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Caregivers' perceptions of desensitisation among sexually abused children

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Abstract
Children react differently to the traumatic experience of sexual abuse. Some children develop symptomatic behaviours associated with Post-Traumatic Stress Disorder, such as apathy, which may be misinterpreted as desensitisation. Others appear less affected by the sexual abuse and may be regarded as desensitised and possessing resilience. Incongruence thus exists, as the one may be taken incorrectly for the other. This study has explored caregivers' perceptions of desensitisation among the children in their care who had been sexually abused in the past. The study is explorative and descriptive in nature and grounded in a qualitative design. Purposive sampling was used to form three focus groups (17 participants). Data collection took place by means of focus groups with the aid of an interview guide. Collected data was transcribed and subjected to thematic analysis. The findings were written up, presented and discussed. The findings are recommended to be used to inform social workers and other members of the helping professions on how to approach and interact in the future with caregivers of sexually abused children.

Introduction

Symptoms of sexual abuse have been noted to be multiple emotional, personality and behavioural problems. These problems include social withdrawal, depression, anxiety, and in some instances the development of PTSD. Other associated symptoms such as an increase in sexualised behaviour (promiscuity), suicidal ideation and attempts, substance abuse and anti-social behaviour, have been widely reported in the literature (Berliner 2003:13; Verduyn & Calam as cited in Britz & Joubert 2003:27). Significant long-term effects include guilt, anxiety, decreased self-worth, apathy, stigmatisation, decreased moral judgment, trust issues, sexual promiscuity, and other forms of sexual maladjustment (Faller, Finkelhor, Glaser & Frosh; Green as cited in Van Rensburgh & Barnard 2005:1).

On the one hand, desensitisation overlaps with symptoms of sexual abuse, particularly those symptoms associated with PTSD. Symptoms such as apathy and diminished affect, along with psychological numbness and a lessening of feeling of involvement with the world around one (Reber & Reber 2001:551), may be seen as desensitisation in some instances. It is believed that up to half of the children who have been sexually abused develop PTSD (Berliner 2003:13). Berliner (2003:13) moreover indicates that a Child Sexual abuse (CSA) history is also linked with other mental health issues,

According to Hewitt (as cited in Intebi 2003:9), parental attitudes and commitment such as being cooperative, respectful and able to put a child's needs first, and not attempting to control or dictate to the child, are important as low-risk factors that affect the child's vulnerability. Intebi (2003:9) holds that high-risk taking care of children parenting is identified as parents denying or minimising their own involvement or contribution to the child sexual abuse incident, such as not believing the child, projecting anger onto others, and being domineering, insensitive, impulsive, angry, and lacking empathy.

Primary caregiver effects

Some of the caregivers in our study appeared highly attached, protective, and involved in their children's lives. They often identified this notion of being present and involved as a measure for why they believed their child was coping better. Two caregivers even indicated that they left their jobs in order to spend more time attending to the child's needs.

"I then left my job so that I could spend more time on *Z."

They are also fiercely protective, and see themselves as taking personal responsibility for the child's ongoing care.

"I am a single parent and the child's father does not worry about the child anymore. I am the one that… currently it is me, my father and my sister who care for her… who help her."
"… and because… I was one of those mothers who cared for my child… uhm grandchild, raised the child as one of my own. Without Coloured-Affairs' money… I was not one of those parents. I cared for them. I worked for them."

A positive person who fulfils the role of primary caregiver is considered a significant factor contributing to a child's coping ability, and therefore a contributing factor in desensitisation. It is noted by Van Rensburgh and Barnard (2005:7) that such a bond needs to be reciprocal, as the child needs to identify with the caregiver and not yearn or long for another person to occupy that role. Bolen and Lamb (2007:46) indicate that caregiver-child attachment is correlated with coping, and thus also desensitisation. Poorer coping in terms of withdrawal and other internalising symptoms has often been reported with caregivers who were dismissing or fearful. Bolen and Lamb (2007:46) note that a child who exhibits greater anxiety symptoms, depression and dissociation has a heightened need for caregiver closeness or attachment. The caregivers indicated that their relationships with their CSA children as follow:

"Yes that is what I am encouraging for her to stand on her own two feet…"
"I think this because at first the child stayed with her father only and now there is a woman figure in the house. She feels that connection… [with me]"
"I am like her mother, like a mother to her. Someone who like brings her comfort…"
"I put myself in the shoes of the child so I am very vigilant, not like many other parents…"

Caregivers who are older, educated, with a predominant internal locus of control, have a reasonably high self-efficacy and self-esteem, an optimistic attribution style, mature defences, efficient coping, an ability to empathise, rational expectations, and accurate understanding of child development, are ideal protective factors for their children (Carr as cited in Hilarski 2008:37). Reyes (2008:54) indicates that Morrison and Clarenna-Valleroy have found that sexually abused adolescents who see their mothers to be supportive, have a better self-concept and lower depression levels than those who find their mothers non-supportive. Support from a significant other has been regarded as connected with resilience and better outcomes (Banyard, Williams, Siegel & West 2002:54). Luster and Small (as cited in Edmund *et al.* 2006:4) indicate that adolescents with a CSA history are resilient against substance abuse and suicidal ideation when they have had a supportive relationship with their caregivers/parents.

The caregivers in the present study were older, but their education levels were low. They often took on the role of protecting their child against the world and other persons, which may be seen as being controlling limiting and not giving the children age-appropriate room. They engaged other persons when their children were discriminated against, or when they felt the child was being misunderstood, or that the other parties lacked understanding of the child's conditions. The caregivers often indicated that they were very open in communication, and that they were involved in their children's lives, meaning that they were present and reachable for whenever the child needed them, and offered support. Caregiver ability to give support and guidance in the face of stress and trauma is linked with positive coping outcomes (Van Rensburgh & Barnard 2005:4).

Family effects

Apart from caregiver influences, family members of the CSA victim were perceived to influence further positive aspects of desensitisation, affect positive changes, and contribute towards resilience of the victims. Van Rensburgh and Barnard (2005:7) indicate that the presence of clear rules and boundaries in a family that allows for a degree of freedom and development of a personal identity which helps a CSA child to cope. Resilience is linked to being raised in a stable home, with lesser disruptions in care situations (foster care) and lesser parental/care- giver substance abuse (Banyard *et al.* 2002:54).

There was no control for caregiver substance abuse in this study. The majority of the caregivers were not the natural parents of the children in their care. They were rather grandmothers, aunts, sisters or foster parents. Mixed results have been reported for linkages between PTSD and CSA. Dubner and Motta (as cited in Breno and Galupo 2007:100) have found higher prevalence rates of PTSD in alternative care, a prevalence for CSA and physically abused children, especially female child victims of CSA.

Perceptions held by some of the caregivers were that they adopted effective parenting strategies and that they used clear rules and boundaries in their family to guide behaviour. A degree of freedom was given as an example of encouraging a child to become more independent and to stand on their own feet. The following is in support of this:

"I got help from my neighbour and my family members…. My brothers and sisters. They would visit and talk to her about her behaviour and its consequences."
"The family now is also very supportive, we sit down with him and explain to him that he must not play far, he must always be near to the house. Because what happened to him can always happen again."

A family that communicates openly and effectively is beneficial for the child's coping (Kolbe 2005). Furthermore, a family that gives support and is understanding of the needs of the child is also linked to improved coping. Family conflict and isolated families are seen to be a negative influence on a child's coping abilities (Van Rensburgh & Barnard 2005:7). Supportive factors found as expediting the abatement of CSA symptoms were first and foremost supportive family environments and maternal support (Kolbe 2005:28). Positive family bonding is held as indicative of better stress handling and coping of children with a CSA history (Van Rensburgh & Barnard 2005:3).

"And my family did talk about it … and then I said to keep it a secret it is not good. You can also help other kids."

Personal characteristics of the CSA victim
Individual (personality) characteristics include effective interpersonal skills, sound intra-psychic functioning, adjustment, stress control, and general satisfaction with life, according to various authors such as Freitas and Downey, as well as Masten and Coatsworth (as cited in Van Rensburgh & Barnard 2005:2).

Hilarski (2008:40) indicates that an internal locus of control may be a protective factor for CSA victims, as reported by Pearce and Pezzot- Pearce (as cited in Hilarski 2008:40). Van Rensburgh and Barnard (2005:3) indicate that a good deal of the literature points towards higher intelligence as a major resilience factor. In their study, Van Rensburgh and Barnard (2005:11) further find that female children with a CSA history who understand their situation and who approach dealing with it in a logical manner, are much more capable of progressively acquiring and sustaining a sense of competence. Hewitt (as cited in Intebi 2003:9) notes that lower risk factors for re-victimisation of the CSA child are personal qualities such as clarity regarding boundaries, good communication skills, problem identification ability, being assertive and confident in communicating their views despite adult opposition, and being older than five years of age. Higher risk children are reported to be younger or older children who are passive, dependent, withdrawn, anxious, scared, and powerless, and have poor communication skills (Hewitt as cited in Intebi 2003:9).

"She is very clever…"
"Then she said to me mommy I can't be angry forever at them. They did something wrong, because I did not give them… they took. But I also asked the Lord to forgive them and I forgave them in my heart."
"I would say her and I are… like we can handle stuff. And that my mother was not always around… so I would say that she has learned to handle it, because we were

taught so. Because you have to be able to handle stuff on your own until there comes someone who can help you to make it through this together. So my mother handles her, but she is just like… it does not matter…" [referring to the child exhibiting an apathetic attitude]

The findings point towards the children being perceived as intelligent, having sound intra- psychic functioning for example, for understanding they are not at fault or to blame for the abuse, and showing mature responses by forgiving others and making peace with what has happened to them. This neatly fits in with the available literature, as has been shown.

Social effects

Van Rensburgh and Barnard (2005:4) indicate that social support as well as a supportive social environment is associated with better coping with CSA children. They identify, inter alia, teachers, neighbours, peers and positive role models as protective agents. Masten and Coatsworth (as cited in Van Rensburgh & Barnard 2005:4) note that peer acceptance and positive peer relationships enhance self-image, and are therefore protective factors contributing to resilience. They also note that poor peer group interaction and association may lead to inappropriate behaviour, externalisation, behavioural disorders, academic problems and problems associated with aggression.

Hilarsky (2008:4) indicates that adolescents who seek social supportive relationships are more resilient than those who do not. They note that even a single caring person may be able to mitigate the negative effects of CSA, as referred to by Perkin and Jones, (as cited in Hilarsky 2008:4). Werner and Smith (as cited in Edmund, *et al.* 2006:4) have conducted a pivotal study into resilience, and note that the absence of conduct problems in school and supportive resources such as the family, neighbourhood, school and community, are important associations with resilience and better outcomes. Blundo (as cited in Edmund *et al.* 2006:4) has co- documented the importance of social networks and community agencies such as schools, churches, clubs, and the like, in bringing about resilience. Mental health and stress reduction are reported to be positively affected by social relationships (Edmund *et al.* 2006:4).

School connectedness is deemed a major protective factor by Resnick *et al.* (as cited in Edmund *et al.* 2006:4). School success has been linked to fewer mental health and conduct problems by Luster and Small, (as cited in Edmund *et al.* 2006:4). Completing and attending school is indicated as a very good protective factor (Banyard *et al.*; Valentine & Feinauer; Grotberg as cited in Van Rensburgh & Barnard 2005:4). This is, however, not the case with a few children as reported by the respondents, whose children either dropped out of school or wanted to drop out.

The responses by the participants indicated that such social effects may have been present. The caregivers said that they themselves ensured that they maintained social contact with the child's school, and that they engaged community members and neighbours for support. Yet on the other hand, some indicated that their children were still exhibiting behaviours that are regarded as anti-social, such as aggression, not

wanting to attend school, and being isolated, very quiet and withdrawn. These types of behaviours have been referred to in previous sections, such as dropping out of school, exhibiting anger and aggression in school, and withdrawal from friends and social situations.

Intervention services effects

The majority of the respondents reported that the child in their care accessed professional treatment, ranging from trauma counsellors to social workers and psychologists. In the second focus group, the respondents did not indicate much professional intervention in the demographic questions, but they did indicate that their children had attended a camp for victims of sexual abuse that was organised by the social workers of the Department of Social Development in Paarl. Numerous positive responses were voiced regarding the benefit and impact of such interventions.

"I think it must be the help of the social workers because they used to see her at school when she was still in school last year. Also this year early this year, they also came to talk to her..."
"Yes the child is seemingly coping she is also receiving counselling from nearby social workers in NY 111 ag, in Jooste Hospital, you know in Jooste."
"Ja and I did, we did take him to a psychologist..." "They also did for me.... Because my child is now part of... they organised a SOS camp" [Referring to the child attending a therapeutic and life skills kamp]

Van Rensburgh and Barnard (2005:4) note that psychologists and other health care workers are sources of resilience. Hilarski (2008:41) indicates that CSA children and their families should be involved in treatment programmes. Formal treatment is not regarded as necessary when the child does not display any or only a few symptoms; then only psycho-educational training may be sufficient as an intervention method (Berliner 2003:13). If symptoms do present, then it is recommended by Berliner (2003:13) that a full assessment be done before deciding on a treatment.

On the other hand, receiving abuse-specific therapy is purported to not be significantly linked to resilience in CSA among African American women in a study by Banyard *et al.* (2002:54). They indicate that only a small portion of their population have attended such therapy. Harvey (as cited in Banyard *et al.* 2002:54) notes that many victims of CSA who do not receive formal abuse-specific treatment may find other ways to minimise its effects. Only half of the participants who took part in this study received some kind of intervention.

Perpetrator consequences

The consequences, or what became of the perpetrator, were strongly identified as a contributing factor for, or a barrier against, the children's perceived coping and desensitisation. In their study, Van Rensburgh and Barnard (2005:7) report that in their study they found when a perpetrator was immediately removed from the proximity, or if future access to the child was deemed prohibited, (e.g. the perpetrator is incarcerated, barred from the house, or legal steps taken against him) it was linked to

better resilience in molested girls. The following statements link perpetrator outcomes to positive coping and resilience:

"Ok first of all I have moved away from where the child was abused, so she is no longer in contact with the abuser."
"I think it was because this guy was arrested few minutes after the incident happened so the child felt safe. And then he was away for a long time, it was 3 years and then she also felt safe because he is not there in the community anymore."

Kolbe (2005:27) indicates that the identity of the perpetrator being known, being a relative or acquaintance of the child, as opposed to being a complete stranger, causes more serious symptomatology. This is supported by literature which notes that forceful or violent CSA has been linked to depression, anxiety and nightmares, and better resilience reported when CSA was not incestuous or intrafamilial in nature (Banyard *et al.* 2002:50-54).

"... or when she sees him she says to me grandma, grandma there he walks again, look how he stares at me, look how he is standing there. She wants me to go hit him. Now she has that attitude."
"There was a positive coping before...when the perpetrator was in jail. But now everything is back to where it was before because the perpetrator is now back in the community. So the child is afraid and she does not even want to see this guy's girlfriend."
"After it happened there was no problem. She was just happy that the person who did this was caught, but now because the guy is now back, she is does not want to go to Langabuya where the incident... she does not want to go there anymore."

In a number of cases the perpetrators were unknown, were never arrested, or were released from prison. This was given as a reason for the children not coping well and relapsing, or for the advent of fears and avoidant behaviour. Perpetrator consequences are thus taken to be perceived as a direct indication to the caregivers of the child's desensitisation, coping and resilience. This is in support of the literature which has been reviewed.

Recommendations

The study was limited in scope, as the sample was not highly representative of all caregivers of all children with a CSA history. A larger-scale study may yield more comprehensive insights into the matter. It is therefore recommended that the research tradition be carried forward, and that more studies be undertaken to expand, confirm, challenge and/or validate the findings of the present study.

The researcher identified a need for caregivers to express their feelings and to receive support in their roles and responsibilities that relate to caring for the CSA child in their care. It is necessary that social workers present debriefing and support group sessions to the caregivers of CSA children. In these groups the unresolved issues which many of these caregivers are deemed to have, and the possible secondary trauma effects, can be addressed. Programmes should provide the space to air feelings, discuss

challenges faced, provide psycho-education about the special needs of the CSA child, and teach caregivers practical skills which may assist them in caring for the children.

In light of the caregivers at times having limited knowledge of the vast effect that CSA may have on a child victim, it is recommended that organisations and government departments working with CSA victims and their caregivers, ensure that the caregivers receive adequate training regarding expected effects that CSA may have on children. This could be specifically done with new foster parents who will assume the caregiver role in the lives of CSA victims.

CSA appears to be an issue that is dealt with less than other forms of child abuse, as it appears to occur less often. Social workers may therefore have less exposure to such cases, which may create misconceptions and stereotypes among these professionals. It is important to expose social workers to ongoing studies in the field of CSA in order to instil a deeper understanding of the challenges faced by CSA children and their caregivers. If the social workers are better informed, it is argued that they will be in a better position to identify risks and problems early on, and put the needed preventative and corrective measures in place.

Conclusion

The researcher uncovered perceptions held by the caregiver respondents regarding expected symptoms in the CSA victim, as well as perceptions of currently exhibited symptoms by the children in their care. Their perceptions regarding desensitisation, or a lack thereof, were shown and discussed. The caregivers' perceived explanations for the presence of desensitisation and better coping by some children were indicated and discussed, and shown to include caregiver, family, individual, and intervention services, and perpetrator effects and consequences. The findings of the study thus provided insights and a better understanding of the caregivers' perceptions of desensitisation among sexually abused children.

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