety or helplessness or may not want to communicate during the interview.
- The FSW must recognise and be aware that deeper feelings of betrayal as experienced by a child may be focused on and directed towards the mother figure. The child may further present with anger and blame towards the unprotecting parent during the assessment and also towards the FSW who is the significant other in the assessment.
- The child may feel inhibited to disclose their sexual abuse during the interview as a result of their sense of fear. Such children communicate or act out that they were not believed; the parent denied abuse; the parent blamed the child; the parent did not

protect the child or the abuse continued despite the parent knowing; the child received no emotional support from the significant adult; abuse continued despite parents knowing or parent blamed child. This could be identified by the child presenting with the following signs: helplessness, fear, anxiety or feeling out of control during the assessment.

- The FSW should further recognise and consider any threats of negative consequences for the child and their family by the perpetrator if they disclose.

Respond:

- When interacting with the child the FSW needs to be cognisant that the child may also not trust them during the interview as a result of the general loss of trust in adults and therefore must respond in a way that will allow the child to feel emotionally safe. This can be done by: 1) the FSW should firstly display a warm and accommodating non-verbal body language towards the child; 2) thereafter the FSW can create an interview environment where the child feels safe by explaining to the child how the interview will work and to ensure that the child understands what is expected of them; and 3) ensure that the child feels empowered by giving them the control to say if they do not understand a question, is tired, thirsty or want to go to the bathroom.
- The child's feeling of betrayal towards significant others must be acknowledged and can be done by: 1) the child must be guaranteed that it is ok if they get upset towards their mother or other significant adults during the interview and must be motivated to verbalise these feelings; and 2) the child must further be ensured that the FSW will not get angry or upset with them.
- The FSW should further respond by investigating the parent's initial response and possible negative reactions to the child's disclosure and thereby recognise the impact of this on the child and on the child further disclosing, even during the assessment.
- The FSW must register and be mindful that disclosure in itself is a traumatic process for the child and respond by guiding the child sensitively in this regard by asking appropriate probing questions.

Report:

- This trauma-causing factor should be reported in process notes and taken into consideration in the assessment of the veracity of the allegation.

4.4.2 Emotional and behavioural dysregulation

Emotional and behavioural dysregulation was indicated in this research in the form of emotional dysregulation and deprivation as well as self-destructive behaviour, which can direct the FSW to certain trauma-causing experiences that the child might have suffered. Trauma can widely be seen as any experience that causes various negative emotions like fear, anxiety, emotional pain or distress (Bowen & Murshid, 2016). Trauma, such as CSA, can have an impact on a child's stress regulatory system, which leads to children having difficulty in regulating these negative emotions (Lotty et al., 2020). As highlighted by Spies and Bezuidenhout (2006), sexually traumatised children often experience that emotions are connected to pain and therefore suppress them, deny them, diminish them or distract themselves from them, finding it easier than disclosing the pain that they are suffering. Van der Merwe (2009) states that the impact of trauma can even have a numbing effect on emotions or can cause a child to emotionally disconnect. Not only emotions, but also challenging behaviour can be an indication of emotional dysregulation (Bowen & Murshid, 2016). Ullman et al. (2014) are of the opinion that self-destructiveness can manifest in many different ways in sexual abuse victims.

Forensic social workers must be mindful and recognise how emotional dysregulation as a negative outcome of trauma may present. This research indicated that self-blame was evident; participants kept their emotions to themselves, were emotionally deprived, felt inhibited to express their feelings, and suppression of their emotions were reported. The trauma-causing experiences that lead to this were reported as parents having denied the abuse; the child was not protected; the child was threatened or manipulated by the perpetrator; and physical violence. This study indicated that children further do not only present with emotional dysregulation, but also with behavioural dysregulation that often presents as self-destructive behaviour where self-blame; being prevented from disclosing; and exposure or regular contact with the abuser contributed to these negative outcomes. Kenny (2018) notes that suicide attempts and dysfunctional eating patterns as negative outcomes can be regarded as intentional self-destructive behaviour as was also reflected by participants in this research. Spies and Bezuidenhout (2006) further explain that overeating and putting on excessive weight can lead to a body that is unattractive and will thus not be of sexual interest to others, as was also elaborated on by one of the participants in this study.

The FSW can respond in a trauma-sensitive manner by acknowledging the dysregulated emotions of the child and can further respond in a way that will allow the child to feel safe to share these emotions by feeing emotionally supported.

Trauma-sensitive 3-R guidelines for children who present with emotional and behavioural dysregulation

Recognise:

- The FSW must be cognisant of the direct impact the trauma has on the child's stress regulatory system and must, therefore, explore the dysregulated emotions of a child as these emotions can direct them to certain trauma-causing experiences that the child might have suffered.
- The FSW must recognise that traumatised children's emotions are connected to pain and, therefore, these children may rather suppress, deny or distract themselves from their emotions so as to distance themselves from pain. This could be identified by the child relaying the following indicators: child manipulated by perpetrator; child not emotionally supported by significant adults; parents inhibited child to express feelings; or parents denied abuse.
- The FSW must recognise when the child presents with negative emotions such as fear, anxiety, emotional pain or distress, or challenging behaviour, which can be indications of physical violence, being threatened by the perpetrator, and self-blame. The FSW can thus regard these symptoms as indicators of trauma that the child has suffered and must then explore further to determine the cause.
- The FSW must be mindful if the child presents with self-destructive behaviour, which could present in different forms and include: self-harm, suicide attempts, and dysfunctional eating patterns. The FSW must further be aware and be informed of the serious consequences thereof, as well as the different trauma-causing experiences that can lead to self-destructive behaviour like self-blame.

Respond:

- When interacting with the child, the FSW needs to be cognisant that the child may present with dysregulated emotions or behaviour during the interview and, therefore, must respond in a way that will allow the child to feel safe to share these emotions. This can be done by: 1) the FSW assuring the child that they are accepted to experience and express feelings and emotions; 2) probing questions can be asked in a sensitive way to explore the trauma-causing experiences that lead to these emotions; and 3) when a child is emotionally very distressed during the interview,

the FSW can allow them a minute or two to recover before continuing with the interview.

- The FSW must be mindful that the child may not want to share their emotions during the forensic assessment as a result of their emotional deprivation and, therefore, respond in a way that will allow the child to feel emotionally supported. This can be done by: 1) acknowledging the pain that the child suffers whilst verbalising their emotions or feelings; 2) the FSW can ask probing questions in a sensitive manner to guide the child to verbalise their emotions; and 3) the FSW must ensure the child that it is accepted to experience and express any emotions.
- When interacting with the child, the FSW needs to be cognisant that the child may relay self-destructive behaviour in the assessment as a result of their feelings of helplessness and worthlessness and must consider responding in a way that will allow the child to experience self-worth and empowerment. This can be done by: 1) assure the child that they are heard and that their narrative is believed; 2) acknowledge the child's feelings; and 3) the FSW must explore the child's perspective and understanding of this behaviour as the negative outcome of self-destructive behaviour can lead to serious consequences.

Record:

- The emotional and behavioural dysregulation of the child as consequence of sexual abuse should be reported in detail in the process notes and the effect thereof on the child should be reported in the court report.

4.4.3 Worthlessness

Worthlessness was indicated in this research as one of the most profound consequences of CSA and was reported as the result of low self-concept and self-blame. This also often leads to the detachment of the child from other people. A global body of research states the detrimental effect that sexual abuse has on a child's self-concept and self-esteem (Baker, 2015; Collin-Vézina et al., 2015; Gonzalez & McCall, 2018; Kenny, 2018). The concepts of low self-esteem and worthlessness are also closely related and the one often leads to the other (Spies & Bezuidenhout, 2006). Self-blame was found to be another factor leading to feelings of low self-concept and worthlessness. Being exposed to sexual abuse over a period of time cognitively engages victims in trying to work out why the abuse has occurred, leading to self-blame (Kenny, 2018; Van der

Merwe, 2009). Younger children tend to think that there was something that they could have done to stop it or that they deserved it, leaving them with feelings of low self-worth and embarrassment and shame (Ullman et al., 2014). Literature states that an additional reason, which may also contribute to self-blame, is the constant external blame from the family for the abuse over a period of time, and this may result in the internalised effect of self-blame (Collin-Vézina et al., 2015), as was also highlighted in this study. Self-blame also positively correlated with the frequency, duration, and severity of the abuse (Ullman et al., 2014; Zinzow et al., 2010) as was further noted in this study. Low self-concept and worthlessness were indicated as significant factors leading to detachment from others. Research from the USA correlates with South African research by noting that sexually abused children seek ways to protect themselves, of which one is to detach or isolate themselves from other people (Knight, 2019; Spies & Bezuidenhout, 2006). Van der Merwe (2009) further defines a low self-esteem, self-blame, betrayal, and stigmatisation as reasons leading to detached response behaviour, resulting in feelings of loneliness and isolation, which supports findings in this research.

The negative outcomes of worthlessness and low-self-concept was noted in this South African sample as the consequences of being blamed by the family, self-blame, stigmatisation, feelings of inadequacy or powerlessness, loss of self-respect, and perceiving self as a sexual object. The negative outcome of self-blame was initiated by regular exposure to the abuser and manipulation by the perpetrator. The two main reasons for detached behavioural responses were found to be the fact that parents did not believe a child upon disclosure or did not emotionally or physically protect or support the child.

The FSW working from a trauma-sensitive approach must, thus, acknowledge the child's feelings of worthlessness and self-blame and be open-minded to the various traumatic causes thereof. When a child reveals during a forensic assessment that they often detach themself from other people, the FSW conducting a trauma-sensitive assessment must understand this concerning behaviour in the light of the child's trauma experience that led to this behaviour.

Trauma-sensitive 3-R guidelines for responding to children who present with worthlessness.

Recognise:

- The FSW must recognise when a child presents with worthlessness, as indicated by the following: self-blame or inadequacy and powerlessness during the interview as a result of perceiving themselves as a sexual object; experiencing manipulation and/or coercion by the perpetrator; and regular exposure and contact with the perpetrator.
- The FSW must also register and be aware of the negative impact that sexual abuse can have on the child's self-concept, presenting in the interview as loss of self-respect for themselves or even for the FSW conducting the interview.
- The FSW must recognise if and when the child presents with low self-worth, as indicated by embarrassment, shame and feeling that there must have been something that they could have done to stop the abuse; that they must have deserved the abuse; is exposed to regular contact with the perpetrator; and that they should have done something to prevent this contact.
- The FSW must recognise the dynamics and various reasons that may have led to self-blame and that self-blame is positively correlated with the frequency, duration, and severity of the abuse.
- The FSW must recognise whether or not the child detaches themselves from other people. This behaviour can be regarded as the child's attempt to safeguard or protect themselves against the harmful emotional and physical consequences of sexual abuse.
- The FSW must further recognise if the child presents detached behaviour during the assessment. These could be indicated by: low self-esteem, self-blame, betrayal and stigmatisation, loneliness and isolation, as well as the parents not believing the child upon disclosure or parents not emotionally or physically protecting the child.
- The FSW must be cognisant that the child's detachment behaviour can also result in the child detaching themselves from the FSW during the assessment.

Respond:

- When interacting with the child, the FSW needs to be cognisant that the child may feel worthless, or present with feelings of inadequacy during the interview and, therefore, needs to respond in a way that will allow the child to experience

empowerment. This can be done by: 1) the FSW can empower the child by giving the child control to say when they do not understand a question, allow the child to use their own words for incidents or body parts and to correct the FSW if she makes a mistake; 2) give the child control to say when they are tired, thirsty or want to go to the bathroom; 3) ensure the child that they are heard and their narrative is believed; and 4) ask probing questions in a sensitive manner to explore the causes of low self-concept and worthlessness.

- When interviewing the child, the FSW needs to be mindful that the child may present with feelings that they were responsible for the CSA as a result of self-blame and must respond in a way that will allow the child to regain a feeling of self-worth. This can be done by: 1) the FSW can focus on the factors leading to the CSA, which may result in the child realising that they were not responsible for the CSA; 2) acknowledge the child's feelings of embarrassment and shame; and 3) asking probing questions regarding to what led to self-blame, which may shed light on the dynamics of the sexual abuse regarding frequency and severity of the abuse; and 4) the FSW must evaluate if self-blame is not translating into negative behaviour patterns.
- When interacting with the child, the FSW needs to be aware that the child may detach as a result of their own attempts to protect themselves against further emotional pain and should respond in a way that will allow the child to feel safe, protected and supported during the interview. This can be done by: 1) the FSW must express warm and acknowledging non-verbal behaviour towards the child that will result in the child feeling supported; 2) the FSW must ensure the child that it is safe to share their emotions and experiences in the interview environment; and 3) the FSW must acknowledge and be sensitive towards the pain that the child relays that led to the detachment.

Report:

- The feeling of worthless should be reported in the process notes and taken into consideration and be reflected when the court report is compiled.

4.4.4 Re-traumatisation

Re-traumatisation was indicated in this research through the re-victimisation of the child victims and the huge impact thereof became evident in participants relaying a loss of childhood innocence

and normal childhood. Forensic social workers should be aware that sexually abused children may experience re-victimisation due to various reasons. Hardy (2017) and Mayhall (2012) both note that the absence of protection from parents leads to the exposure of sexual abuse, thus re-victimising the child. Regular contact with the abuser has also been linked to the continuous sexual abuse taking place, thus, re-victimising the child with the result of re-traumatisation (Kenny, 2018). Forensic social workers further need to acknowledge the huge impact that sexual abuse has on the loss of normal childhood. The loss of childhood innocence is regarded as one of the biggest losses as a result of the trauma of sexual abuse (Knight, 2019).

The negative outcome of feeling re-victimised was reported in this research by participants as a result of the trauma-causing experiences of not being protected by their parents; being exposed to and having regular contact with the perpetrator; and the abuse continuing despite their parents knowing. When a child relays these trauma-causing experiences during the interview, the FSW must be mindful that the child may be re-traumatised and should respond appropriately. This research further identified two categories of loss of childhood, namely loss of normal teenage development as a result of the trauma-causing factors of manipulation by the perpetrator and regular exposure and contact with the perpetrator; as well as loss of childhood through parentification where the child had to take over the adult parent's role. Parentification as referred to in the second scenario, must be understood in the unique South African context where cultural influences play a role as it is regarded acceptable in certain ethnic groups for a young child to take on the caring and nurturing role of younger siblings. In both instances mentioned above, additional trauma is imposed upon the child that needs to be acknowledged by the forensic social worker working from within a trauma-sensitive approach.

Trauma-sensitive 3-R guidelines for responding to children who present with feelings of re-traumatisation.

Recognise:

- The FSW must recognise the possible causes of re-victimisation that can be indicated by the child as not being supervised or protected by the parents or significant others; parents that are absent; being exposed to and having regular contact with the abuser; and the abuse continuing despite the parents knowing, all leading to the re-traumatisation of the child.

- The FSW must further be mindful and aware of the huge impact that sexual abuse has on the loss of childhood innocence and that a child's normal childhood could have been jeopardised due to the CSA. During the interview, the child can indicate loss of normal childhood through: relaying that they are exposed to and have regular contact with the perpetrator, as well as being manipulated by the perpetrator; or indicators of parentification, which can appear as additional responsibilities for the child.
- The FSW must also be cognisant that the forensic interview in itself can re-traumatise the child when it is expected of them to share the traumatic event with the FSW.

Respond:

- When interacting with the child, the FSW needs to be cognisant that the child is sensitive to being re-traumatised as a result of regular contact with the abuser and not being protected by the parents and should respond in a way that will allow the child to feel emotionally safe and protected during the interview. This can be done by: 1) the FSW must explain to the child how the interview will proceed and what is expected of them in order to ensure that the child feels safe.
- When interviewing the child, the FSW needs to be mindful of the loss of their normal childhood and parentification as a result of CSA or added responsibilities assigned to them and respond in a way that: 1) will ensure the child that it is only expected of them to act according to their own developmental level by the FSW utilising age and developmental appropriate interview techniques and media during the interview; and 2) the FSW can ask probing questions in a sensitive manner to further explore the loss of normal childhood as a result of regular contact and manipulation by the perpetrator.
- The FSW must acknowledge the child's feelings of fear and anxiety as the forensic interview in itself causes stress for the child when they must share intimate feelings and experiences about themselves, thus, preventing the child from feeling re-traumatised.

Record:

- Traumatisation as trauma-causing factor should be reported in the process notes and the impact thereof on the child should be taken into consideration in the forensic assessment and be reflected in the court report.

4.4.5 Sexual reactive behaviours

CSA often leads to children presenting with sexual reactive behaviours. This research reported on children exchanging sexual acts for nurturing and love as well as some children experiencing feelings of confusion and aversion towards sexuality and sexual acts or images. When a child learned from a young age that they can get physical contact and nurturing through sexual abuse, they may continue to look for closeness through sexual acts in their teenage years, resulting in promiscuous behaviour (Gonzalez & McCall, 2018). McGuinness (2019) and Van der Kolk (2017) further argue that when a physically and emotionally immature child is exposed to inappropriate sexual activities or pornography, they are not always capable of organising these experiences in an intelligible manner. If they do not have the opportunity to articulate what they have seen and observed, it can result in feelings of confusion or uncontrolled emotional reactions.

Negative outcomes were reported in this research by participants that they reverted to promiscuous behaviour as a result of the trauma of being perceived as a sexual object. Forensic social workers should be informed about the dynamics of how a child's perception of feeling as a sexual object can result in looking for closeness through sexual acts. Participants further reported that they felt confused and developed aversion towards sexual activities and images as a result of the trauma of inappropriate sexual exposure. During forensic assessments conducted using a trauma-sensitive approach, the FSW must always be mindful of the trauma that inappropriate sexual activities and pornography can cause for a young child that is emotionally and developmentally not ready for this exposure.

Trauma-sensitive 3-R guidelines for responding to children who present with sexual reactive behaviours.

Recognise:

- The FSW must recognise if and when a child presents with promiscuous behaviour, which may be indicated by looking for closeness through sexual acts. The FSW must further be mindful that this behaviour can be an indication of the child perceiving themselves as a sexual object.
- The FSW must recognise that when a child experiences feeling of confusion or aversion towards sexuality, sexual activities or images, or present uncontrolled emotional reactions, the reason can be that the child had inappropriate sexual

exposure that they were not developmentally ready for or did not have the opportunity to articulate what they had seen and observed.

Respond:

- When interacting with the child, the FSW needs to be cognisant that the child may act in a promiscuous manner as a result of the trauma of feeling like a sexual object and should respond in a way that will allow the child to experience love and acceptance without performing sexual acts. This can be done by: 1) the FSW should display a warm and accommodating non-verbal body language towards the child in order for the child to feel accepted; and 2) acknowledge the child's feeling of perceiving themselves as a sexual object.
- The FSW needs to be informed that the child may present with confusion or uncontrolled emotional reactions as a result of inappropriate sexual exposure and must respond in a way that will allow the child to feel that their emotions are normal and acceptable. This can be done by: 1) the FSW acknowledging the feelings or emotions that the child presents with; and 2) if the child presents with uncontrollable emotions during the interview, the FSW can allow them a minute or two to recover before continuing with the interview.

Report:

- This trauma-causing factor should be reported in the process notes and taken into consideration in the assessment of the veracity of the allegation.

In summary, the above 3-R guidelines were contextualised with available literature (Section B, step one) and were further deduced from the findings of the empirical study in this research (Section B, step two). The guidelines only include the trauma-causing factors and related negative outcomes or symptoms that became evident in this research data sample and therefore do not include all possible trauma-causing factors or symptoms that traumatised children may present with. The purpose was to assist FSWs in conducting trauma-sensitive assessments by being aware by recognising, responding and reporting to the emotional and behavioural messages that the child relays or presents with during the forensic interview, in the context of the child's past trauma-causing experiences.

4.5 Discussion

The above mentioned 3-R guidelines, in order to conduct trauma-sensitive social work forensic assessments, were developed by incorporating literature and empirical findings from this research study. The aim was to guide FSWs in conducting trauma-sensitive assessments by being able to use the 3-R guideline of recognising, responding and reporting to the emotional and behavioural messages that the child presents with or indicates during the forensic assessment, in the context of the previous trauma experiences that the child has suffered. Working from a trauma-sensitive approach thus means that the FSW understands and has a well-informed awareness and knowledge of the prevalence and symptoms of CSA trauma and be sensitive to traumatic triggers during the forensic assessment. It must be mentioned that these suggested guidelines are only a few of many possibilities, which every forensic social worker can expand on and approach in order to address the trauma-causing factors presented by each child. Literature further informs that trauma-sensitive assessments must always be conducted within a relationship of trust, in an emotionally safe environment, and at the pace of the child (Bowen & Murshid, 2016; Johnson, 2017; Knight, 2019; Mosley & Lanning, 2020; Wilson et al., 2015).

4.6 Limitations

The proposed guidelines were deduced from the empirical study in this research (Section B, step two). The guidelines thus only include the trauma-causing factors and related symptoms that became evident in this research and do not include all possible trauma-causing factors or symptoms that traumatised children can present with. Furthermore, the data used in the empirical study was obtained from adult women, and their reflection on the trauma they suffered as a result of CSA that they experienced as small children may have, over time, lost certain aspects and intensity. If the data was obtained from children, they maybe could have reported different or additional trauma-causing factors or symptoms that could have then been incorporated in this guideline that would have resulted in more comprehensive guidelines.

4.7 Conclusions

The literature review of this study revealed that limited research is available regarding forensic social work assessments in general in addition to limited guidelines for trauma-sensitive social work forensic assessments in the uniquely and broad ethnic and cultural South African context. It became evident in this research that cultural factors do play a role in sexuality and ways of communication. The forensic social worker must thus be sensitive towards cultural differences in

forensic assessments. It must also be mentioned that each child will present their trauma in a different way during the assessment. Therefore, these guidelines can be used as guidance, but must be individualised for each child.

4.8 Recommendations

Since forensic social work as a specialised field in South Africa is regarded as fairly new, it is recommended that more research in this regard must be conducted in order to incorporate the knowledge gained into more guidelines that can assist forensic social workers working in this challenging field.

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SECTION C

CONCLUSIONS, LIMITATIONS, AND RECOMMENDATIONS

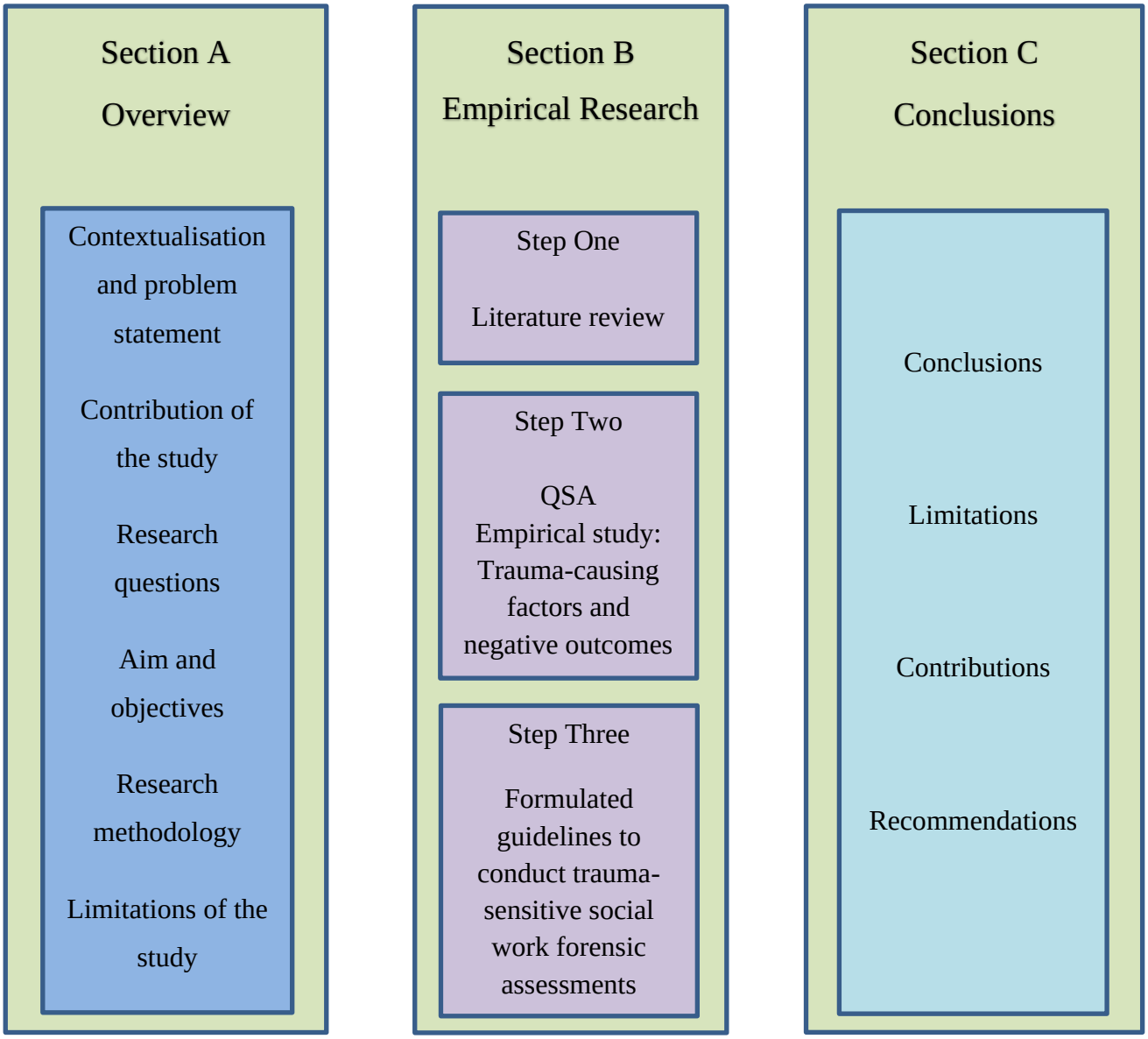

Figure 8: Research summary

5.1 Introduction

The main aim of this qualitative study was to explore what is known from literature and practice (empirical study) about trauma-causing factors from women survivors of CSA who participated in the S2T collaborative strengths-based group intervention programme. The findings of these trauma-causing factors were then contextualised into guidelines while conducting trauma-sensitive

social work forensic assessments. To achieve that, the objectives of the study were as follows: (1) to conduct a literature review to obtain a better understanding of trauma-causing factors in the context of CSA; (2) to conduct QSA to identify what trauma-causing factors and negative outcomes experienced during childhood sexual abuse were reported by SA women survivors participating in two S2T group intervention treatment sessions; and (3) to suggest guidelines for trauma-sensitive social work forensic assessments.

In order to accomplish the above-mentioned objectives, a literature review was firstly done with the aim of better understanding the trauma-causing factors and negative outcomes relating to childhood sexual abuse. A conceptual framework for the purpose of this study was then formulated from the literature review. In order to fulfil objective two, the following steps were used in conducting the QSA: 1) thematic analyses was done on the data and relevant quotes from participants were identified; 2) a coding framework was developed and was followed by analysing the quotes; 3) independent coding was done; and 4) consensus discussions were held to verify and confirm the themes and sub-themes. To fulfil the last objective successfully, namely to suggest guidelines to do trauma-sensitive social work forensic assessments, the guidelines were then deduced and proposed from the literature review and empirical study (QSA).

5.2 Research questions reconsidered

This study was guided by a primary research question and three secondary research questions as is illustrated by the following schematic representation:

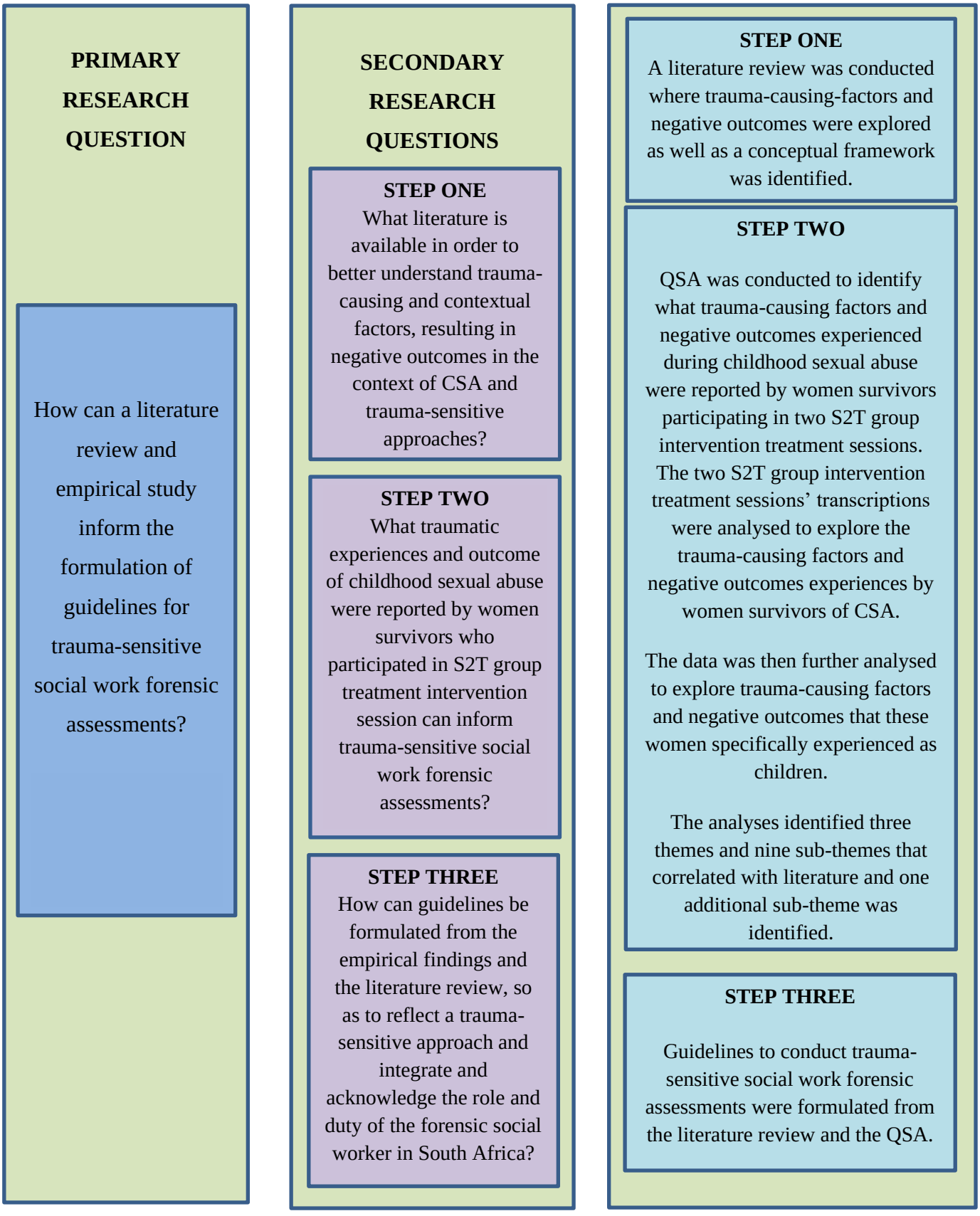

Figure 9: Research questions reconsidered

5.3 Conclusions emanating from the study

5.3.1 Step one: Literature review

The literature review revealed that limited literature is available regarding forensic social work in general as well as trauma-causing factors within the South African context. Inadequate information regarding doing forensic social work assessments whilst acknowledging the cultures of different ethnic groups is available. Furthermore, guidelines to do forensic social work assessments in the unique South African context is also not readily obtainable. The literature review indicated the conceptual framework for this research, that included: 1) theory on a trauma-sensitive approach; 2) Finkelhor and Browne's (1985) Traumagenic Dynamics Model; and 3) context-specific trauma-causing factors, namely: family-, abuse-, and child-specific factors.

5.3.2 Step two: Qualitative secondary analysis (Manuscript one)

The findings from the QSA on the two data sets of S2T collaborative strength-based group intervention programme treatment sessions correlate with the three main themes found in literature regarding the context-specific trauma-causing factors experienced by children during CSA. The themes explain the factors that contribute to the degree of trauma that children experience during and after the sexual abuse experience. These three themes are as follows: 1) family-specific factors (focusing on the non-supportive response of parents and significant caregivers or others to disclosure); 2) abuse-specific factors (focusing on emotional manipulation and threats by the perpetrator); and 3) child-specific factors (focusing on the child that is exposed to sexual activities they are not emotionally or physically ready to cope with). One additional sub-theme, not categorised internationally under the abovementioned themes, was identified in this research, namely parentification. The data sample that was used was a uniquely South African sample, which incorporated different ethnic groups that culturally accommodate older children to take over the caring and nurturing role of younger siblings. It must thus be mentioned that parentification must be taken into consideration when forensic assessments are done in South Africa and must also be included in guidelines for social work forensic assessments.

5.3.3 Step three: Formulated guidelines for trauma-sensitive social work forensic assessments (Manuscript two)

Limited research and literature are available regarding forensic social work assessments in general as well as guidelines for trauma-sensitive social work forensic assessments in the uniquely and

broad ethnic and cultural South African context. It became evident in this research that cultural factors do play a role in sexuality and ways of communication. The forensic social worker must thus be sensitive towards cultural differences in forensic assessments. It must also be mentioned that each child presents their trauma in a different way. Therefore, these guidelines can be used as guidance, but must be individualised for each child.

5.4 Overall conclusion

The overall conclusion drawn from this research is that the experience of childhood sexual abuse has the consequence of causing tremendous trauma in the lives of these children. This study offered a deep understanding of the complex nature of CSA and provided rich evidence of the trauma-causing factors and negative outcome relating to CSA. The context-specific trauma-causing factors experienced by children were found to be influenced by family-specific factors, abuse-specific factors, and child-specific factors. These factors are interdependent and the trauma of the abuse in one area will affect the other areas of functioning as well.

A further conclusion was made that limited research and literature is available regarding forensic social work assessments in general as well as doing assessments whilst acknowledging the cultures of different ethnic groups in the uniquely and broad South African context. Furthermore, guidelines to do forensic social work assessments in the unique South African context is also not readily obtainable. When guidelines are used during assessments, the forensic social worker must be mindful to apply these guidelines in a child and situation specific manner.

5.5 Limitations of the current study

5.5.1 Step one: Literature review

Only studies that were done in English were used and valuable research done in other languages may have been overlooked. The use of certain search terminology by the researcher may have restricted the scope of identifying valuable resources, but the researcher did try to counteract this limitation by using various different search terms.

5.5.2 Step two: Qualitative secondary analysis (Manuscript one)

The sample size of participants in the two S2T intervention groups that were used as data, was small. The researcher was not involved in the data collection and was thus not able to ask relevant questions or make observations. Furthermore, the fact that secondary data is used in QSA can be

regarded as another limitation as the data was not gathered to answer the research question for this study. Data may thus not include comprehensive information and experiences relating to the specific research question, namely the trauma-causing factors and negative outcome relating to CSA. The data was gathered in a group intervention context, and the participants may not have been truly open and honest due to concerns about confidentiality and possible distrust of other group members. Only female participants formed part of the group sessions and possible valuable contributions from a male perspective were not accounted for. Lastly, the data was obtained from adult women, and therefore their reflection on the trauma they suffered as a result of CSA that they experienced as small children may have, over time, lost certain aspects and intensity.

5.5.3 Step three: Formulated guidelines for trauma-sensitive social work forensic assessments (Manuscript two)

As the proposed guidelines were formulated from the empirical study in this research, only the trauma-causing factors and related symptoms that became evident in this research were used. The framework for formulating the guidelines was further based on a trauma-sensitive approach and an FSW nature and role and does not include all possible trauma-causing factors or symptoms that traumatised children can present with. As the data for this empirical study was collected from adult women, the significance of the trauma they experienced as a result of CSA, may have diminished with the passage of time. If the data was obtained from children, they maybe could have reported different or additional trauma-causing factors or symptoms that could have then been incorporated in these guidelines that would have resulted in more comprehensive guidelines.

5.6 Contributions of the study

The literature review in this study contributed to the existing body of knowledge on how trauma-causing factors and negative outcomes manifest in childhood sexual abuse. To the researcher's knowledge, this QSA study further provided the first known summary of reports of trauma-causing factors as arising from the data sets of the second and third group of female South African participants of the S2T strengths-based group intervention programme. Although Finkelhor and Brown's (1985) Traumagenic Dynamics Model was acknowledged and used as valuable framework for this research, this study indicated that trauma-causing factors can also be categorised in other themes, namely child-specific factors, family-specific factors, and abuse-specific factors. Furthermore, the findings from the secondary analysis emphasised the importance of conducting research in the uniquely South African context were cultural influences play an

important role. Parentification, as a contributing factor to more trauma-related symptoms, was identified where the child must take the mother role upon themself in the absence of a strong mother figure. This exceptional scenario is not often referred to in existing literature.

In addition, guidelines for trauma-sensitive social work forensic assessments were formulated in this research. As limited guidelines for forensic social workers practicing in the South African context could be found in literature, these proposed guidelines will hopefully guide these professionals to do forensic assessments in a trauma-sensitive way as well as assist them to work in this challenging field.

5.7 Recommendations for future research

Further qualitative studies are needed to expand on the global knowledge base regarding trauma-causing factors related to CSA in the South African context. The very rich cultural diversity in South Africa must be explored more in order to accommodate different cultural beliefs and behaviour with regards to sexuality as this may have a direct influence on CSA and the way that forensic social work assessments are conducted.

Furthermore, it is recommended that research be conducted with children as the information that they will provide would not have lost certain aspects and intensity over time. It must be mentioned that the researcher is mindful that this kind of study can be challenging, as children must be respected as a very vulnerable population.

Since forensic social work as a specialised field in South Africa is regarded as fairly new, it is recommended that more research in this regard must be conducted in order to incorporate the knowledge gained into more guidelines that can assist forensic social workers in practice.

5.8 Personal reflection

I undertook this study as part of the fulfilment of my Master's Degree in Forensic Social Work. I was motivated to embark on this journey due to the current alarmingly high prevalence of gender-based violence, which includes sexual abuse in South Africa, which has a devastating long-term impact on the lives of these vulnerable children and adults, especially the small children exposed to childhood sexual abuse (CSA).

I was granted the opportunity by Prof. Ansie Fouché and Prof. Hayley Walker-Williams to do my research on existing qualitative data from their S2T collaborative strengths-based group

intervention programme for adult women survivors of CSA. Prof. Fouché identified a possible research question and I therefore decided to focus my study on the trauma-causing factors and negative outcomes of CSA. I realised that this topic can contribute to the global and national knowledge base of forensic social work as a specialised field in South Africa, as this field is still fairly young in this country. I further felt encouraged to broaden my research to formulate guidelines for conducting trauma-sensitive social work forensic assessments in order to support forensic social workers in practice in this challenging field of work. This study further expanded my own understanding and knowledge about the severe trauma that sexually abused children are exposed to and experience.

Whilst conducting this study, I gained much respect for the perseverance and constant dedication of well-established researchers. I, as a novice researcher, will always stay inspired and stimulated in realising that no research is ever quite complete but rather paves the way for something still better to come.

I knew from the start that this study journey was going to be challenging, but that perseverance and hard work will see me through. This study was not only a valuable and positive academic learning experience, but also a journey of personal growth and gaining confidence in my own abilities. I conclude with the words of Christian D. Larson:

"Believe in yourself and all that you are. Know that there is something inside you that is greater than any obstacle"

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ADDENDUM 1: ETHICS APPROVAL LETTER OF STUDY

Private Bag X1290, Potchefstroom
South Africa 2520

Tel: 086 016 9698
Web: http://www.nwu.ac.za/

North-West University Health Research Ethics Committee (NWU-HREC)

Tel: 018 299-1206
Email: Ethics-HRECApply@nwu.ac.za (for human studies)

2 April 2020

ETHICS APPROVAL LETTER OF STUDY

Based on approval by the North-West University Health Research Ethics Committee (NWU-HREC) on 02/04/2020, the NWU-HREC hereby approves your study as indicated below. This implies that the NWU-HREC grants its permission that, provided the general conditions specified below are met and pending any other authorisation that may be necessary, the study may be initiated, using the ethics number below.

Study title: Guidelines for trauma-sensitive social work forensic assessments
Principal Investigator/Study Supervisor/Researcher: Prof A Fouché
Student: J van Huyssteen – 24949043

Ethics number:

N	W	U	-	0	0	3	0	4	-	2	0	-	A	1
Institution				Study Number						Year			Status	

Status: S = Submission; R = Re-Submission; P = Provisional Authorisation; A = Authorisation

Application Type: Single study
Commencement date: 02/04/2019
Expiry date: 30/04/2020

Risk: Minimal

Approval of the study is provided for a year, after which continuation of the study is dependent on receipt and review of an annual monitoring report and the concomitant issuing of a letter of continuation. A monitoring report is due at the end of April annually until completion.

General conditions:

While this ethics approval is subject to all declarations, undertakings and agreements incorporated and signed in the application form, the following general terms and conditions will apply:

- *The principal investigator/study supervisor/researcher must report in the prescribed format to the NWU-HREC:*
  - *Annually on the monitoring of the study, whereby a letter of continuation will be provided annually, and upon completion of the study; and*
  - *without any delay in case of any adverse event or incident (or any matter that interrupts sound ethical principles) during the course of the study.*
- *The approval applies strictly to the proposal as stipulated in the application form. Should any amendments to the proposal be deemed necessary during the course of the study, the principal investigator/study supervisor/researcher must apply for approval of these amendments at the NWU-HREC, prior to implementation. Should there be any deviations from the study proposal without the necessary approval of such amendments, the ethics approval is immediately and automatically forfeited.*
- *Annually a number of studies may be randomly selected for active monitoring.*
- *The date of approval indicates the first date that the study may be started.*
- *In the interest of ethical responsibility, the NWU-HREC reserves the right to:*

- *request access to any information or data at any time during the course or after completion of the study;*
- *to ask further questions, seek additional information, require further modification or monitor the conduct of your research or the informed consent process;*
- *withdraw or postpone approval if:*
  - *any unethical principles or practices of the study are revealed or suspected;*
  - *it becomes apparent that any relevant information was withheld from the NWU-HREC or that information has been false or misrepresented;*
  - *submission of the annual monitoring report, the required amendments, or reporting of adverse events or incidents was not done in a timely manner and accurately; and/or*
  - *new institutional rules, national legislation or international conventions deem it necessary.*

- *NWU-HREC can be contacted for further information via Ethics-HRECApply@nwu.ac.za or 018 299 1206.*

The NWU-HREC would like to remain at your service and wishes you well with your study. Please do not hesitate to contact the NWU-HREC for any further enquiries or requests for assistance.

Yours sincerely,

Digitally signed by Petra Bester
DN: cn=Petra Bester, o=NUTlab, ou=HWG, Faculty of Health Sciences, email=petra.bester@nwu.ac.za, c=ZA
Date: 2020-04-02 18:26:30 +02'00'

Chairperson NWU-HREC

Current details (23239522) G:\My Drive\9. Research and Postgraduate Education\9.1.5.4 Templates\9.1.5.4.2_NWU-HREC_EAL.docm
20 August 2019

File Reference: 9.1.5.4.2

ADDENDUM 2: ETHICS APPROVAL OF PROJECT

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

Private Bag X6001, Potchefstroom
South Africa 2520

Tel: (018) 299-4900
Faks: (018) 299-4910
Web: http://www.nwu.ac.za

Ethics Committee
Tel +27 18 299 4852
Email Ethics@nwu.ac.za

ETHICS APPROVAL OF PROJECT

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

Project title: The Efficacy of a Survivor to Thriver Strengths-based Intervention Programme facilitating Posttraumatic Growth in Women who experienced Childhood Sexual Abuse

Project Leader: Dr H Walker-Williams

Ethics number: NWU-00041-08-A1

Approval date: 2014-10-01 **Expiry date**: 2019-09-30

Special conditions of the approval (if any): None

General conditions:

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

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

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

Yours sincerely

Prof Amanda Lourens
(chair NWU Research Ethics Regulatory Committee (RERC)

ADDENDUM 3: CONSENT TO USE TRANSCRIPTIONS

Faculty of Health Sciences
School of Psychosocial Health
Psychology Department
Tel: (016) 016 910 3416
Email: Hayley.williams@nwu.ac.za

16 January 2020

Dear Mrs Jean Van Huyssteen

CONSENT TO USE TRANSCRIPTIONS OF S2T TREATMENT SESSIONS (GROUP TWO AND THREE):

RESEARCH PROJECT: The Benefit of a Survivor to Thriver (S2T) Strengths-Based Group Intervention Programme for Women Who Experienced Childhood Sexual Abuse

NWU ETHICAL CLEARANCE NUMBER: NWU 00041-08-A1

PRINCIPAL INVESTIGATOR: Prof Hayley Walker-Williams

CO-INVESTIGATOR: Prof Ansie Fouché

ADDRESS: North-West University, School of Psychosocial Health, Faculty of Health, Hendrik Van Eck Blvd, Vanderbijlpark, 1900

CONTACT NUMBER: 016 910 3416/ 016 910 3428

We hereby grant permission to Mrs Jean Van Huysteen (Student number: 24949043) a Masters in Social Work student in the above research project and consent to the following:

- To have access to the transcriptions of the recorded S2T group treatment sessions for groups two, and three for which group participants have provided their written consent. Access will be made available once her proposal has been approved by the Optentia's committee for advanced degrees and ethical clearance has been obtained.
- To make use of the above transcriptions for qualitative secondary data analysis for the purpose of her proposed MSc study

Conditions for consent:

- Keep all the research information shared with me confidential by not discussing or sharing the research information in any form or format (e.g. transcripts) with anyone other than Prof Hayley Walker-Williams and Prof Ansie Fouché;

- Keep all research information (biographical questionnaires and transcripts) in any form or format secure while it is in my possession;
- Return all research information in any form or format to Prof Hayley Walker-Williams and Prof Ansie Fouché when I have completed the research tasks;
- The data will be treated confidentially and kept in a lock up facility;
- The data will be treated with sensitivity.

Prof H.J. Walker-Williams 16/01/2020

Prof. Ansie Fouché 16/01/2020

ADDENDUM 4: CONFIDENTIALITY AGREEMENT

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

Faculty of Health Sciences
School of Psychosocial Health
Psychology Department
Tel: (016) 016 910 3416
Email: Hayley.williams@nwu.ac.za

16 January 2020

Dear Mrs Jean Van Huyssteen

Masters in Social Work Student Confidentiality Agreement

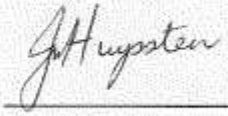
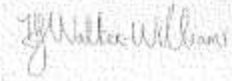
This study, ***The Benefit of a Survivor to Thriver (S2T) Strengths-Based Group Intervention Programme for Women who experienced Childhood Sexual Abuse (Ethical Clearance Number: NWU-00041-08-A1)***, is being undertaken by Prof Hayley Walker-Williams and Prof Ansie Fouché at North-West University, Vanderbijlpark Campus.

The study focusses on the implementation of a strengths-based group intervention programme for women who experienced childhood sexual abuse.

You will have access to the transcriptions of the recorded S2T group treatment sessions (Groups two and three) for which participants have provided their written consent. These will be made available once your proposal has been approved by the Optentia's committee for advanced degrees and ethical clearance from HREC has been obtained.

I, Mrs Jean Van Huyssteen (name of Masters in Social Work student), agree to:

1. Keep all the research information shared with me confidential by not discussing or sharing the research information in any form or format (e.g. transcripts) with anyone other than Profs Hayley Walker-Williams and Ansie Fouché;
2. Keep all research information (biographical questionnaires and transcripts) in any form or format secure while it is in my possession;
3. Return all research information in any form or format to Prof Hayley Walker-Williams and Prof Ansie Fouché when I have completed the research task.

Mrs Jean Van Huyssteen		16/01/2020
Prof H.J. Walker-Williams		16/01/2020
Prof Ansie Fouché		16/01/2020
Prof. Ansie Fouché	(signature)	(date)

If you have any questions or concerns about this study, please contact:

Prof Hayley Walker-Williams
Deputy Director:
School of Psychosocial Health
Associate Professor: Psychology
Faculty of Health Sciences
North-West University, Vanderbijlpark Campus
Hayley.williams@nwu.ac.za
(016) 910 3416

Prof Ansie Fouché
Associate Professor: Social Work
School of Psychosocial Health
Faculty of Health Sciences
North-West University, Vanderbijlpark Campus
Ansie.fouche@nwu.ac.za
(016) 910 3428

ADDENDUM 5: AUDIT TRAIL OF THEME DEVELOPMENT

Data segments from S2T treatment session transcripts		Open codes	Axial codes (Similar open codes grouped)	Theme
P5 G2	And now I think maybe she [mother] realised what was happening, but she didn't do anything about it. And that kind of made me so angry, because instead of doing something, she said I should move in with my grandmother … I told my teacher, told my grandmother and I told her about it but she didn't believe me … I told them and they still didn't believe me … So, I tell my grandmother about it and then she said that I am having an affair with him [abuser] … and like the message my grandma gave me was that if word came out, I would actually be destroying my family. So, if I did something about it … or the family knew about it … it would be on my shoulders … I don't want to repeat myself … I don't want to talk about it a lot…	Not believed by significant adult Blamed for abuse Inhibited further disclosure Keeping a secret	Non-supportive reaction from parent upon disclosure Minimised or prevented disclosure	Family-specific factors
P8 G2	… because I also haven't told my mother … I feel like I am protecting her because my mother has also been through a lot herself … but I don't want her to go through all of that … So, from that time I just tried to ignore it. I was even in denial.	Felt responsible for family's well-being		
P7 G3	I've been on my own since I was little, I never had anyone I can trust so I've learned to just keep to myself. My coping is I just cut off my emotions and go on … I also locked myself from anyone else. Stayed in my bubble, no - one could get through. The first time when I finally got the courage to tell my mother to ask for help, she told me: "go play, I don't want to hear stories" … I was made out to be a lair, trying to get attention.	Emotional or physical absence of parent Loss of trust Feeling betrayed	Let down by parent / Absent parent	Family-specific factors
P5 G3	Since childhood … I was the one who was busy with my siblings, I mean at the age of nine years I was doing laundry, doing the cooking, my mom was never there … I was taking care of my brother and sister at a very young age. When my mother was out galivanting, my father was also out there, they were doing their thing. I had to be the responsible one, I had to be the strong	Worthlessness		

	one. I had to make sure that my siblings are fed, my siblings have something. I was a mother; I was a father to them	Responsibilities above developmental age	Parentification	Family-specific factors
P2 G2	I lied because I already being hit and so that it wouldn't leave a mark because they sort of hit me places like, like not my arms or legs where you could see. So it would be in the stomach and kick me in the back and that sort of things … So it was like them having their guilt projected onto me and saying well you know, you deserved it, you looked for it, but I didn't… and saying if you tell, or if you say that, do you know that you are dirty, you did this, you know? … So as many times afterwards I was beaten and told it's my fault ... like it was drawn, physically beaten into me …. is that you feel like you're not worthy. I interpreted it as not being accepted because everything I did was unacceptable and everything I was, was unacceptable	Losing normal childhood and childhood innocence Physical abuse	Exposure to physical violence	Family-specific factors

ADDENDUM 6: ARTICLE SUBMISSION GUIDELINES: HEALTH AND SOCIAL CARE IN THE COMMUNITY

ARTICLE SUBMISSION GUIDELINES

1. SUBMISSION

Authors should kindly note that submission implies that the content has not been published or submitted for publication elsewhere except as a brief abstract in the proceedings of a scientific meeting or symposium.

ORCID

The submission system will prompt authors to use an ORCID iD (a unique author identifier) to help distinguish their work from that of other researchers. This journal requires the submitting author (only) to provide an ORCID iD when submitting a manuscript.

2. AIMS AND SCOPE

Health and Social Care in the Community is an international peer-reviewed journal with a multidisciplinary audience including social workers, health care professionals with a community or public health focus e.g. public health practitioners, GP's, Community Nurses and Social Care researchers and educators.

The Journal promotes critical thinking and informed debate about all aspects of health and social care. Original papers are sought that reflect the broad range of policy, practice and theoretical

issues underpinning the provision of care in the community.

Health and Social Care in the Community publishes systematic and other types of reviews, policy analysis and empirical qualitative or quantitative papers including papers that focus on professional or patient education.

3. MANUSCRIPT CATEGORIES AND REQUIREMENTS

Qualitative Articles

WORD LIMIT: 5000 (excluding figures, tables and the reference list) double-spaced with a wide margin on either side.
MAIN TEXT: Should be structured under the following headings: Introduction; Methods; Findings; Discussion.
RESEARCH REPORTING CHECKLIST: May be required

4. PREPARING THE SUBMISSION

Cover Letters

Cover letters are not mandatory; however, they may be supplied at the author's discretion.

Parts of the Manuscript

The manuscript should be submitted in separate files: title page; main text file; figures.

Title Page

The title page should contain**:**

i. A short informative title containing the major key words. The title should not contain abbreviations and include country of origin of data collection if not UK, in the title.
ii. The full names of the authors and contact information of corresponding author;
iii. The author's institutional affiliations where the work was conducted;
iv. Acknowledgements;
v. Conflict of Interest statement (for all authors);
vi. Funding or sources of support in the form of grants, equipment, drugs etc

The present address of any author, if different from where the work was carried out, should be supplied in a footnote.

Title

Titles should include the country of data collection, if data has not been collected in the UK

Acknowledgments

Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section at the end of the paper. Financial and material support should also be mentioned. Thanks to anonymous reviewers are not appropriate.

Conflict of Interest Statement

Authors will be asked to provide a conflict of interest statement during the submission process. Authors should ensure they liaise with all co-authors to confirm agreement with the final statement.

Main Text File

As papers are double-blind peer reviewed, the main text file should not include any information that might identify the authors.

The main text file should be presented in the following order:

i. Title, abstract, and key words;
ii. What is known about this topic and what this paper adds;
iii. Main text;
iv. References;
v. Tables (each table complete with title and footnotes);
vi. Figure legends;

Figures and supporting information should be supplied as separate files.

Abstract

This should be **non-structured** and should not exceed **300 words**. Where appropriate authors should cover the following areas: objective; study design; location, setting and date of data

collection; selection and number of participants; interventions, instruments and outcome measures; main findings; and conclusions and implications.

What is known about this topic and what this paper adds?

Please provide up to three bullet points on what is known about this topic, and three bullet points on what the paper adds. This should be written in terms of outcome statements (what is known/added) and not process statements (what was done). For example: Authors could report a specific outcome such as "experiences of patients and carers in the community did not always concur with guideline recommendations" NOT the generic process "This qualitative study reports on experiences of patients and carers in the community". This should be no more than 110 words (exclusive of the titles). Authors should avoid repeating sentences in the Abstract within the bullet points.

Keywords

Please provide seven keywords. When choosing keywords, Authors should consider how readers will search for their articles.

References

References should be prepared according to the *Publication Manual of the American Psychological Association* (6th edition). This means in text citations should follow the author-date method whereby the author's last name and the year of publication for the source should appear in the text, for example, (Jones, 1998). The complete reference list should appear alphabetically by name at the end of the paper.

A sample of the most common entries in reference lists appears below. Please note that a DOI should be provided for all references where available. Please note that for journal articles, issue numbers are not included unless each issue in the volume begins with page one.

Journal article

Beers, S. R., & De Bellis, M. D. (2002). Neuropsychological function in children with maltreatment-related posttraumatic stress disorder. *The American Journal of Psychiatry, 159,* 483–486. doi:**10.1176/appi.ajp.159.3.483**

Book

Bradley-Johnson, S. (1994). *Psychoeducational assessment of students who are visually impaired or blind: Infancy through high school* (2nd ed.). Austin, TX: Pro-ed.

Internet Document

Norton, R. (2006, November 4). How to train a cat to operate a light switch [Video file]. Retrieved from **http://www.youtube.com/watch?v=Vja83KLQXZs**

Tables

Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings. Tables should be submitted one per page, numbered using Arabic numbers, e.g. Table 1, Table 2, etc, at the end of the manuscript.

Figures

Although authors are encouraged to send the highest-quality figures possible, for peer-review purposes, a wide variety of formats, sizes, and resolutions are accepted. Figures should be referred to in the text as figures using Arabic numbers e.g., Fig. 1, Fig. 2, etc., in order of appearance, and submitted one per page at the end of the manuscript.

Main Text General Style Points

The following points provide general advice on formatting and style.

- **Language and Spelling:** The journal uses British UK English; however, authors may submit using either UK or US options, as spelling of accepted papers is converted during the production process.
- **Excerpts:** (other than a short sentence within quotation marks in the text) should be single spaced and indented in the text. A colon is used at the end of the text prior to the quoted data excerpt.

- **Quotations:** Authors should include the code number (or facsimile, i.e. pseudonym) in brackets at the end of the quote. When there is more than one category of participants in the study (such as social workers and clients or particular age groups), authors should use an identifier (i.e. SW01 could refer to the first social worker participant; C03 could refer to the third client participant; YA 10 could refer to the tenth young adult participant). Including the participant number and/or participant group helps the reviewer ascertain the range of the sample used to report the findings, which assists in assessing the credibility of the findings. Occasionally, authors prefer to include quotes in a box or table at the end of the paper. This is acceptable providing the data are well organised and presented.
- **Footnotes**: to the text are not allowed and any such material should be incorporated into the text as parenthetical matter.
- **Abbreviations:** In general, terms should not be abbreviated unless they are used repeatedly and the abbreviation is helpful to the reader. Initially, use the word in full, followed by the abbreviation in parentheses. Thereafter use the abbreviation only.
- **Units of measurement:** Measurements should be given in SI or SI-derived units.
- **Numbers:** numbers under 10 are spelt out, except for: measurements with a unit (8mmol/l); age (6 weeks old), or lists with other numbers (11 dogs, 9 cats, 4 gerbils).
- **Trade Names:** Chemical substances should be referred to by the generic name only. Trade names should not be used. Drugs should be referred to by their generic names. If proprietary drugs have been used in the study, refer to these by their generic name, mentioning the proprietary name and the name and location of the manufacturer in parentheses.
- **Internationality:** *HSCC* encourages authors to write for an international multidisciplinary audience.

5. EDITORIAL POLICIES AND ETHICAL CONSIDERATIONS

Editorial Review and Acceptance

The acceptance criteria for all papers are the quality and originality of the research and its significance to journal readership. Except where otherwise stated, manuscripts are double-blind peer reviewed. Papers will only be sent to review if the Editor-in-Chief determines that the paper meets the appropriate quality and relevance requirements.

Conflict of Interest

The journal requires that all authors disclose any potential sources of conflict of interest. Any interest or relationship, financial or otherwise that might be perceived as influencing an author's objectivity is considered a potential source of conflict of interest. These must be disclosed when directly relevant or directly related to the work that the authors describe in their manuscript. Potential sources of conflict of interest include, but are not limited to: patent or stock ownership,

membership of a company board of directors, membership of an advisory board or committee for a company, and consultancy for or receipt of speaker's fees from a company. The existence of a conflict of interest does not preclude publication. If the authors have no conflict of interest to declare, they must also state this at submission. It is the responsibility of the corresponding author to review this policy with all authors and collectively to disclose with the submission ALL pertinent commercial and other relationships.

Authorship

The list of authors should accurately illustrate who contributed to the work and how. All those listed as authors should qualify for authorship according to the following criteria:

1. Have made substantial contributions to conception and design, or acquisition of data, or analysis and interpretation of data;
2. Been involved in drafting the manuscript or revising it critically for important intellectual content;
3. Given final approval of the version to be published. Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content; and
4. Agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section (for example, to recognize contributions from people who provided technical help, collation of data, writing assistance, acquisition of funding, or a department chairperson who provided general support). Prior to submitting the article all authors should agree on the order in which their names will be listed in the manuscript.

ADDENDUM 7: ARTICLE SUBMISSION GUIDELINES: JOURNAL OF CHILD SEXUAL ABUSE

Journal

Journal of Child Sexual Abuse

Aims and scope

The Journal of Child Sexual Abuse is interdisciplinary and provides an essential interface for researchers, academicians, attorneys, clinicians, and practitioners. The journal advocates for increased networking in the sexual abuse field, greater dissemination of information and research, a higher priority for this international epidemic, and development of effective assessment, intervention, and prevention programs.

Divided into sections to provide clear information, the journal covers research issues, clinical issues, legal issues, prevention programs, case studies, and brief reports, focusing on three subject groups - child and adolescent victims of sexual abuse or incest, adult survivors of childhood sexual abuse or incest, and sexual abuse or incest offenders. Research, treatment approaches and techniques, prevention, intervention, and other programs concerning any of these groups are general categories of the published articles and brief reports. The articles emphasize applying research, treatment, and interventions to practical situations so the importance of the results will be clear.

Instructions for authors

About the Journal

Journal of Child Sexual Abuse is an international, peer-reviewed journal publishing high-quality, original research. Please see the journal's Aims & Scope for information about its focus and peer-review policy.

Please note that this journal only publishes manuscripts in English.

Journal of Child Sexual Abuse accepts the following types of article: original articles.

Peer Review and Ethics

Taylor & Francis is committed to peer-review integrity and upholding the highest standards of review. Once your paper has been assessed for suitability by the editor, it will then be double blind peer reviewed by independent, anonymous expert referees.

Preparing Your Paper

Structure

Your paper should be compiled in the following order: title page; abstract; keywords; main text introduction, materials and methods, results, discussion; acknowledgments; declaration of interest statement; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figures; figure captions (as a list).

Word Limits

Please include a word count for your paper.

A typical paper for this journal should be no more than 30 pages, inclusive of the abstract, tables, references, figure captions, footnotes, endnotes.

Style Guidelines

Please use American spelling style consistently throughout your manuscript.

Please use double quotation marks, except where “a quotation is ‘within’ a quotation”. Please note that long quotations should be indented without quotation marks.

Papers may be submitted in any standard file format, including Word and LaTeX. Figures should be saved separately from the text. The main document should be double-spaced, with one-inch margins on all sides, and all pages should be numbered consecutively. Text should appear in 12-point Times New Roman or other common 12-point font. Submissions should not exceed 30 double-spaced pages, including abstract, references, tables, and figures. Please submit a separate document clearly outlining if: (a) if the author has any financial conflicts of interest, (b) if you have approval from your Institutional Review Board for a study involving animal or human patients, (c) if there are any informed consent notifications to state.

Checklist: What to Include

1. **Author details.** All authors of a manuscript should include their full name and affiliation on the cover page of the manuscript. Where available, please also include ORCiDs and social media handles (Facebook, Twitter or LinkedIn). One author will need to be identified as the corresponding author, with their email address normally displayed in the article PDF (depending on the journal) and the online article. Authors’ affiliations are the affiliations where the research was conducted. If any of the named co-authors moves affiliation during the peer-review process, the new affiliation can be given as a footnote. Please note that no changes to affiliation can be made after your paper is accepted.
2. Should contain an unstructured abstract of 250 words.
3. You can opt to include a **video abstract** with your article.
4. Read making your article more discoverable, including information on choosing a title and search engine optimization.
5. **Funding details.** Please supply all details required by your funding and grant-awarding bodies.
6. **Disclosure statement.** This is to acknowledge any financial interest or benefit that has arisen from the direct applications of your research.
7. **Biographical note.** Please supply a short biographical note for each author. This could be adapted from your departmental website or academic networking profile and should be relatively brief (e.g., no more than 200 words).
8. **Data availability statement.** If there is a data set associated with the paper, please provide information about where the data supporting the results or analyses presented in the paper can be found. Where applicable, this should include the hyperlink, DOI or other persistent identifier associated with the data set(s). Templates are also available to support authors.
9. **Data deposition.** If you choose to share or make the data underlying the study open, please deposit your data in a recognized data repository prior to or at the time of submission. You will be asked to provide the DOI, pre-reserved DOI, or other persistent identifier for the data set.

10. **Supplemental online material.** Supplemental material can be a video, dataset, fileset, sound file or anything which supports (and is pertinent to) your paper. We publish supplemental material online via Figshare.
11. **Figures.** Figures should be high quality (1200 dpi for line art, 600 dpi for grayscale and 300 dpi for color, at the correct size). Figures should be supplied in one of our preferred file formats: EPS, PDF, PS, JPEG, TIFF, or Microsoft Word (DOC or DOCX) files are acceptable for figures that have been drawn in Word.
12. **Tables.** Tables should present new information rather than duplicating what is in the text. Readers should be able to interpret the table without reference to the text. Please supply editable files.
13. **Equations.** If you are submitting your manuscript as a Word document, please ensure that equations are editable.
14. **Units.** Please use SI units (non-italicized).

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