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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,

relationship problems, and re-victimisation in adulthood, all of which have a great effect on the adjustment and functioning of the child. A study conducted by Green (as cited in Pollio *et al.* 2008:90) has found a number of symptoms in reaction to sexual abuse that are common to the symptoms exhibited in PTSD. In addition, the aforementioned study indicates that between 40% and 60% of children who have been sexually abused develop PTSD. Reliable and valid clinical measures for children are, however, generally lacking (Green as cited in Pollio *et al.* 2008:90).In contrast, some children are known to react differently to sexual abuse, or appear to exhibit fewer symptoms in comparison with other victims of abuse. These are regarded as desensitised children, who are taken to be more resilient. Van Rensburgh and Barnard (2005:1-2) assert that resilient children are in the minority. Desensitisation, then, could be taken to imply good functioning in spite of specific traumas, risks, and environmental hazards crossing an individual's path (Van Rensburgh & Barnard 2005:2). Children who are not resilient do not have access to such sources of resilience in their lives. They do not have these protective factors referred to by Van Rensburgh and Barnard (2005:1) to a degree where they counteract the development of the common symptoms associated with sexual abuse.

Problem formulation

Children react differently to sexual abuse. Some are impacted extremely negatively and develop a range of dire symptoms such as emotional, relationship, behavioural and personality problems suggested by Pullins and Jones (2006:3); Van Rensburgh and Barnard (2005:2); Berliner (2003:13) and Britz and Joubert (2003:27). Other children appear to be more resilient and exhibit fewer of these symptoms over the long term (Van Rensburgh & Barnard 2005:2).

A grey area exists because resilience factors are deemed inadequate to explain desensitised behaviour in sexually abused children. There is an overlap between symptoms associated with sexual abuse, such as apathy, withdrawal, depression, and specific PTSD symptoms as noted by Green (as cited in Pollio *et al.* 2008: 90). The researcher deemed it necessary to explore and describe the perceptions of desensitisation among sexually abused children.

Research question

What are caregivers' perceptions of desensitisation among sexually abused children?

Goal and objective

Goal: To explore and describe caregivers' perceptions of desensitisation among sexually abused children.

Objective: To explore what caregivers' perceptions are of desensitisation among sexually abused children, by means of focus group interviews

Research approach

A qualitative approach was followed in this study. Qualitative studies are attempts to get a so-called "insider's view" of a phenomenon, with a focus on describing rather than explaining or making predictions (Babbie and Mouton 2007:53). This approach allows the researcher to study selected issues in depth (Durrheim 2006: 47). It is

furthermore a research approach that sees the researcher make an interpretation of observations which cannot be separated from the researcher's own background, history, context, and prior understanding of the problem (Creswell 2007:39).

Research Design

Explorative and descriptive design was used for this study. An explorative study aims to generate new information and make preliminary investigation into a relatively unknown phenomenon (Mouton 2002:103). Descriptive studies, on the other hand, aim to make accurate descriptions of phenomena (Durrheim 2006:44). This study set out to explore and describe what the caregivers have in common and how they differ in terms of their perceptions of desensitisation among sexually abused children in their care.

Population and sampling:

A "population" refers to a group about whom a researcher wants to draw conclusions (Babbie & Mouton 2007:100). Durrheim and Painter (2006: 133) note that a population comprises the larger group from which a sample is taken. The population of this study consisted of those caregivers of children with a sexual abuse history who made use of social work services of the Western Cape Provincial Department of Social Development's Paarl and Gugulethu Local Offices. Purposive sampling was proposed, as selected cases were sought that could shed light on the phenomenon being studied. This method is often used in qualitative research (Durrheim 2006:50) and is regularly used with focus group interviews in order to select and examine a particular type of participant (Kelly 2006:304).

The participants were purposefully selected along the criterion of geographical proximity to simplify logistical arrangements for them to attend the focus group interviews and make it more convenient for them to partake in the study. The criterion of affiliation with the Western Cape provincial Department of Social Development's Local offices of Gugulethu and Paarl was followed because the researcher was employed by this Department in the role of social worker at time of conducting the study, first at the Gugulethu office and later at the Paarl office. The researcher thus had well-established networks with the Department and its staff, and was therefore able to identify participants from existing caseloads who met the criteria of the study.

Each participant had to be a caregiver either presently or in the past, of a child with a history of sexual abuse. These caregivers were mainly parents, grandparents or foster care mothers. The identified caregivers were asked to partake voluntarily in the study, and those willing to participate were included in one of three focus group interviews.

Data collection

Focus group interviews were selected as the means of data collection for the study rather than one-on-one interviews because the researcher believed that the interaction between respondents in such a setting might stimulate in-depth participation and not only elicit minimalistic answers. In doing so, much more detailed information may be gathered in a shorter space of time. A focus group interview is defined by Sarantakos (2005:194) as a loosely constructed group discussion in which the researcher guides the discussion. It is also known as a group discussion as it focuses

not on one member but on the group as a whole (Kruger as cited in Sarantakos 2005:195). Sarantakos (2005:195) also notes that it is just as effective as any other method of data collection.

Participants who met the criteria were informed about the study by the researcher or the relevant social worker. Ten respondents from each of the three residential areas were invited to an arranged venue at a time and date that they agreed to. Turnout of respondents varied among the three focus groups. Only four respondents arrived to partake in the Gugulethu focus group, eight for Chicago, and six for Mbekweni. A possible reason for the poor turnout in some of the focus group interviews may have been the cold and rainy weather at the time.

The services of two isiXhosa-speaking facilitators were employed during two of the focus group interviews, while the third group were conversant in English. The facilitators were qualified social workers with four and eight years' experience respectively. They therefore had sufficient experience to assist in the role of facilitators. They were given clear instructions to provide a verbatim translation of the responses by the isiXhosa-speaking respondents who felt more comfortable to express themselves in isiXhosa than English or Afrikaans.

During the ensuing focus group sessions each member was required to give his or her opinion and input. Semi-structured interviews with open- ended questions were used to promote respondent interaction. The researcher made use of interview techniques such as probing, paraphrasing, summarising and clarification in order to obtain rich data and to ensure that rapport was established with the respondents. According to Babbie (2004:266), probing is used to require respondents to elaborate when an inappropriate or incomplete response is given to a question. Babbie and Mouton (2007:289) also indicate that probing is useful for getting in-depth answers without prejudicing later answers, and they advise the researcher to develop good listening skills.

At the end of the discussion of each point, the respondents were asked to indicate whether they agreed with the researcher's summary of what had been given as answers. An audio tape recording was used to record the responses. It was explained that the audio recording was only used to ensure accurate transcription of the data. Field notes, in the form of observational notes, were taken by the researcher to supplement the verbal information from the respondents. Observations of such things such as the tone of voice, emotional state, and physical actions of the participants were recorded in writing, in order to keep a record of which respondent made which points. Observational notes are deemed vital to the accurate description of what has transpired during an interview, and are used to make empirical observations and table the researcher's interpretations of such comments (Babbie 2004:304).

Once all the focus group interviews were concluded, the researcher transcribed the audiotapes verbatim, so that a word-for-word retelling of the respondents' perceptions was documented. Copies of the transcribed interviews were made as back- up, and the respondents' names and personal details were masked in the recordings, as proposed

by Creswell (2007:142-143). The recordings were destroyed as soon as the data transcription had been made, so as to further protect the privacy of the respondents.

Trustworthiness

Characteristics of truth value, applicability, consistency and neutrality were used to assess trustworthiness. The researcher also took cognisance of reflexivity as an assessment of the influences that the researcher's own beliefs, perceptions, history and worldview have on the research process (Krefting 1991:218).

Ethical considerations

Ethical considerations, such as voluntary participation, the right to withdraw, informed consent, confidentiality and no harm was adhered to (De Vos, Strydom, Fouche & Delport 2011). Ethical clearance was also obtained from Senate Higher Degrees at the University of the Western Cape and The Department of Social Development was also obtained.

Data analysis

Babbie (2004:345) states that the fixed model of data analysis in qualitative inquiry is an analysis method that typically occurs once all data has been collected and transcribed, and is done with the written transcriptions. The researcher read through all the transcripts a number of times to become familiar with the data through immersion.

The researcher's notes and field observations were used to guide the process of coding, as proposed by Babbie (2004:377). Data was thus put through a process of thematic analysis, as is often done in qualitative studies, according to Creswell (2007:75). From these descriptions the researcher proceeded to formulate combined descriptions representative of the essence of the phenomenon, grouped into themes and sub-themes.

This representation of data allowed the researcher to initiate discussion and debate regarding the findings, as well as comparing and contrasting findings to other studies and the literature.

Findings

A total number of 17 persons formed part of the three focus group interviews, as one person withdrew from the study for personal reasons. and their details were removed from all records.

Four respondents came from Gugulethu, seven from Chicago and six from Mbekweni in Paarl. These areas are all sub-economic and previously disadvantaged communities. The majority of the CSA victims that were currently being cared for by the participants were female children. Thirteen girls and only four boys were indicated to be in the care of the participants. The ages when the CSA victim occurred varied greatly. The youngest child was three years old at the time of being abused and the eldest was 16. Half of the children were ten years and younger when the CSA occurred while the other half were 11 and older. Half of the children in care of the Ω services and the other half had

not. The themes that were uncovered during the study are presented in the table below (Table 1).

Table 1: Themes and sub-themes

Theme	Sub-theme
Perceived desensitisation, coping and current functioning of the CSA victims	• Marginal desensitisation of CSA victims • Unwillingness to portray children as approximating desensitisation • Perceived aspects that influence desensitisation, positive changes and resilience
Issues perceived to influence desensitisation, positive changes and resilience	• Primary caregiver effects • Family effects • Personal characteristics of CSA victims • Social effects • Intervention services effects • Perpetrator consequences

Perceived desensitisation, coping and current functioning of the child sexual abuse victims

Classic work conducted by Finkelhor (1990:327) indicates that more consideration has been given in the research arena since the mid-1980's regarding children who escape child sexual abuse relatively unscathed, as almost every CSA study has a subgroup of victims who were asymptomatic in comparison to their fellow victims. Van Rensburgh and Barnard (2005:1) also note that numerous authors support the notion that some victims of CSA do not experience troubled functioning, but instead progress to function relatively well after CSA. It is important to note that such children with more functional abilities after CSA are found to be in the minority.

Marginal desensitisation of CSA victims:

The participants gave mixed responses in communicating their general beliefs surrounding coping and perceived functioning in light of desensitisation to the effects of CSA. A fairly large number of participants agreed that the children in their care were coping somewhat better than after the incidents of child abuse, but reports were situation-specific or only related to certain aspects, while other issues were still perceived to be unchanged or current. It could be put forward that at best the children were perceived as exhibiting marginal levels of desensitisation.

"Covert distress", as it is termed by Edmund, Auslander, Elze and Bowland (2006:19), is apparent coping or functioning, which is actually superficial, and is visible only in terms of external behaviours (Luthar *et al.* as cited in Edmund *et al.* 2006:19). However, internal distress may be still present. According to Edmund *et al.* (2006:19), some young people may appear resilient (or desensitised in this study's approach), because they function relatively well on one level, such as socially getting along with friends, following social norms or performing well in school, but may be experiencing internal turmoil such as anxiety, depression and so forth. This could be postulated from the following examples:

"Yes the child is seemingly coping"
"Yes, she is coping a bit better now than in the beginning"

The caregiver perceptions are not convincingly seen by themselves as indicative of desensitisation among the CSA victims. According to Finkelhor (1990:328), some

hypothesised that such children were in a "denial pattern" and that they would later become symptomatic. Some studies found exhibited worse symptoms at an older age, support for this, and even noted that these children might be those that for example the study by Tufts (as cited in Finkelhor 1990:328). Some support for this is evident in the following quotation:

"There are no major changes, because before it happened and after it happened she did not give me many problems."

This is, however, an exception and not the rule, which is the notion that resilient children are in the minority (Van Rensburgh and Barnard 2005:1-2). Finkelhor (1990:328) further notes that it was children who were troubled after the CSA incident who often got worse. This takes on the meaning that their symptomatic responses or reactions to CSA became progressively more negative. The following supports this idea:

"Yet the child made it through it, or not totally. Often the child still speaks about it. You will just mention something then the child is away again. Mostly… the child is withdrawn. Now, we leave the child like that so that she can carry on."[Indicating the child is still distant and withdrawn, and that the family have accepted this symptom display as the norm]

Some of the respondents indicated that they perceived the children in their care to be coping to a degree when compared to other children who also had a CSA history. In other words, respondents noted the abatement of symptoms, which they put forward as indications of desensitisation. They were quick to point out that these were marginal, and linked them to specific situations or instances which made them situation-specific and not indicative of a general state. This is evident in the following:

"I have to tell you that from that time to now there is a large improvement."
"But now the behaviour is improving" [referring to levels of anger and cheekiness/disrespect]
"Now she stopped being scared. But she has days sometime that you see she… when the incident comes back…" [Fears have subsided, but return at times]

Responses from participants indicated that improvements did occur. How significant these were interpreted to be by the caregivers, in light of the overall symptomatic response, is hard to establish. Some indicated noteworthy improvements, and others little to none. Some even indicated that no changes occurred from before the CSA occurred to the present, which was specifically related to problematic behaviour. What one can interpret from this is that the expectations held by caregivers were mostly negative; they were more on the lookout or cautious about negative behaviours which they expected to be manifested by the children, either internalising or externalising.

Reluctance to represent CSA victims as approximating desensitisation

Although some caregivers indicated positive notions regarding the children's levels of adjustment and coping, the majority were still reserved in the extent to which they would categorise such positive changes as being indicative of the child overcoming the CSA.

Some indicated that changes had only begun recently, and that they did not perceive the children as largely desensitised. Van Rensburgh and Barnard (2005:1) as well as Hilarsky (2008:37) note that a smaller portion of children are affected to a lesser extent by CSA, but the majority exhibit long-term side effects. Most of the children had been sexually abused in the past two-and-a-half years, as the average age of the child victims in the respondents' care was 12 years and they were sexually abused at an average age of nine- and-a-half years. Thus the time span may be indicative of the onset of long-term side effects which went against the notion of overcoming short-term symptoms before they evolved into long-term side effects.

The respondents perceived desensitisation among the children in their care as marginal, and said that in some cases it was not perceived, which is evident in the following:

"Mmmmm not 100%, but let's say 80% or close to 90% better…"
"I would not say he has overcome but he is getting there…"
"I don't know if the child has…" [Referring to respondent's opinion on whether the child has overcome the trauma of CSA]
"But now I cannot say negative or positive. But like [the child] is behaving in school. Like at home she can play with her friends. While she was staying at home, she didn't want to go outside to play, even here in the streets. I think she is safer there." [Indicating that the child is better off residing in the Eastern Cape with the participant's mother than with the participant self in Mbekweni].

Kouyoumdjian, Perry and Hanson (2009:41) note that research has identified parental (caregiver) support after CSA that has been linked to how well a child recovers from CSA.

For the present study, parental support could be either biological parents or caregivers in instances where the child did not live with their biological parents. The absence of parental support is reported to be linked to an increase in both internalising and externalising difficulties (Adams-Tucker as cited in Kouyoumdjian *et al.* 2009:41).

Caregivers hold perceptions and expectations of the way a CSA child should and will behave, adapt, adjust and function. They in essence attach a label to the CSA child, which has undertones of expectations. These expectations then "rub-off" on the child, and pressurise him or her to live up to expectations. This is referred to by various authors noted by Kouyoumdjian *et al.* (2009:42), as a "self-fulfilling prophecy". These assumptions that adults may hold tend to be negative in nature rather than positive, as reported by Holguin and Hansen, and Kouyoumdjian *et al.* (as cited in Kouyoumdjian *et al.* 2009:42). The following serves to illustrate this point:

"No I would not say she is coping well, but I mean from that then to now there has at least been an improvement"
"I think worse, but she is changing now, only starting now"

These comments show that in their perceptions a negative undertone or expectation appears. The caregivers who made these statements may hold expectations of more

negative outcomes, and downplay improvement, which may in fact have an interactive effect on the actual outcomes and desensitisation of the CSA children in their care.

In view of the above literature compared with the respondents' perceptions of the behavioural and psychological manifestations exhibited by the children in their care, it can be suggested that some of the children may at best be placed at risk of later developing PTSD, although their current symptoms may overlap with those of PTSD. The following quotations refer to the CSA child's behavior:

"She has a lot of anger… She is very disrespectful; she is fighting with me a lot."
"This one also has nightmares…"
"Because she hits other children, and I have constantly got to go to the school"
"She is very violent and that causes a conflict between me and the other parents as they don't understand the situation as I do of what happened in the past"
"His schoolwork improved a bit, but now the only problem is he forgets a lot…"
"The child would be someone who likes like sugar daddies, that men and everything"
"The child will not be stable, not be staying in a stable family she will go around with other people, go around with other men."
"…after the incident when the child is playing she will like to like… sexual demonstrate what the guy did with the other children…"

Literature has shown support for desensitisation, which is taken in this study to mean that it may only occur on the surface, the so-called "covert coping" of Edmund *et al.* (2006:19). The findings of this study may tend to support this notion.

Some respondents appeared careful or unwilling to depict the children as better adjusted, desensitised or functioning well. This may be out of fear of losing what support they were receiving from professional services such as the Department of Social Development and other organisations. As opposed to embracing the desensitisation effect, it was replaced by conditions of better coping. This was done in that the caregivers indicated that noted improvements had only started recently; were occurring but stopped or subsided; were small, un-noteworthy or insignificant; or were situation-specific, meaning they existed in only one area such as aggression, but withdrawal and fears still existed.

Issues perceived to influence desensitisation, positive changes and resilience

According to Finkelhor (1990:328), since the mid-1980's, significant studies have been done on the conceptualisation of the impact that sexual abuse has on the child victim. Kendall- Tackett (2003:228) notes that responses of a child to sexual abuse are greatly dependent on the child, the family, whether it was reported to the authorities, and what support was available following disclosure. Van Rensburgh and Barnard (2005:1-2) further note a range of factors that may serve as protective agents against the development of harmful symptoms in reaction to child sexual abuse. Various other authors, including Reyes (2008:52), support this notion, and identify factors such as personality traits, the nuclear family, and social support systems, as such.

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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