AN EVALUATION OF A GROUP PROGRAMME FOR ADOLESCENT GIRLS WHO HAVE SUFFERED SEXUAL ABUSE

THABISO RAPAPALI

Thesis submitted in partial fulfilment of the requirements for the degree of PhD (Community Psychology) in the Department of Psychology, University of Zululand.

May 2012

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Promoter: Dr.P.B. Msomi-Mbele.
Co-Promoter: Prof. H.S.B. Ngcobo.

DECLARATION

I Thabiso Rapapali declare, that the thesis hereby submitted by me for the PhD study in Community Psychology degree at the University of Zululand is my own independent work and has not been submitted by me at any other University/Faculty. I furthermore cede copyright of this thesis in favour of the University of Zululand.

Signed: _____ Date: _____

DEDICATION

This thesis is dedicated to my family, who has been there for me throughout the work on this thesis.

ACKNOWLEDGEMENTS

To my family, my daughter Mpho, my son Katleho it has been the most challenging time of my life ever that has affected you so much. I love you always.

He is the living Father, glory be his name. No words can fully express my joy for having him in my life. I thank Him for giving me guidance, courage and wisdom to focus and complete this work during the trying times. I thank Jesus Christ His beloved Son who motivated me all the way and summoned a winning team around me.

I extend my heartfelt thanks to my Mum who raised me instilling respect and perseverance. I thank you for the many years of sacrifice, prayers and love that have carried me through difficult times in my studies; may her soul rest in peace. To my Father with love, my siblings for the encouragements and looking up on me as the role model. Love you guys!

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I thank Annemarie Coetzee from Tshepong Victim Centre at National hospital in Bloemfontein in the Free State, South Africa. Mamello from Tshwaranang Victim Empowerment, an NGO from Freedom Square, Bloemfontein in the Free State, South Africa. Thank you so much for your support and may the Almighty Bless you keep you strong always.

I also thank the Sister-in-charge of Tshepong Victim Centre and her staff, thank you so much and God Bless.

To all the girls who volunteered to participate in this study, my sincere gratitude and Best wishes in all your endeavors.

ABSTRACT

The aim of this study was to evaluate a group clay therapy programme that was conducted among teenage girls who have suffered sexual abuse in the rural district of the Free State Province in South Africa. The strength of this programme lies in the fact that it is a group therapy programme, therefore is able to reach a number of subjects at the same time, as opposed to individual consultation, which is a common approach in psychological interventions.

Literature shows that the incidence of sexual abuse among young girls is alarmingly high (National Department of Social Welfare, 2004; Bolen, 2001; Conradie & Tanfa, 2005). While government and non-profit organizations try their best to fight this crime, health care delivery is lagging behind. Pillay and Lockhart (1997), identified the shortage of psychologists as one of the reasons for poor delivery of mental health care services to children. Bolen (2001), states that child sexual abuse invades the inner being of a child, and may result in psychopathology, if not treated early. This is of concern to everybody including the government hence a solution is sought in many different forms.

The study adopted a quasi-experimental research design. A sample of forty (40) adolescent girls who are survivors of sexual abuse was selected. They were divided into two groups; twenty (20) formed the experimental group, and the other twenty (20) the control group. The experimental group received clay therapy whilst the control group underwent a routine intervention programme that is offered by the health clinic for survivors of sexual abuse. At the end, both groups were evaluated in order to check the difference with regard to their response to these treatments. A higher positive response was observed in the experimental group. This was an indication of the effectiveness of clay therapy.

Clay therapy was given for eight sessions. This is taken as brief therapeutic intervention. It therefore minimises time spent in health care facilities. Brief therapies are more effective and helpful with clients of low socio-economic status, simply because some of them lack funds for daily trips to see the therapists, who are usually located in urban areas. The subjects for this research were all from a rural area.

Individuals who have suffered traumatic experiences such as sexual abuse, usually find it difficult to express themselves in words because they usually get overwhelmed with emotions. Children also lack vocabulary to express their innermost feelings. Body-based therapies such as clay therapy, are usually successful in accessing thoughts, feelings, and bodily experiences which are all intimately related. Clay therapy is therefore recommended as a therapeutic modality of choice when working with traumatised individuals.A

South Africa is made up of nine provinces and the provinces are further divided into districts.

Through poverty, politics, e.g. forced removals, faction fights, etc., and societal factors such as the migrant labour system, marriages and others, people have migrated from their places of origin, so that one finds mixed cultural groups all over the country. A therapeutic modality that reaches a number of clients of different backgrounds at the same time is more relevant. The clay therapy modality reflected no language barriers; all the girls grasped the activities well, even though they were from different cultural groups. Playing with clay is culture friendly, because no level of education is needed to master the art of playing. This makes clay therapy much easier to integrate into child therapies. Confidentiality is also maintained in such therapy because the subjects do not have to talk about their feelings in the group if they do not want to, but they get a chance to interact with people who are of the same age, who have experienced the same trauma as theirs.

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CHAPTER 1
INTRODUCTION

1.1 INTRODUCTION

The purpose of this study is to evaluate a group treatment programme for teenage girls that have suffered sexual abuse. Literature shows that the incidence of sexual abuse among young girls is alarmingly high (National Department of Social Welfare, 2004; Bolen, 2001; Conradie & Tanfa, 2005). While government and non-profit organizations try their best to fight this crime, health care delivery is lagging behind. Pillay and Lockhart (1997), identified the shortage of psychologists as one of the reasons for poor delivery of mental health care services to children. Collings, Bugwandeen, Suliman & Wiles (2007), and Collings, Bugwandeen & Wiles (2008), state that the number of child survivors of sexual abuse who attend clinics for psychological and medical help, declines before completion of their course of treatment.

This is of concern to everybody including the government hence a solution is sought in many different forms. Departments such as Justice, Social Welfare, and Health are taking steps to fight this crime (Children's Act, 2005; Child Care Amendment Act, 1999; Childhood Matters, 1996; South African Law Commission, 1999). The South African government has introduced scarce skills incentives for health workers in the rural areas of the country (Pillay & Lockhart, 1997). Non-governmental organizations such as Child First and Free State Network are also making their contributions. As measures to eradicate these crimes are being implemented, it is also important to look at measures that can help survivors to recover fully. Intervention measures therefore need to be varied.

This study discusses clay therapy that was conducted among teenage girls who have suffered sexual abuse in the rural district of the Free State province in South Africa. What is important about this program is that it is a group therapy programme for an emotionally vulnerable group of people who have

suffered one of the most gross human violations there is. Discussion in this document will give light to the rationale, process and results of this study.

1.2 BACKGROUND TO THE STUDY

Child sexual abuse is a global public health problem that continues to escalate (Guma & Henda, 2004; Riley, 1990). Various studies indicate that the prevalence of child sexual abuse is increasing every year. Childhood Matters (1996), estimate that up to 100 000 children in a year may have been sexually abused. Maughan (2003), states that a child is molested every five minutes in South Africa.

According to the National Department of Social Welfare (2004), on average, eighty (80) children were sexually abused daily between 2004 and 2006. South African Police Service statistics indicated that in 2008/2009, reported child sexual abuse incidences increased to 7 276 from 2 014 of the previous year. According to Intebi (2003), exact incidences and prevalence of child sexual abuse in the general population is not known precisely.

Research indicates that young girls are more prone to sexual approaches than boys (West, 1985). These figures render South Africa as a dangerous country to live in for young girls. In most incidences, children are abused by people they know and trust, e.g. a father, teacher or priest. (Longwood, 2003; and Macking, 2003). According to Nurse (1996), only one out of every 800 sexually abused children is noticed. This indicates that current statistics of child sexual abuse are only the tip of the iceberg.

Survivors of child sexual abuse exhibit physical health problems as well as psychological challenges (Wolfe, 1999). These challenges may take the form of acting out behaviours such as delinquency, drug abuse, promiscuity, or other self-destructive behaviours. If left untreated, these may continue into adulthood and disrupt normal functioning of an individual permanently. In addition to this Sheri (2006), states that child sexual abuse can result in multi-

functional deficits such as plasticity of intelligence and impaired memory, which affects the child's optimum scholastic functioning.

The ever increasing incidence of child sexual abuse requires various treatment approaches. The lack of health care facilities suggests that the majority of children who are survivors of abuse, do not receive adequate health care. Pillay and Lockhart (1997), state that in most urban health care centres, psychologists are unable to meet the needs of children for the following reasons:

- There is a shortage of psychologists, especially community psychologists;
- The available psychologists only visit health care facilities once a month and for one day only;
- Psychologists in private practice cater for only a few children whose parents can afford the services.

The concentration of health care services in urban areas is another cause for concern that has received the attention of the authorities. In order to address this problem, the South African government has introduced a system of compulsory community service for clinical psychologists who have just completed their internship and scarce skills allowances for psychologists and other health personnel working in rural areas.

The number of child survivors of abuse who go to the clinics for medical and psychological help, declines before completion of the course of treatment (Collings, Bugwandeen, Suliman & Wiles, 2007; Collings, Bugwandeen & Wiles, 2008). Stigmatisation, long queues to receive treatment, and long distances to health care facilities, may be some of the reasons for this decline.

The intervention programme that is proposed in this research will contribute towards minimizing the time spent in health care facilities because it is a group intervention programme that applies the medium of clay in order to heal the survivors. The value of this programme is its ability to accommodate a number of clients within one treatment programme. If successful, the

programme will shorten the period of suffering and increase support structures for survivors.

1.3 MOTIVATION FOR THE STUDY

Statistics in the previous discussion indicate that child sexual abuse is ever increasing, therefore concerted efforts from all stakeholders are a requirement. Focus is on female adolescents because literature indicates high incidence of sexual abuse in this group (Collings, Bugwandeen, Suliman & Wiles, 2007; Intebi, 2003; and West, 1985). While the government and other interested parties try their best to eradicate this crime, there appears to be a need for varied and effective health care programmes to heal the survivors.

1.4 OBJECTIVES OF THE STUDY

The objectives of this study are as follows:

- To implement a holistic counseling therapy programme through the use of clay therapy.
- To evaluate the programme for effectiveness.
- To adapt the programme for future application.

1.5 VALUE OF THE STUDY

The results may bring about a much needed community based treatment programme for sexually abused children. As the incidence of child sexual abuse is reported to be increasing every year, a group oriented and effective modality will be of great benefit.

1.6 DEFINITIONS OF TERMS

i. According to the Children's Act, 2005, the word "Child" "*means a person under the age of 18 years*". This is a general term that is

used to exclude human developmental stages that are mostly used by health care professionals including psychologists.

ii. Adolescence is a stage of development between childhood and adulthood (Thom, Louw, Van Ede & Ferns, 1998). At this stage a child prepares herself or himself to become an adult who will be prepared to meet the demands of being an adult.

iii. The word "psychological" indicates anything that has to do with psychology and this may entail pathologies such as mood or behavioural disorders. It also pertains to psychological assessments and treatments or interventions.

iv. Kempe & Kempe (1978), define child sexual abuse as *"the involvement of immature children and adolescents in sexual activities they do not truly comprehend, to which they are unable to give informed consent, or that violate the social taboos of family roles".*

According to the Children's Act, 2005, child sexual abuse means:

- *Sexually molesting or assaulting a child or allowing a child to be sexually molested or assaulted.*
- *Encouraging, inducing or forcing a child to be used for the sexual gratification of another.*
- *Using a child in or deliberately exposing a child to sexual activities or pornography*
- *Procuring or allowing a child to be procured for commercial sexual exploitation or in any way participating or assisting in the commercial sexual exploitation of a child.*

According to the Child Care Amendment Act, 1999, child sexual abuse means:

- *Sexually molesting or assaulting a child or allowing a child to be sexually molested or assaulted.*

The above definitions of child sexual abuse reflect conceptualizations by different professionals involved in addressing this problem, and also in accordance with the intervention strategies relevant to their area of expertise, e.g. health professionals, legal and social welfare professionals.

1.7 SUMMARY

Child sexual abuse is a long-standing problem and it appears to escalate despite various efforts invested in curbing it. Consequences of child sexual abuse leave lasting emotional scars that can impair the survivor's social and psychological functioning, if not addressed in time.

This chapter covered the following areas: statement of the problem, objectives of this study, motivation for the study as well as its values. Various definitions by different stakeholders who are playing a meaningful role in eradicating this crime were also stated. The next chapter will focus on various issues related to child sexual abuse, and clay therapy as the modality of choice for this study.

CHAPTER 2
LITERATURE REVIEW

2.1 INTRODUCTION

This chapter reviews literature on child sexual abuse, starting with the description, causal factors and its effects. Prevention programmes are also discussed, as well as adolescence as a critical developmental stage for individuals.

2.2 CHILD SEXUAL ABUSE

2.2.1 Description

Child molestation or child sexual abuse is defined by the South African Law Commission (1999), and Management Protocol on Child Sexual Abuse and Neglect (1996), as an act or acts that result in the exploitation of a child or a young person, with or without their consent, for the purpose of erotic gratification. Adults, children or young persons may commit these acts. Sexual abuse may include, but is not limited to the following:

- Non-contact abuse: exhibitionism, voyeurism, suggestive behaviours or comments, exposure to pornographic materials or producing visual depictions of such conducts.
- Contact abuse: genital or anal fondling, masturbation, cunnilingus, fellatio, object or digital penetration, penile penetration of the anus or vagina, and/or encouraging the child/young person to perform such acts on the perpetrator.
- Exploitation: involving the child in exploitative activities such as pornography, prostitution, and sex tourism.

2.2.2 Causal factors

Different theorists have tried to give an in-depth explanation on the perceived reasons for sexual abuse of children. Frosh & Glaser (1988) suggest that the cause of child sexual abuse lies in the biological and psychological make-up

of the abuser, and the constellation of relationships, social arrangements and values that make the child more or less likely to be victimised. The following different but common goal orientated theories provide an important insight regarding the possible reasons for child sexual abuse.

2.2.2.1 Biological explanation

The biological approach to deviant sexual behaviour is explained in terms of the evolutionary perspective, chemical make-up and neurological aspects of the potential perpetrator as well as the arousal theory.

2.2.2.1.1 The evolutionary perspective

From the evolutionary perspective it is argued that human sexual behaviour, like that of animals, is driven by the need to attempt to maximize their potential for successful reproduction. Sampson (1994), indicates that males differ from females in that males are mostly preoccupied with reproduction. For these men to be successful they need to attract and impregnate a large number of fertile females. Females on the other hand, are interested in males who will be able to care for them and their children after mating. Males who are unable to attract fertile females may not possess characteristics that indicate that they can provide care and support for mother and offspring and are therefore forced to engage in rape in order to enhance their chance for reproduction. According to this view, rape is therefore to be seen as a mating strategy entered into by relatively unsuccessful males.

Even though the proponents of this perspective have some evidence to support their argument (e.g. Money, 1981; Russell, 1986; Wilson, 1987), their theory has not been universally endorsed. Sampson (1994), argues that despite the claims by some proponents to scientific rigor, the scientific basis remains unproven. Firstly, the comparison of human sexual behaviour with that of animals as a human reproductive strategy is controversial. Secondly, it is controversial to regard the differing rates of rape around the world to be a result of genetic influence without giving an indication of the existence of a gene or a combination of genes to explain behaviours as complex as rape.

Thirdly, girls below the age of puberty and women past childbearing years are victims as well, placing into question the belief that rape is a reproductive strategy.

It could be concluded that the evolutionary perspective of the biological theory is very limited and cannot be applied to all forms of sexual deviance, certainly not to child sexual abuse.

2.2.2.1.2 Hormonal influences

The possibility of hormonal imbalances involved in the biological makeup of sex offenders has received increasing attention (Araji & Finkelhor, 1985; Lanyon, 1991). Since sexual assault often includes both sexual behaviour and aggression, it was hypothesized that rapists could have elevated levels of plasma testosterone (Bain & Hucker, 1990). Another contention in this regard is that sexual offenders have a strong sex drive (Barlow & Durand, 2002), and that this is related to elevated plasma testosterone (Berlin, 1989; Bradford, 1985). No consistent pattern of higher testosterone levels were observed (Bain & Hucker, 1990). Conversely, some indications of significantly elevated levels of adrenal androgen were found in a group of rapists, suggesting that a disorder of sex hormones in rapists could lie in the adrenals rather than in the testes (Bain, Langevin, Dickey, Hucker & Wright, 1988).

In their study to determine the influence of hypothalamic pituitary gonadal dysfunction in paedophilia, Berlin and Gaffney (1984), pointed out that paedophiles have a markedly abnormal luteinizing hormone (LH) response to luteinizing hormone-releasing hormone (LHRH). According to them this documents a specific endocrinological abnormality in a group of patients with sexual deviancy as the primary diagnosis. These researchers, however, indicated that their results should be considered preliminary until they are replicated, as their study group was representative of a subpopulation of paedophiles. They further suggested that more in-depth investigation is needed before the LHRH test can be proclaimed a diagnostic marker.

From the above discussion, it is clear that the issue of possible hormonal deviance in sexual assault is inconclusive.

2.2.2.1.3 Brain functioning

Langevin (1990), suggested that brain functioning can play a vital role in the causes of child sexual abuse. As interest grew in brain involvement, it was suggested that child molesters showed neurophysiological impairment more than non-sex offenders, and that the implicated lobe was the left parieto-temporal lobe (Lanyon, 1991).

In order to show that sexual deviations are a consequence of the male pattern of cerebral organization, Lanyon (1991), outlined some studies as proof of this argument. Two neuropsychological tests, the Halstead-Reitan (H-R) test and the Computerised Tomography (CT) Scan used in one specific study, showed a clinically significant impairment of the left hemisphere of the brain, indicating a left hemispheric pathology. Langevin (1990), however, pointed out that the interpretation of the results was problematic because of the lack of normative information.

In addition, Howitt (1995), indicated studies of brain symmetry in which the brain scans of a variety of sex offenders were compared with non-offenders. Paedophiles differed from the normal controls in that they had smaller left brain hemispheres than right brain hemispheres. This could possibly suggest that structural abnormalities are more common in the brains of sexual offenders.

Some early researchers, seeking to explain the aetiology of paedophilic behaviour, looked towards intelligence scores as a means to explain child sexual abuse. Popular theories suggested that paedophiles are socially and mentally handicapped and therefore are seeking children as their companions as they deem them more appropriate in keeping with their mental development (Langevin, 1990). The assumption was not supported. However, learning disorders or other brain pathology was suggested since the

intelligence scores of paedophiles tended to skew to the lower end of the normal range (Langevin, 1990).

Although there is a paucity of studies that examine brain damage and dysfunction in other sex-offender groups, the above discussion suggests that brain impairment and dysfunction, especially in the left hemisphere, could play an important part in sexual deviance, although more research is needed in this regard.

2.2.2.1.4 The arousal theory

The arousal theory suggests that paraphilics exhibit a high sexual drive. For example, Barlow and Durand (2002), indicate that paraphilics have a weak biologically based behavioural inhibition system, suggesting the possibility of elevated sexual urges. These authors postulated that sexual offenders' sexual drive may be influenced by their efforts to try and suppress their sexual thoughts and fantasies, thus leaving them with heightened sexual arousal. The heightened sexual arousal and weak behavioural system could suggest that these men may be involved in sexual abuses, in this instance with children, if they are sexually aroused towards them.

Barbaree (1990), highlighted studies that examined sexual arousal of men towards children. Some of these studies evaluated the strength of arousal towards children, adolescents and adults, while other studies assessed the age-preference (the so-called age-preference-profile) of these men.

Regarding strength of arousal, studies suggested that men who molested non-familial female children showed greater arousal to young girls than non-offenders, although they also responded strongly to adult women. Incestuous child molesters as a group did not show strong responses to children, but their responses to adults were relatively weak (Barbaree, 1990). Non-offenders showed strong arousal to adult women and a diminished arousal to adolescent and child targets.

Regarding the age-preference-profile, an analysis of profile shapes among female-child molesters, father-daughter incest offenders and non-offenders, Barabaree and Marshall (1989), found the following: of the incest offenders, 40% showed an adult profile (strong responses to adult females), while an equal number showed a non-discriminating pattern (moderate arousal to all targets, i.e. children, teens and adults). Most of the remainder of the incest offenders showed a teen-adult (targets 13 years and older) profile.

Regarding the child molesters, the largest subgroup (35%) showed a child profile (children 11 years and younger). The remainder of the child molester group was approximately equally distributed among the other profile categories (adults, teen-adult, and child, non-discriminating). None of the non-offenders showed profile shapes that indicated responses to children. This analysis suggested that child molesters do not uniformly show sexual responses to children, and that they do not show exclusive sexual responses to children (Barbaree, 1990). It can therefore be concluded that the arousal theory does not adequately explain child sexual abuse.

2.2.2.2 Psychological explanation

Psychological theorists approach the explanation of men sexually abusing children by trying to understand these men's thinking and motivation regarding sexual relationships. In order to explain these factors, several theoretical viewpoints are discussed below.

2.2.2.2.1 The psychodynamic viewpoint

The most prominent theoretical explanation for child molestation has been, until quite recently, psychodynamic in nature (Lanyon, 1991). The psychodynamic viewpoint seeks to explore the underlying motivation for human beings that may influence them to sexually abuse children.

One prominent explanation, offered by Groth (1982), points out that offenders' underlying motivation involves the expression of non-sexual needs and

unresolved love issues. Molestation is viewed as a pseudo-sexual act – sexual behaviour in the service of non-sexual needs. According to Groth (1982), there are two basic types of child sexual abusers, outlined with regard to their primary sexual orientation and level of socio-sexual development. These are the fixated and regressed types.

The *fixated types* develop primary or exclusive sexual attraction towards children early in their sexual maturation. Psychosexually they have never developed beyond this level.

The *regressed types* exhibit a more conventional peers-orientated socio-sexual development and are not sexually attracted to children at the early stages of their sexual maturation. Their sexual activities and interests are solely focused on their age-mates. They might, however, encounter particular circumstances such as excessive marital and financial demands, and unable to cope, then regress to sexual involvement with children.

The underlying motivations for both types are various and complex; and include the need to cope with feelings of powerlessness, attempts to process their own abusive childhoods, and misplaced needs for affection. Hartley (2001), pointed out that all offenders' motives in child sexual abuse are self-serving. He explained further that although they are parental figures to their victims, child sexual abusers either do not see, or are unable to set aside, their parental obligations in the pursuit of their own gratification.

Socarides in his modern psychoanalytic account of paedophilia, distinguishes between paedophiliac behaviour of fantasy and the obligatory paedophile pervert, (Howitt, 1995). The first refers to the situational offender, which is, according to Socarides, much more common. In this case the seductive and affectionate child causes men to offend against their sexual natures, much the same as intoxication can lead them to offend against adults. The obligatory paedophile perverts on the other hand, "must have sexual activity with a child or suffer intolerable anxiety" (Howitt, 1995, p.138). According to Socarides,

the types of paedophile differ in terms of the developmental stage in which their deep-seated psychological conflicts were fixated.

Family systems theories can also be viewed as psychodynamic in nature. However, these are more relevant to incestuous, than non-incestuous child sexual abuse. These theories contend that the psychodynamic interplay among family members is of prime importance in the aetiology of the problem (e.g. Groth, 1982; Mrazek & Kempe, 1987). Based on the viewpoints of various authors in this regard, Sandler and Sepel (1990), describe two kinds of families, namely:

The multi-problem family, where incest forms one aspect of the total family disorganization, which includes financial difficulties, alcoholism and unemployment.

The classic incest family which presents a façade of role competence and stability. Each family member tends to have an innate fear of family disintegration, therefore problems are well concealed. Some of the main features of the classic incest family are the following:

- The family is usually patriarchal and family members do not question the father's authority, which makes it easier for him to abuse his children as his actions are not questioned and not reported.
- There is usually a poor marital relationship (emotionally and sexually) between the parents; the mother often condones the incest, as she prefers to keep her husband's infidelity within the home.
- There is usually a role reversal between the mother and daughter (the daughter not only takes over the household activities, but also her role as sexual partner to the husband).

It is clear from the above exposition that although the psychodynamic viewpoint attempts to describe the motivational factors involved in child sexual abuse, empirical research is lacking in this regard.

2.2.2.2.2 The personality viewpoint

According to Marshall and Starzyk (2003), childhood personological and interpersonal characteristics are increasingly becoming salient risk factors for sexual offending. They indicated that these characteristics emanate from negative childhood experiences and promote the development of characteristics related to increased risk for sexual offending later in life.

Characteristics such as poor interpersonal style, lack of appropriate social skills, social isolation, inability to convey empathy, inability to form close and trusting relationships, impulsivity and antisocial behaviour are some of the risk factors identified in child sexual offenders. These characteristics are influenced by family factors such as negative child-parent bonding and parental neglect during early childhood development (Overholser & Beck, 1986; Saunders & Smith, 1995; Marshall & Starzyk, 2003).

In addition, Sandler and Sepel (1990), indicate three types of personalities that characterize incestuous sexual offenders.

The *introversive personality type* who experiences feelings of masculine and sexual inadequacy, has a low self-concept and is emotionally immature. Inadequate social relations, especially of a social nature, are also evident.

The psychopathic personality type, exhibits indiscriminate promiscuity and has sexual relationships outside the home with adults and other children, while also sexually abusing their own children. These persons have low moral standards, and no guilt feelings or remorse for their actions.

The third personality type is *the psychosexually immature personality type* who prefers children for his sexual gratification. These persons may have been sexually abused themselves in childhood and are sexually using children in order to convince themselves that their own past personal experience can be rendered harmless and can be idealized through repetition.

Ward (2003), developed a comprehensive personality focused aetiological pathways model of child sexual abuse. He identified the following five clusters of problems typically found among adults who sexually abuse children:

In the first pathway Ward (2003), identified an *intimacy deficit* on the part of the sexual offender. The individual possesses normal sexual scripts but sexually abuses children when preferred sexual partners are unavailable. Preferred sexual partners are not always available as a result of deficits such as inappropriate social skills. They regard children as “pseudo-adults” and abuse them sexually because of their inability to have a lasting intimate sexual relationship with their age-mates. They therefore transfer their sexual needs and intimacy to children.

Deviant sexual scripts are explained in the second pathway. An individual exhibits distorted mental representations with regard to sexual relationships that are thought to have developed during early childhood. They tend to confuse sexual issues with those that signal affection and closeness. They may resort to children because of their feelings of loneliness resulting from constant rejections from age-mates and therefore see children as trustworthy and accepting.

The third pathway is the *emotional dysregulation model*, which is hypothesized to contain individuals who have difficulties in some aspects of the emotional regulation system. These people have a problem in identifying emotions and lack ability to utilize social support in times of emotional distress. Some individuals may primarily have difficulties in controlling their anger and sexually abuse children as a way of punishing their partners. At times strong negative mood states could result in a loss of control, which, in conjunction with sexual desire, leads an individual to opportunistically use a child to meet his sexual needs.

Some child sexual offenders may possess general pro-criminal attitudes and beliefs in conjunction with their sexual offending, reflecting general antisocial

tendencies. According to Ward (2003), this constitutes *an antisocial cognitions model,* the fourth pathway model. Child sexual abuse tendencies of this group, are influenced by their pro-criminal attitudes, and may be exacerbated by patriarchal attitudes towards children. They have a tendency to disregard social norms that forbid sex with children so as to fulfill their sexual needs.

In explaining the fifth aetiological pathway model, *the multiple dysfunctional mechanisms,* Ward (2003), asserts that these individuals have distorted sexual scripts that coincide with pronounced flaws in all the other primary psychological mechanisms. These individuals not only possess distorted beliefs and attitudes concerning their sexual needs and inclinations, but there are also intimacy deficits, deviant sexual arousal, emotional regulation problems and cognitive distortion. This group is therefore likely to exhibit a multitude of related deficits and constitutes a “pure” paedophilia.

Regarding key characteristics within couple dyads, prevalent contention in clinical literature is that the parents (non-offending mothers, father/ perpetrator) have distinctive, yet complimentary personality traits. The mother is usually portrayed as submissive and insecure, while the father is depicted as cold, distant, aggressive and domineering. However, in examining individual traits of the father/perpetrator and non-offending mother as well as the within-couple association of these traits in incestuous families, Saunders & Smith (1995), detected that the mother and father/perpetrator tend to associate with partners who have similar personality traits. This suggests that partners may be more alike than be different. Key characteristics seem to be anxiety, low warmth, social deficits and social isolation.

However, according to Saunders & Smith (1995), even though offenders may exhibit characteristic qualities, there is no prototypic personality of perpetrators by which discrimination between the offenders and non-offenders can be used with any degree of certainty. While some perpetrators of child sexual abuse may meet the diagnostic criteria for personality disorders, others may not be suffering from any psychiatric disorder (Herman, 1997).

2.2.2.2.3 The cognitive viewpoint

Cognitive distortions on the part of the perpetrator of child sexual abuse play a vital role in the aetiology of child sexual abuse. For example in their study on the sexual abuse myth acceptance, Collings & MacArthur (2000) found that child molesters scored significantly higher than rapists, non-sexual offenders and community comparison samples on the Child Sexual Abuse Myth scale. These results suggest that child molesters hold certain cultural myths and stereotypes towards children that may give them tacit “permission” to commit sexual abuse. These myths pertain to blame diffusion (i.e. blaming others for the abuse) denial of abusiveness (i.e. minimizing the abusive nature of child sexual abuse) and restrictive stereotypes (i.e. denying the reality of abuse).

Along the same lines, Gizzarelli, Hanson & Scott (1994), outlined three models of entitlement concerning incest offenders that focus on the abuse of power inherent in the act. In these entitlement models the potential offender abuses children sexually because he believes that satisfying his own needs is more important than the negative consequences for the victim. Each model suggests that offenders hold certain beliefs, attitudes, cognitive distortion (Gizzarelli, Hanson & Scott, 1994).

In the first model, the under assertive model, the child sexual offender sexually abuses children because he perceives himself to be sexually frustrated and holds a negative attitude towards extra-familial affairs. He then sexually abuses children in order to fulfill his impulses.

The second model, the blocked model, suggests that the offender views children as sexual and perceives no harm in having sex with them. In some instances he may feel justified in acting out the impulses when feeling aroused by a particular person, including his own children, even if other sexual options are available. The offender abuses because he has general difficulties in distinguishing sex from simple friendliness and affection.

Regarding the third model, the under-controlled model, the offender believes that men have strong sexual needs that must be satisfied, and that men are entitled to act out their sexual impulses.

Benedict (1987), argued that perpetrators sexually abuse children because they regard children as their properties to which they have rights. Dr. Rachel Jewkes, a senior scientist with the South African Medical Research Council, endorses this view. In her argument (Abrahams & Jewkes, 2002), she blames the attitude of men as one of the reasons for child sexual abuse by pointing out that one of the key problems in South Africa is that people who commit rape do not think they are doing anything wrong (Abrahams & Jewkes, 2002).

While sexual abuse is also being unleashed on children with disabilities, they unfortunately are forgotten most of the time by the community and the justice system (Hesselink-Louw, 2001). Goldson (1998), postulates that their abusers abuse them because they regard them as being less human and therefore less worthy of care and concern. These men also perceive these disabled children as having no feelings. Parental stress and the frustration of caring for the disabled children can lead to caregivers lashing out at them, thus making them more vulnerable to exploitation by men.

2.2.2.3 The Learning Theory

Early developmental history features in most learning theorists' explanation of child sexual abuse, suggesting that the typical learning modes such as conditioning, association, reinforcement and modeling play a major role in perpetrators' behaviour. Learning theory regarding child sexual abuse can be viewed from three vantage points as follows:

The first assumption holds that sexual abusers may have been sexually abused themselves as children. According to this viewpoint, perpetrators literally reenact (or model) their childhood experiences (Murray, 2000; Sandler & Sepel, 1990). In their empirical research review concerning the reason why

paedophiles find children sexually arousing, Araji & Finkelhor (1985), indicated that sexual abuse in childhood, conditions sexual arousal to children. The experiences of abuse in childhood provide a model for deviant sexual behaviour pattern. However, the belief that a generational cycle of abuse results is largely unfounded, as only a small minority of perpetrators who had been abused as children, become abusers themselves (Herman, 1997).

The second assumption refers to children's normal engaging in various sexual activities during childhood. According to this viewpoint, postulated by Howells (1981), high rates of normal sexual experiences with peers, and the subsequent association of sexual arousal with immature body characteristics of other children, may condition a long-term sexual response to childlike or immature bodies. This, together with the emerging sexual drive during puberty, could enhance the individual's learning process and since most children's first sexual arousal is directed to similarly aged children, this could be a learned process carried over into adulthood.

It is, however, important to take note that not all individuals who have had peer sexual experiences during childhood or adolescence become paedophiles. Howitt (1995), suggests that reward and punishment contingencies are involved. In this regard, peer rejection and parental hostility may act as punishment and create an aversion to adult-oriented sexuality. Therefore the maturing individual may have anxieties about the prospect of approaching sexually mature individuals. Problems in relating sexually to adults during adulthood may result in the individual failing to "grow out of" his paedophilia (Howells, 1981).

A third viewpoint relates to the encountering of violence against women in the home environment. Benedict (1987), for example, postulates that the child internalizes longstanding abuse perpetrated against the mother. This child learns to associate violence with sex, and the only sex he can enjoy includes hurting others, especially during his adult years. Sometimes lack of parental

and/or maternal love and security can teach the child to be angry towards the mother who did not protect him from these pains. He then tends to vent his anger on other females, dominating them, and believing that he is in control.

The proponents of the learning viewpoint outlined a broader discussion on the aetiology of child sexual abuse. Theirs is, however, an inadequate explanation of why these men are sexually attracted to children as young as nine months and at times even their own.

2.2.2.4 The Social Perspective

From the social perspective, operations of power as well as gender relationships are important aspects that may determine reasons leading to child sexual abuse, while certain social conventions and conditions, as well as cultural practices could also play a role. The proponents of the social perspective are of the opinion that child sexual abuse is a social phenomenon that should be understood and treated as such.

The social viewpoint focuses on the societal relationship patterns between males and females, which are seen as catalysts of the acts of child sexual abuse. Mokonyane (2003), argues that the continuing gender inequalities and culture dominance in South Africa are factors that contribute to the scourge of child sexual abuse. The patriarchal social structure for example, renders children inferior in their social status. As a result of their social dominance, men may ignore opinions from children because they regard them as inferior, and they can override these children's rights, dignity, and wishes, thus making them feel more inferior (Tomison, 1995). Perpetrators of child sexual abuse believe that children are properties – objects for their sexual gratification whose consent for sex is not important (Benedict, 1987). They maintain power and authority over their victims and keep them in a state of fear so that they can unleash their sexual acts without being questioned (Herman & Marshall, 2000).

Feminist literature also implicates the patriarchal structure of male dominance in child sexual abuse, and specifically setting the stage for incest (Sandler & Sepel, 1990). Feminist analysis of incest links the sexual abuse of children to social and cultural values and the behaviour that supports them. Certain social conventions such as the media are thought to play an important part in enhancing these practices. For example, according to Benedict (1987), in entertainment films and television, females are always depicted as sexual objects that should be used by men with no deserved respect.

In addition, sexual violence against women and children has different meanings and different prevalence within different societies at different times. While feminist and other social movements have widened awareness of what might be abusive, especially towards children, certain paedophilic organizations have attempted to "normalize" paedophilic activity (Howitt, 1995).

However, even though it is assumed that men hold these power and dominance attitudes towards children, there is a tendency to go through various preconditions before sexual abuse can occur. In his efforts to explain child sexual abuse, Finkelhor (1984), developed a model of four preconditions, which usually occur for child sexual abuse to eventuate.

- Motivation on the part of the potential sex offender has to be there before child sexual abuse can occur. The potential sex offender must at the same time feel some emotional congruence with the child and be sexually aroused by the child. Other sources of sexual gratification such as his age mates must be unavailable.
- Even though a man may feel emotionally inclined to children or a certain child, there are internal inhibitions such as social norms that prevent men from having sexual relationships with children. For child sexual abuse to occur the potential sexual offender must be in a position to overcome these inhibitions.

- Any external impediments to enacting his sexual fantasies must be overcome. External impediments may be in the form of adequate supervision by parents or guardian. Any failure in this aspect provides an opportunity for sexual abuse to occur.
- Once sexually aroused by the child, the potential sexual offender has to overcome the resistance of the child before he can succeed in sexually abusing the child. Tomison (1995), indicated that the overcoming of the child's resistance might involve enticing the child into accepting inappropriate attention or overt coercion to achieve domination over the child.

The model does not explain the aetiology of child sexual abuse, although it casts useful light on understanding why and how the acts of sexual abuse occur.

Pertaining to social conditions, Lamers-Winkelman (2002), is of the opinion that poverty could be an important contributing factor to child sexual abuse. More specifically, poverty-related factors such as abandonment, lack of supervision, migration from rural arrears to towns, and migration of male workers to industrial areas, could erode the social safety net of the child and leave him or her at risk for sexual abuse and exploitation.

While the social perspective does provide some insight into situations and conditions that could result in the sexual abuse of children, it still does not provide all the answers. For example, a question that needs to be answered is why some people sexually abuse children while others under the same situations and conditions do not.

2.2.2.5 Cultural Perspective

Most of the theories of child sexual abuse discussed above are based on Western paradigms and ideologies, yet the trend does not differ much from the African paradigm. As child sexual abuse appears to be rampant globally, South Africa as part of the globe does not differ much with the increasing

figures (Herman & Marshall, 2000). Some researchers have focused on certain factors such as African cultural practices and beliefs that are assumed to be playing a significant role in the aetiology of child sexual abuse.

Certain patriarchal cultural practices are evident and involve parents or relatives secretly arranging for the abduction of their daughters, some younger than fifteen years, for lobola, i.e. money paid when the girl is being married, (Hlongwa, 2002). Abduction or elopement (ukuthwalwa in Zulu or ho shobedisa in Sesotho) refers to an African tradition in which a young woman is taken, sometimes by force by a prospective husband, and kept at his residence before all the formalities, including lobola, are arranged (Hlongwa, 2002, p.15). Usually sexual intercourse is forced onto the young girl.

These male-dominated practices also reflect young Black adolescent girls' experience of early sexual encounters (Boult & Cunningham, 1992; Preston-Whyte & Zondi, 1991;). The study of Amoko, Buga & Ncayiyana (1996), revealed that for most girls, their first sexual encounter was under duress, since they were forced into acceding to coitus against their will. This illustrates that many girls find themselves participating in sexual activities against their will, because of their little bargaining power regarding their sexuality.

In some incidences victims suffer physical injury from sexual abuse (Briere, 1992; Diaz, Rickert & Simatov, 2000). The sexual behavior of perpetrators that is motivated by physiological sexual arousal most of the time involves aggression. This aggressive behavior is, in most cases, motivated by affective states such as depression and anger (Gordon & Nagayama, 1996). This may be the reason why there is a high incidence of deaths that occur as a result of perpetrators killing their victims.

Certain cultural beliefs are implicated in the reasons behind men sexually abusing children. Some of these beliefs are highlighted by Schoubben-Hesk (1980), in her phenomenological study on five traditional healers' viewpoints on child sexual abuse. Interestingly, their views supported certain eurocentric

approaches. For example, there was high congruency with Finkelhor's pre-conditions model and the feminist approach, less congruency with the family dysfunction and psychological approaches and minimal congruency with the psychoanalytic approach.

Some important socio-cultural factors may be peculiar to the South African situation. For example, certain people, who are of the opinion that they are experiencing bad luck, believe that having sexual intercourse with a child will bring them good luck (Schoubben-Hesk, 1980). She went further to indicate another belief that in a family where there are stepchildren, the stepfather commits acts of sexual abuse in order to "punish" their mother, as the children are not his. One traditional healer indicated a belief that men who are HIV positive have a high uncontrolled libido and are to have sexual intercourse with little children or they would become insane (Schoubben-Hesk, 1980).

In addition, these traditional healers were of the opinion that political dislocation, which has triggered unemployment, substance abuse and an erosion of traditional ways, as well as the uncertainties involved in the recent move towards democracy, are impacting negatively on the environment, family structures and relationships. These traditional healers, however, expressed powerlessness in dealing with the problem and indicated that it is the government's responsibility to stop these unacceptable practices and to punish the perpetrators.

Traditional healers' powerlessness in dealing with the problem enhances perpetrators' beliefs that having sexual intercourse with a virgin child will "cleanse" them of their HIV infection (Deane, 2002; Redpath, 2001; Swart, 2001). The Women's Health Project investigated the following three theories of child sexual abuse during their study of sexual myths and child rape in Galeshewe Township in the Northern Cape:

- The cleansing theory, which is the belief that sleeping with a virgin child or a grandmother can cleanse a man of HIV.

- The prevention theory, according to which men are encouraged to choose young children because they believe they cannot get HIV from a virgin.
- The vengeance theory, which suggests that rape occurs as a result of men purposely spreading the HI-virus so that they will not die alone.

Regarding the cleansing theory, the study indicated that 60% of participants first heard this through the media. Although there have been reported cases where this was a motivating factor for child rape, it does not seem to be the prevailing motivating factor. However, the idea of spreading the HI-virus so that they will not die alone seems to be fuelling the spread of HIV and possibly rape. The most controversial finding of this study, however, was the belief that having sex with a child younger than 10 was not an act of rape. They did not consider it sexual molestation, but merely a sexual act (Deane, 2002).

These beliefs and the inability of the traditional healers to inculcate a sense of responsibility in these men, encourage perpetrators to see children as their property that can be used to their own “advantage”. The use of children as perpetrators’ property may be seen in a cultural belief where a tikoloshe (a man-made beast, which has supernatural strengths and powers, and is used to bewitch other people) becomes involved. If someone wants to have revenge or bewitch someone else he/she uses a tikoloshe to unleash his/her plans. For example, he uses the tikoloshe to sexually abuse his/her enemy’s children in order to avenge something.

According to Hlope & Kekana (2001), the tikoloshe might appear in the form of a person or family member known to the child. This cultural belief may encourage perpetrators to sexually abuse children as well as to continue with their acts, as it may be believed that it is the tikoloshe that is abusing the child, and that they are not to be blamed.

Even though it provides some light in the understanding of sexual abuse in the South African context, the African perspective fails to provide sufficient answers to the reasons behind men sexually abusing children.

Although the above exposition of the various viewpoints and theories of the reasons why specifically men sexually abuse children provide some insight into this phenomenon, many questions are still unanswered. For example, as mentioned elsewhere, the question arises why some men abuse children, while others subjected to the same conditions, will not.

2.2.3 Psychological disorders associated with child sexual abuse

According to the Diagnostic and Statistical Manual of Mental Disorders (APA, 1994), sexual attraction to a child by an adult is regarded as paraphilia. The essential features of paraphilia are recurrent, intense sexual arousal fantasies, and sexual urges or behaviours, towards children. This specific disorder is known as paedophilia. Murray (2000), distinguishes between paedophilia and child molestation. According to him the latter may not be recurrent; therefore a history of paraphilic behaviour is absent. Individuals with paedophilia as well as individuals who molest children generally show preference for children within a particular age range. Some will prefer younger and some older children. Some are attracted to females, while others may be aroused by both genders. Acts of paedophilia include voyeurism, exhibitionism, fondling, fellatio, cunnilingus, and object, digital and penile penetration of bodily orifices.

Individuals may limit their activities to their own children, stepchildren, family members, i.e. intrafamilial, or victimize children outside their families, i.e. extrafamilial.

2.2.4 Traumatic consequences of child sexual abuse

Child sexual abuse is one of the transgressions that can result in short and long-term negative consequences on the affected individuals (Spies, 2006). Children who suffer sexual abuse often experience four traumagenic dynamics (Finkelhor, 1986). These dynamics indicate the core of psychological trauma on the victims and include:

2.2.4.1 Traumatic sexualisation

Child survivors may experience various symptoms that may produce patterns of inappropriate sexualised behavior, preoccupation with intrusive thoughts and fears, insomnia, poor peer interactions, hopelessness about the future and decreased interest in appearance and cleanliness. These symptoms may lead to difficulties in areas of achievements such as scholastic work and relations with class or school mates.

2.2.4.2 Betrayal

Children are generally trusting, especially with somebody or some people they know. Research has, however, showed that in most cases people they know and trust often end up abusing the children. This leaves them with a feeling of betrayal that manifests in bouts of depression, anger, aggression, distrust, and hostility.

These survivors may develop dependency and clinging behaviors that may, later in their lives, turn them into adults with poor judgment about the trustworthiness of other people.

2.2.4.3 Stigmatisation

This refers to the shame and guilt as well as the badness of the incidence perceived by survivors. They think that people will talk ill about them, and sometimes this does happen. This leads to the feeling of shame, guilt and low self-esteem.

Feelings of self-blame and low self-esteem make it a challenge to help the survivors.

2.2.4.4 Powerlessness

Sometimes survivors are often left with a feeling of being unable to do anything to deal with the situation of abuse. They find themselves disempowered because their will and desires are contravened. This turns into fear and anxiety that may be debilitating if not treated effectively.

Bagley (1986), postulates that the legacy of sexual abuse trauma stays with the individual for a lifetime, even though his argument is based on child sexual abuse within the family. Child sexual abuse brings about a number of noticeable trauma signs and symptoms in most cases (Doyle, 1994).The trauma can either bring about psychosocial, biological or economical implications.

2.2.4.5 Psycho-social implications

In most cases children who have been sexually abused during their childhood years, tend to suffer from impaired mental health (Bagley, 1986). These mental impairments include but are not limited to personality disorders, such as Bipolar Mood Disorders and Depressive Disorders. Doyle (1994), indicated that conditions such as low self-esteem and self-destruction are common in adults who have been sexually abused as children. According to Bagley (1986), survey studies indicate that sexual assaults on children were often casually related to runaway teenagers, young drug users and young prostitutes. In most incidences these victims have problems with sustaining relationships.

There are of course many psychosocial problems that result from sexual abuse of children. These problems need to be resolved early so that the victim can have a better psychosocial life.

2.2.4.6 Bio-physical implications

Child sexual abuse is seen, in most cases by perpetrators, as a way of cleansing the perpetrator of his infections especially the Human Immune Virus (Schoubben-Hesk, 1980). The belief is that after being infected with this virus, having sexual intercourse with a child who has never had sexual intercourse, will cleanse one from the infection. This usually leaves this child with infection that may destroy her future (Jewkes, 2004).

In most cases acts of child sexual abuse are forceful and may lead to damage of the child's reproductive organs. There may be complications such as pelvic pain during coitus and experiences of anorgasmia later in life (Doyle, 1994).

In some cases of child sexual abuse there are damages to organs such as the uterus or the bladder. Damage to these organs may give rise to permanent deformity and disability such as loss of childbearing ability and/or ongoing urine control problems. These pathologies are not only embarrassing, but often lead to permanent malfunctioning and incapacities, both behavioural and biological (Brakarsh & Killian, 2004).

2.2.4.7 Economic implications

Children are the future and an economic backbone of every society. If one child is sexually abused, that child loses a chance of contributing fully to the economy.

As the figures of child sexual abuse show a daily increase against the scarcity of resources for intervention, it therefore becomes compelling for all stakeholders to find additional methods of dealing with the problem (Lander, Lytle-Barnaby, Sirles & Walsma, 1988; Sherwood, 2004).

2.3 ADOLESCENCE AS A CRITICAL DEVELOPMENTAL STAGE

Childhood is a period in human beings that is characterized by a long journey from weakness and total dependence on adults, to independence and a psychologically healthy individual, when adequate support and care have been provided. Older people are faced with the responsibility of providing the protection and support to the younger ones. According to Wolfe (1999), childhood development normally follows a predictable, organized course, beginning with the mastery of physiological regulation such as eating and sleeping, continuing throughout to the development of higher skills such as problem solving.

Adolescence is a developmental stage when an individual crosses over from childhood into adulthood. This period is marked by rapid physical growth and maturation of the reproductive system which starts at about the age of eleven years to the age of twenty. Usually there is a lot of insecurity and confusion on the part of a teenager because of these physiological changes and societal expectations (Schaffer & Kipp, 2007). A child needs to be well protected and cared for during this period, if we are to have a healthy nation.

In his theoretical explanation, Freud posits that the genital stage is achieved at the adolescent stage and is characterized by sexual drive (Louw, van Ede, & Louw, 1998). He further argued that adolescents relive the phallic stage to a large degree but have also developed a sound ego and superego **(**Louw *et al*, 1998). Both the ego and superego help the adolescent to think properly and behave well. It is at this stage that individuals enter heterosexual relationships **(**Louw *et al*, 1998). Heterosexual relationships are important in every individual's life as they determine her/his psychological wellbeing in most cases.

Piaget's work on cognitive development identified eleven to sixteen year old children as being characterized by formal operations (Bjorklund, 2000). The period of formal operations is characterized by thinking about self (Bjorklund, 2000). It is during the period of formal operations that children are able to generate hypotheses **(**Bjorklund, 2000; Louw *et al*, 1998). During this stage of development children are able to think abstractly and logically. When solving problems adolescents are likely to consider all options and possibilities.

The healthy development of every individual needs successful completion of each stage. Challenges for each stage differ in their degree and intensity.

In his theory of psycho-social development, Erikson (1963), argues that adolescence is characterized by an identity crisis (Louw *et al*, 1998). Identity formation is a key developmental task during this period. One of the

challenges facing adolescents is to acquire a secure sense of identity, which consists of three components as follows:

Certainty about own characteristics

This is a feeling that addresses the uncertainty of not knowing oneself. It answers the question: “who am I?”. Every person feels in control if he/she knows who he/she is. This enables the person to relate better with self and others. Once this feeling is well attained and maintained it enhances a healthy development of the adolescent child, thus allowing for development of healthy interpersonal relations.

Certainty about social identity

Every person is fulfilled when he/she is able to interact with others in a healthy way. This happens when he/she knows with whom he/she interacts and is able to see self as a different person in those interactions. Being different but part of the social group that works harmoniously with others is a psychologically healthy state. Individuals are unique and thus different from others even though they form part of the bigger society.

Certainty about own values and ideals

As individuals interact with others in the community they should be aware of their own values and ideals. These may differ most of the time but work towards the bigger ideal, that of a healthy society. Differences should be embraced and respected all the time. A healthy and fully functioning person is always aware of his/her values and ideals. (Louw *et al*, 1998).

During this period, children are highly vulnerable to sexual abuse. Young female children are increasingly becoming victims of sexual abuse in the communities (van Niekerk, 2004). Children are raped by men who are in most cases fully aware of the impact of sexual abuse. The crime on young girls is committed by men from all walks of life, and this includes politicians, teachers, priests and their own fathers (Mandiwana, 2007; Zulu, 2007; Letshwara, 2007). Babies as young as one year old are raped by grandfathers as old as

seventy-three years (Mandiwana, 2007), and girls as young as ten years old become pregnant at schools (Rampedi, 2008). The age of these pregnant girls indicates that they have been raped.

Familial support and protection is therefore of utmost importance during this stage of development.

2.4 PREVENTION OF CHILD SEXUAL ABUSE

2.4.1 Introduction

Much work has been done on the prevention of child sexual abuse. In South Africa this has taken many forms such as community education, e.g. Child Law Matters, (2008); and legislation, e.g. Children's Act (Act No. 38, 2005), which sets out principles relating to the care and protection of children, and makes further provisions regarding children's courts.

According to Finkelhor (1986), prevention of child sexual abuse was a rapidly growing field in the 1970s. The prevention programs were specifically designed with the child's needs in mind. These needs include the need for knowledge regarding sexual abuse and its side-effects. An informed person in a situation has a better chance of handling the situation than the person who is not informed. In his explanation Furniss (1991), suggested that child sexual abuse is a minefield for all concerned – for the abused, the abuser and the professionals involved in the intervention. Child sexual abuse requires the cooperation of everybody so that the victim and the perpetrator can be helped (Edinburgh, Saewyc & Levitt, 2008).

Various intervention approaches are implemented in the helping of the victim and in some ways the perpetrator (Dwivedi, 1993). The agencies may be for criminal prevention, child protection or therapeutic (Luckock, 2007). These agencies implement their intervention through various and important basic programs.

2.4.2 Intervention programmes.

According to Furniss (1991), there are three basic types of intervention programmes that help in cases of child sexual abuse. They have different aims and deal with child sexual abuse differently as indicated below:

2.4.2.1 Primary Punitive Intervention (PPI)

This approach is mainly aimed at punishing the perpetrator in order to discourage the abuse of children. Legislation is designed in such a way that it takes into consideration that children are mostly powerless and vulnerable. It therefore actively protects children and imparts knowledge to them.

Through the new justice system developments, courts of law are taking steps now in trying to discourage perpetrators from continuing with their actions. Government departments like Justice, are making sure that Acts that are designed for children are implemented well, and speak on behalf of children.

Courts have been designed in such a way that they are child-friendly, so that children can disclose freely without any duress. These are courts of law such as Children's Courts that are specifically designed for children.

The leniency that these perpetrators were treated with previously has since stopped. Gone are the days when perpetrators were sure that they would either win the case easily or get a few months or a few years in jail. It is difficult for perpetrators to win in cases of child sexual abuse these days. The aim is to protect the rights of the child as outlined in the Constitution of the country. Legislation is designed towards children's interests as outlined in the Children's Act, Act No. 38 of 2005, Child Care Amendment Act No. 13 of 1999, as well as the Domestic Violence Act, Act No.116 of 1998.

In this way perpetrators are being removed from society, put in jail and rehabilitated there, thus encouraging a speedy healing process for the victim.

2.4.2.2 Primary Child Protective Intervention (PCI)

This style of intervention, as the name indicates, focuses mainly on protecting the children. Agencies may be governmental such as Department of Social Welfare. This department, like the police, has a legal and statutory function to protect children and they employ their powers to protect these children.

Non-governmental agencies also play a significant role in protecting children, e.g. taking to the street in the form of marches, to voice their grievances regarding increasing incidences of child sexual abuse. In some incidences they embark on education campaigns in the communities and for children. The Health Department is also playing a part in helping child victims of sexual abuse by protecting the identity of the victim(s). In most or all cases, help that is given to the children is from the children's specific clinics with well trained professionals. Departments such as Education and Social Welfare are also playing a pivotal role regarding prevention of child sexual abuse. Their concerted efforts in disseminating information on how to deal with the sexual abuse situations cannot go unnoticed. The need to educate children cannot be left for tomorrow any longer as perpetrators commit this crime against these children in most cases because they regard them as their properties (Parton, 1990). Anyone who has a voice needs to raise it higher so that everybody, including authorities, can realise this scourge of child sexual abuse (Abrahams & Jewkes, 2002; Benedict, 1987; van Niekerk, 2004).

Organisations such as Childline and Child First are pulling out all stops to make sure that the rights of the children are respected. They engage in educating children and highlighting issues of child sexual abuse in our communities. These activities are mostly peaceful and drive messages and information to perpetrators about sexual abuse and its effects, especially on children. It is believed that if perpetrators are educated in this regard, they will be in a position to refrain from any sexual abuse and protect children.

2.4.2.3 Therapeutic Intervention

In order to structure an effective therapeutic intervention, it is imperative that the therapist begins with an understanding of the psychological impacts of child sexual abuse on the individual child (Brakarsh & Killian, 2004). According to Schetky (1980), and Brakarsh & Killian (2004), the long-term sequelae of child sexual abuse may include, but is not limited to, the following:

- depression
- anxiety disorders
- psychiatric hospitalization
- substance abuse
- suicidal behaviours
- eroticization
- poor parenting
- increased likelihood of becoming a perpetrator

Erikson (1963), states that trust is the foundation upon which future aspects of personality are built. During the sexual abuse of the child, victims lose trust as the perpetrators in most cases are people they know and trust (Herman & Marshall, 2000; Machakela, 2007; Rampedi, 2008). The lack of trust then manifests itself in the victims' inability to have a sense of belonging or a feeling of love and affection towards others. They develop a high need for immediate gratification and develop a need or tendency to exploit and manipulate others.

Child sexual abuse leaves the victim with many uncertainties and bitterness in her life (Bacon, 2008; Spies, 2006). These feelings may create a barrier between the victim and other people, which may prevent proper relationships and impair the rendering and effective acceptance for interventions. It is therefore imperative for the therapist to know and be sensitive with this barrier so that he/she can be able to gently remove this "wall".

The purpose of therapeutic intervention following child sexual abuse is to help the child to recover and be fully functional. In most cases, therapists focus on

helping the child without realizing the most effective modality to be followed. The cost and effectiveness of the implemented modality, in most cases, are the last things to be thought of, if even considered at all. What goes through the minds of the helping team is just to see the victim in a therapy session receiving treatment. The belief is that once the child is in a therapy session without considering its duration, she will get help. Brakarsh & Killian (2004), however, postulate that long-term individual therapy is costly in both time and human resources; but unfortunately clients mostly prefer these modalities. Intervention programs are wholly directed towards helping child survivors, as well as potential victims of sexual abuse.

There is also a need for an intervention that is rendered to the family of the survivor, so that the family is able to cope after the victimization of their child. Different forms of therapy in child sexual abuse can therefore be employed concurrently, in order to achieve the desired goals and aims of primary therapeutic intervention.

The goal of treatment should be directed towards addressing the deficits and the introduction of the experience and management of feelings as positive and life affirming (Hall, 2008). In this way the child survivor will be afforded an opportunity to understand and develop a good cause and effect and further have good interpersonal relations necessary for good interaction with others.

Memorandum of Good Practice (MOGP)

The Memorandum of Good Practice (MOGP) is a guiding tool that helps psychologists to systematically map their way into the “victim’s world” so that help can be rendered. This tool is a means to remove the barriers that may impede smooth running of therapy. It is followed from the first interview with the client until commencement of therapy. It allows for successful therapy if it has been followed well and with care.

According to Brakarsh & Killian (2004), interviews with the alleged sexual abuse victims should be conducted in accordance with the legal rules of

evidence; through the avoidance of contamination of evidence. It is a common practice at times to try and help the victim in totality and forget that one is not skilled in some areas. A caring and knowledgeable psychologist always knows where the skills he/she possesses start and end.

Brakarsh & Killian (2004), indicated that the MOGP describes what should be done before, during and after a forensic interview. They have therefore recommended five stages of MOGP as briefly outlined below:

Stage 1: Rapport building

The first step to get into the adolescent victim's world is to form a trusting relationship with her. She must see the psychologist as a friend in whom she can confide and feel comfortable with.

It is therefore important for the psychologist to engage in various activities such as first playing with the child, so that the child can relax. It is always extremely difficult for the adolescent survivor of sexual abuse to talk about the abuse if there is no warm and trusting relationship with the psychologist. If the rapport is not well built the client may comply with the psychologist's expectations by responding to questions with less than accurate responses that have no validity (Brakarsh & Killian, 2004). This could then compromise the rendering of an effective treatment. Once rapport has been successfully achieved, the scene is now set for the second stage.

Stage 2: Free narrative

The adolescent client is at this stage trusting the psychologist and feels comfortable with him/her. She can be given an opportunity to express herself freely on events leading to the ordeal of sexual abuse and the sexual abuse itself. According to Bacigalupe (2001), child victims of sexual abuse often experience disclosure as a shameful process. This approach enables the client to narrate her full story without much probing and questioning. Once she has given her all, the psychologist can then move to the third stage.

Stage 3: Open-ended questions

Once the approach of giving the client the opportunity to give her story freely has been achieved, questions can now be asked. This is done so as to gain clarity on some of the unclear information.

Care must always be exercised not to interfere with the legal evidence. Open-ended questions can be asked as they are not directing and therefore encourage recollection of information. This helps the victim to put her facts together and remember most of the information. In this way the psychologist gets a clear picture of the events and therefore understands the pain the client went through after the incident of sexual abuse.

Stage 4: Closed questions

Closed questions are mostly asked in order to understand certain unclear issues of the sexual abuse. It is, however, important to refrain from asking too many questions in case a lot of irrelevant information is tapped. Besides interfering with the legal proceedings, this may embarrass the client preventing her from cooperating further.

Stage 5: Closure

The adolescent survivor needs to be reassured that her disclosure will be treated with all the confidentiality it deserves. Her identity will be kept secret and no information relating to her ordeal will be given without her permission.

If this is properly done, it will encourage the victim to do “business” with the psychologist. In this way a foundation for positive outcomes of therapeutic intervention will be laid.

There is no doubt that MOGP opens the doors for a successful therapeutic intervention. Through MOGP, children are encouraged to be open and disclose freely to the helping professionals. It is common that children are not always verbal when they are with strangers. It becomes even worse when they have had a bad experience such as sexual abuse; they experience more difficulties in expressing themselves well verbally. Chew (1998), pointed out

that breaking the silence is a most difficult and formidable process for individuals who have experienced sexual abuse.

Groups as a catalyst to healing

Because of the difficulty young girls experience in talking about sexual abuse, it is useful to make use of as varied treatment modalities as possible, in order to be able to reach the young clients. Chew (1998), posits that:

"In order to pave a pathway for the naming of the oppression and for healing, there is a need for a context in which these individuals can safely explore and express both sides of their truths", pg. 11.

Child survivors of sexual abuse can benefit from group treatment in conjunction with individual therapy on a concurrent or consecutive basis (Chew, 1998; Frances, 1995; Jenson, Jacobson, Unrau, & Robinson, 1996). The group setting benefits the victims by countering and alleviating some of the effects of sexual abuse (Chew, 1998). According to Frances (1995), group work allows the breaking of the secrecy, isolation, and the stigma associated with sexual abuse and enhances exploration and resolution of the trauma and its aftermath.

According to Draucker (1992), receiving confrontation and support from those who have shared similar experiences, can be especially powerful for survivors. It is at the group therapy session that survivors mix with those that went through the same experience (Sigurdson & Strang, 1986). They find themselves talking or mingling with people who understand them well, and this has a healing effect on its own.

There are different types of groups, with various goals, e.g. :

- Decreasing feelings of isolation, stigma and shame
- Challenging survivors' perceptions of themselves as different
- Increasing feelings of self-esteem
- Instilling hope of recovery
- Developing trust in others

- Developing interpersonal skills
- Retrieving repressed memories
- Developing a social support network

(Draucker, 1992).

Survivors of child sexual abuse can participate in the following groups:

Support or self-help group

This is a type of group activity that is mostly managed by survivors themselves. It operates without a clinically trained leader in most or all the cases. Participants decide themselves on the agenda and how to conduct the group. This type of group needs highly motivated and well-informed participants in order to succeed (Draucker, 1992).

This type of group cannot be recommended for adolescent survivors of sexual abuse. The age of these children does not allow them to be in a helping program without guidance. They are still at a stage where they need to be assessed and encouraged to participate in the group activities.

Clinical or professional group

In this type of group, a clinically trained person or a professional often leads the group. The clinician often comes to the group prepared and offers survival skills to the victims.

This type of group is mostly recommended for the healing of child survivors of sexual abuse and it also forms a balancing part with clay therapy. In this group clients are seen by a professional, e.g. a psychologist, who is a leader of the group. The psychologist assesses the survivors and makes relevant changes where necessary, e.g. subjecting those that need individual therapy to individual therapy (Draucker, 1992).

According to Draucker (1992), groups can take one of the following formats:

- Open, unstructured and ongoing

  People may decide to come together informally, just as they meet in a party, or at a football playground. Every time the football match is on, they meet at the secluded place and have their fun. Anyone who notices them can join at any time and have fun with them. In most cases people tend to know each other during these meetings. Thereafter they know and constantly greet each other as they join in a meeting. In these groups there is no particular leader but everybody shares and participates.

  Although this type of group may bring healing in instances such as depression or stress, the opposite can be said about post-traumatic stress, low-self esteem, and anxiety that is brought about by sexual abuse, especially in children.

- Closed, structured and time limited

  A group can be formed in order to fulfill a particular purpose or task and as such it becomes structured in a special way. This group usually follows a specified direction and is led by a particular individual or a leader. The mandate to the leader in most cases is the overseeing of the success of the group on its interactions and results.

  A group that has been formed by a community psychologist to help child survivors of sexual abuse meets the criteria of the closed, structured and time limited group. Survivors are brought together in a group so that they can enjoy social support that offers a healing experience (Chew, 1998). In most cases these children lose hope about life, but by joining a group, their hopes become gradually instilled.

2.5 THEORETICAL PERSPECTIVE

2.5.1 Introduction

This is a community psychology project that applies program evaluation research. Program evaluation can be viewed as formative and summative (Potter & Kruger in Seedat *et al*, 2001).

This research is concerned with formative evaluation because it is focused firstly on implementing a particular therapeutic approach, namely clay therapy as explained in the Sophia model of holistic counseling (Sherwood, 2007), then evaluating it for effectiveness. Summative evaluation applies to programmes that are already established and in operation.

The research adopts a quasi-experimental design because it investigates the influence of an independent variable, which in this research is the therapeutic approach, adopted over the dependent variable, i.e. the emotional status of subjects in this research. Discussion in the next section will focus on the theory in order to give light with regard to clay therapy as per Sherwood (2004).

2.5.2 Theoretical background of the Sophia Model of holistic counseling

According to Sherwood (2007), the Sophia model is based upon the anthroposophical four-fold holistic model for working with the whole of human experience, i.e. the body, mind and spirit. This theory is championed by Steiner's (1994), (cited in Sherwood, 2004) four bodies namely:

- The physical body that can be touched and observed
- The etheric body, i.e. the life body that acts as a buffer between the physical body and our emotional and cognitive experiences.
- The astrality, i.e. the lower layer of mind consciousness. In this body the imprints of human experiences resonates. It reflects the relationship between the outer world, mediated by senses through the physical body, and the most intimate realms of inner consciousness, mediated by the I AM.

- The I AM, which is the self-aware human consciousness, the place of insight. Within this body are the resources of the human spirit, the capabilities to rise above the pain, limitations and darkness of experiences and bring back hope, healing and growth.

Psychological well-being is said to depend on the capacity of the individual to insert his or her I AM into their experiences and to integrate and process all experiences in a meaningful way so that nothing of their experiences remain cut off, denied, or buried under the floorboards. This model provides a framework within which the body-mind-spirit connection in psychotherapy can be elucidated in a precise manner, using appropriately designed therapeutic tools such as clay therapy.

2.5.3 Clay therapy in holistic counseling

Body-based therapies such as clay therapy are able to access our thoughts, feelings and bodily experiences, which are intimately interrelated. Sherwood (2004), states that clay therapy quickly absorbs and expresses what the client is feeling, thus responding to human feelings.

Traditional therapeutic modalities of psychotherapy are said to be mind-based, consisting of reflection, conversation, and words (Sherwood, 2004). Individuals who have suffered traumatic experiences such as sexual abuse, usually find it very difficult to express themselves in words, they are usually overwhelmed with emotions. Sometimes they are unable to express themselves verbally simply because they lack vocabulary to express what they feel inside (e.g. Dalley, 1993).

Gendlin (1974), discovered that clients progress more rapidly in therapy when they experience a felt sense, or physical manifestation of their feelings. Through action metaphors, e.g. where clients are instructed to play with clay and sculpt shapes and figures, clients are able to communicate to the therapist their feelings, and externalise entire images of what is held in their

minds, in a form that the therapist can render safe and useful to them (Sherwood, 2004). In this way the therapist is allowed an opportunity to work on the clients' deeper emotional issues so that the clients no longer feel burdened by negative emotions. The therapeutic goal of bringing to the surface painful experiences so that they are metabolised and re-integrated into the client's system is thus achieved.

Sherwood (2004), adds that clay therapy visits and penetrates the darker sides of our lives and enables us to see our own inner traumas and places of wounding. The 'seeing' (as in concrete evidence, e.g. clay sculptures and figures), provides a remarkable opportunity to experience compassion towards oneself and towards others. It allows people to view their psyche in a manner that is readily comprehensive. Adolescent survivors of sexual abuse in most instances are crippled emotionally, and they display emotions such as fear, grief and anger. Clay work in therapy therefore provides a powerful medium to work through these core issues in order to encourage and inculcate opportunities for inner growth and healing.

"Clinical practice with clay demonstrates that the attraction of clay lies in its capacity to capture experience as it emerges in the immediacy of the moment from the client's body; and in the surprising and often powerfully evocative forms it arouses in the client's consciousness. Long-forgotten memories, unacknowledged imprints of experiences, arise from the hands of the client in a moment of new consciousness, or insight, about the impact of the experience." (Sherwood, 2004, page 3).

In this research, clay therapy will be checked against the traditional approaches that are used in the health care centre for sexually abused children. Details of this process are outlined in the next chapter.

2.6 SUMMARY

Discussions in this chapter clearly illustrate that child sexual abuse is a mental health problem. The perpetrators commit this crime because they suffer gross psychological disturbances and the survivors are often left with emotional scars that usually last for a very long time, depending on the assistance they get following the abuse incident. This research is aimed at implementing and evaluating a therapy program for abused teenage females.

CHAPTER 3
METHODOLOGY

3.1 INTRODUCTION

This research is aimed at evaluating an intervention program for abused teenage girls; therefore the greater part of the discussion in this chapter is on the process followed during clay therapy.

3.2 RESEARCH DESIGN

The study was conducted using a quasi-experimental research design, where Pre-test and Post-test were applied. Subjects were first divided into an experimental group and a control group. All of them were assessed for baseline reading of emotional problems that they could still have, following abuse. After the first assessment the two groups received two different types of treatment/intervention. Clay therapy was introduced into the experimental group, whereas in the control group it was not. The control group was exposed to the usual treatment program that is conducted at the clinic.

3.3 SAMPLING PROCEDURE AND SAMPLE SIZE

This study was conducted at Motheo district in the Free State province in South Africa. The selected area represents a broad spectrum of child victims of sexual abuse in the province (Free Sate Department of Health, 2008/9).

Non-probability sampling technique was applied. Focus was on female subjects who had been sexually abused, and were either not scheduled to attend the court of law at that stage, or had completed their court proceedings. The sample consisted of Black females identified at the clinics when they went for help, or at their schools by their teachers. These subjects were selected randomly by nurses at the clinic, as well as by the attending

social workers at the schools and clinics. A target group of forty (40) sexually abused adolescent girls was eventually obtained and randomly allocated into two groups of twenty (20) each. One group became the experimental group and the other, the control group. Almost all subjects were Sesotho speaking. Three were Xhosa speaking therefore questionnaires were translated and given in their preferred language.

3.4 DATA COLLECTION

Data was collected over a period of three months. Participants were interviewed individually in order to evaluate their psychological well-being. Their responses were captured by means of an audio-tape. Structured questionnaires in the form of the rating scales were given to test the following:

- Assertiveness.
- Depression.
- Anxiety.

3.4.1 Structured audio-tape questionnaires

Numbers are used in these rating scales to measure the reaction levels or intensity of the individual participant. The length of the interviews, both audio and structured questionnaires/rating scales, were on average 45 minutes for each participant. In order to get all data the following instruments were used by the researcher:

- Psychological Well-being questionnaire (see Annexure 1).
- Assertiveness Scale (see Annexure 2) .
- Depression Scale (see Annexure 3).
- Anxiety Scale (see Annexure 4).

3.4.1.1 The Psychological Well-Being Questionnaire

The Psychological Well-Being questionnaire measures numerous personal attributes such as the sense of environmental mastery, positive relations with others, self-acceptance, personal growth and control of an individual over his/her life, which is also called locus of control. This questionnaire as

postulated by Ryff & Keyes (1995), measures the psychological well-being of an individual.

According to Folkman, Lazarus, Gruen & De Longis (1986), people with strong feelings of mastery over their lives or positive locus of control suffer fewer symptoms of psychological stress. This locus of control, however, is not inborn but, as postulated by Klienke (1998), develops as an individual grows up, learns and experiences life.

Klienke (1998), asserted further that individuals can either have an internal locus of control, referred to as internals, or external locus of control, referred to as externals. Internals are those who take responsibility for what has happened in their lives, while externals are those who believe that what has happened to them is beyond their control (Klienke, 1998). In solving problems, internals score better because they see problems as challenges that need to be faced and solved. Externals are in most cases pessimistic and use stress-producing techniques when solving problems.

Stressful life events such as sexual abuse on children may hamper the smooth progress of a child which, in turn, may lead to improper development and poor ability to manage problems at a later stage in life. The questionnaire helps to determine a child's locus of control and through therapy, if found to be battered, tries to shape the locus of control. In this research study, this questionnaire was used as a tool for baseline reading to enable the researcher to have more information on the emotional status of subjects before intervention.

Scoring and interpretation:

Questions were focused on gathering information with regard to the feelings of the subjects. Responses were to be selected from multiple choice answers. The subject had to select the answer most relevant to her from a choice of seven types of responses. In responding to questions like "the demands of

everyday life often get me down", they could answer whether they strongly agree, slightly agree, or agree as outlined below:

- ***Agree (0)***: This suggests their unconditional and open positive response to the question.
- ***Disagree slightly (-3)***: Though they disagree, they have a feeling at certain times that they agree with the question. The opposite is true with (+3).
- ***Disagree somehow (-2)***: They disagree to a certain extent with a feeling of confusion and self blame at times. The opposite is true with (+2).
- ***Strongly disagree (-1)***: The response is a strong NO to the question asked. This is a strong YES in (+3).

These responses give the clinician an indication whether this respondent is currently coping or not, and if not, the cause is investigated.

Mood disorders such as major depressive disorder and anxiety disorder can be confirmed over time by an essential feature plus four or more symptoms (Diagnostic and Statistical Manual of Mental Disorders, 1994). In using the Psychological Well-being Questionnaire, clinical impression about the subject's psychological condition could be determined and confirmed by the subsequent Psychometric Assessments.

3.4.1.2 Assertiveness Scale

There are aspects in our lives that regulate our daily functioning which may be healthy or unhealthy. These include aspects such as decision making and the strength to say no, or succumbing to pressure. These aspects ultimately indicate our personality and include assertiveness and self-trust which lead to positive thinking. These aspects need to be nurtured in a young child so that she/ he can grow with a positive mind.

Lloyd (1995), asserts that an individual who has positive thinking always feels confident and behaves positively as well. The assertiveness quiz (see Annexure 2) as adopted from Lloyd (1995), is a self assessment tool

provided in order for an individual to become aware of his/her assertiveness and to either improve or hold on to it.

A healthily developing child will always acquire important characteristics and behaviour styles of life. These characteristics and behaviour styles are vital in order to strengthen and protect this child throughout life's numerous challenges. One of these behaviour styles is assertiveness and it is as important to the child as it is for others.

According to Lloyd (1995), assertiveness is a natural style that is nothing more than being direct, honest and respectful while interacting with others.

"Assertiveness means standing up for your rights and expressing your thoughts and feelings in a direct, honest, and appropriate manner … when you are being assertive, you show respect for yourself and for others."
(Klienke, 1998, p143).

An assertive individual develops a sound self-efficacy and internal control, which is imperative for the development of a better self-esteem.

It is common that after sexual abuse children develop or show signs of low self–esteem, which may compromise their confidence and then encourage others to take advantage of them. It is therefore important to intervene promptly once an adolescent child shows low self-confidence.

3.4.1.3 Depression Scale

Depression is a pathological condition that has a negative impact on health. If not treated, depression can trigger disease and conditions that were dormant in our bodies such as cancers and psychosis. It is therefore important to assess the level of depression especially in adolescents who have experienced the trauma of sexual abuse. Once diagnosed various intervention approaches can be implemented in order to effectively manage this condition.

The Zung Self Rating Scale (Annexure 3) is an instrument that is used in most cases by psychologists and psychiatrists to measure clients' levels of depression. This is a quick instrument where clients are afforded a chance to rate themselves.

A depressed individual is, in most cases, a potential candidate for suicide and many other psychological as well as medical conditions such as cancers and diabetes mellitus.

After having been exposed to an incident of sexual abuse, a child needs to be assessed thoroughly for signs and symptoms of depression, so that they can receive prompt intervention.

3.4.1.4 Anxiety Scale

People react to their daily hassles or challenges differently. The reaction may be in the form of fear which is, in most instances, used interchangeably with anxiety. According to Klienke (1998), fear refers to the primary appraisal of the actual danger while anxiety is a psychological condition that is related to the resulting emotional state of tenseness and distress.

After the trauma of sexual abuse children go through the emotional state of tension and distress. This state may affect an individual's daily functioning, and may continue up to or beyond adulthood. It is therefore important to identify this state at an early stage in order to treat it.

The Anxiety Rating Scale (see Annexure 4) is a shortened version of the Hamilton Anxiety Rating Scale where clients rate themselves. Anxiety is a reaction of the body to an eminent peril or danger and helps us to pay attention and protect ourselves. Klienke (1998), asserts that it is when our primary appraisal of life events is not accurate or realistic that anxiety can be debilitating.

Adolescents are still developing and so are their abstract thinking skills (Louw *et al*, 1998). When these children are confronted by an attack on their personal being, their appraisal of situations may be that of confusion and fear. This is because of their vulnerability; post-traumatic stress disorder is not uncommon in these cases. This condition, if present, may result in severe mental health effects on these children, if no early psychological intervention is conducted.

Trauma of any nature and at any stage of our lives affects us negatively in all aspects our lives, be it biologically, psychologically, or socially. Adolescent girls who were sexually abused are not immune to these side effects. The above assessments were done in order to identify signs and symptoms of trauma. Once identified, intervention would be implemented and the effectiveness of the intervention program re-assessed with the same assessment tools.

All the above assessments formed baseline reading that would serve as a guideline with regard to the effectiveness of the proposed intervention strategy, namely, clay therapy.

3.5 GROUP CLAY THERAPY

3.5.1 Introduction

Because of the reasons in the preceding discussion, clay therapy was selected for this research project. Furthermore Sherwood (2004), asserts that clay work in therapy provides a powerful medium to work through many core issues of anger, grief, fear and move the client from a crippling emotional experience to flourishing opportunities for inner growth and healing.

3.5.2 The Process

Clay therapy intervention was given over twelve sessions, eight of which were aimed at full psychotherapy. Instruments used during therapy sessions were

soft and moist clay, formalized questionnaires, and the psychometric tests as indicated above. Sessions were conducted as follows:

The two groups, namely the experimental and the control group, were kept as they were after the psychological assessment. It is a normal practice at the clinic that after a child has been sexually abused, psycho-social intervention is rendered by healthcare workers (The Social Worker and the Visiting Psychologist). The social worker sees children weekly while the psychologist comes once a month.

The experimental group was taken by the researcher as a focus group for the research. Caution was exercised most of the time to prevent the subjects from being aware of the fact that there were two groups. An equal number of sessions was given for both groups, though at different times by different people. The intervention process in clay therapy adopted principles of the MOGP as outlined by Brakarsh & Killian (2004).

Session 1: Rapport building.

The experimental group was a clinical or professional group as postulated by Draucker (1992). At this stage the intervention was to be applied and its effectiveness assessed. This was of course the first interaction of the researcher with the subjects leading to the intervention.

The environment created for this interaction was such that it would allay fears and apprehension of these children so as to win their trust as postulated by Erikson (1963). A position that is friendly and equal to all was adopted by the researcher. Once there was a feeling of equality, an atmosphere of trust prevailed and the children expressed themselves freely. This encouraged learning from each other and friendships were formed. An atmosphere of authority therefore was avoided at all costs.

Children were asked for permission to have their parents or guardians involved or to participate. Involvement or participation of the parents or

guardians was aimed at letting them come once or twice during the process of therapy for support. The majority of children were against the suggestion and preferred to undergo therapy without the parents or guardians. They felt that parents or guardians played a sufficient role by giving them permission to participate in the study. Their wishes were respected. Because of the high number of children that were against the involvement of the parents, the wish applied to all.

The researcher introduced himself to the group and explained the purpose of the “meeting”. A vigilant exercise on the protection of these children’s identity was maintained at all times. A few games such as the pulling of a rope as a form of team-building were played. The pulling of the rope invoked laughter and screams as one group exerted all its energies to pull and beat the other group. This led to a discussion of control, understanding, and knowing each other better.

The other game that was challenging and evocative of suppressed emotions was “write a letter to a person next to you”. These children expressed themselves to the child next to them as to what their opinion of the other child is. Expressions such as: “Hello I think you are so beautiful and I want to be your friend”; and “Can I be you friend?”, were written. These positive feedbacks were accepted with smiles by the recipients of the letters and one could see a sigh of relief on their faces.

Session 2: Rapport building (cont.)

In this session, team-building games were continued. At this time children were more relaxed and expressed themselves more freely. They were made aware that their parents or guardians were going to meet with the researcher separately and at separate times. Subjects were reassured that nothing about them and how they feel would be disclosed to their parents without their permission. They were then released earlier so that the researcher could meet with their parents.

After the subjects were released, parents and guardians of these children were met. The purpose was to explain to the adults the research study and how it was going to be conducted. At the same time the researcher took the opportunity to introduce himself to the parents and guardians of these children and also to get to know them. Their unconditional support for the children throughout the program was requested.

Session 3: Psychometric assessments

Once these children were deemed to have adjusted well into the group, psychometric assessment was then believed to be appropriate. The depression scale, which has twenty questions, was then given to all the participants. The environment created for these assessments was such that it is conducive for psychometric testing, especially for children. The children were encouraged to answer the questions according to the way they felt and not according to what others are saying. The depression assessment was then followed by the self-esteem assessment.

Session 4: Psychometric testing

On the fourth week of intervention the anxiety assessment was given to participants. The Anxiety Scale has fourteen (14) questions and it took the children fifteen to twenty minutes to complete this test. This Anxiety assessment was followed by the formalized questions that were audio recorded.

These questions are in English and some children are not English literate. To those, the questions were given in the language they are comfortable with, being either Sesotho or Xhosa.

Session 5: Clay Therapy

The real therapeutic sessions started in the fifth week of the “meetings”. Children were first introduced to the soft, messy and moist clay and mixed feelings of surprise, laughter, and disbelief were evident on their faces. One

could see a multitude of questions on their faces such as “has this man lost it, why does he want us to dip our hands into this messy substance?”.

I could hear the giggling as we took the clay out of its plastic bag and distributed it to everyone. Some were even reluctant to dip their hands into this “mess” as this was only “wasting” their precious time. There were a few who came forward and reluctantly took their chunks and those left behind were encouraged and supported to play with the clay. One after the other they followed and I could now see them beating, moistening, and rolling the clay into different shapes. The agenda on this day was just to play around with the clay.

I could see the children getting “absorbed” in what they were doing with the clay. As they went along playing on their own initiatives, the researcher joined them. Covert observation of their reaction was maintained at all times even when joining them at play.

Session 6 and 7: Clay Therapy

The sixth and seventh week of therapy became more intensive as children where now expected to follow a defined pattern during the play. They were asked to be formal and follow instructions from the group leader (the therapist). According to Oaklander (1988), a group leader should be committed to providing art activities with a high success rate. She further stated that, at some stages, it may mean offering additional special technical assistance to the children.

Oaklander (1988), posits that it is extremely important during the first weeks of clay therapy that all clients have successful experiences with the clay medium. According to her, if this is achieved it would enhance the willingness of the clients to participate freely and faithfully. This is the reason why children were given an opportunity to do their own sculptures during the initial stage of therapy sessions.

In the sixth and seventh sessions children were requested to make sculptures that represent the way they feel these days and weeks. Some of them made weird sculptures; when asked about them, they stated that the sculptures represent their daily feelings. One child made a crying person and a circle of clay around this person. When asked about this crying person, she explained that the sculpture represents herself. She further explained that she cries almost every night as she feels chains around her. According to her, she has experienced these feelings since the abuse incident. Another child made a person, then opened her school bag, took out ink, and dipped this person in the ink. Her explanation was that she feels dirty and smelly most of the time since the sexual abuse incident.

Some objects were knives, swords and knobkerries, and the explanation was that: “I feel angry after what has happened to me and I want revenge and to kill men, I hate them”; “All men are animals who deserve to be killed”. It was touching to see how angry child victims of sexual abuse are, and to think that most of the time they are probably not afforded the opportunity to express these feelings.

Subjects also reported a number of challenging stories. They stated that their day to day feelings towards others and towards themselves are not what they used to be, since they encountered sexual abuse. Among these feelings were feelings of anger, anxiety, fear and feelings of betrayal. Most felt angry because they believed that they were betrayed by people they know and trust. They experienced mostly panic attacks because they had the feeling that they may be attacked again. They feared for their safety and their parents’ safety, as they were threatened by their abusers.

Session 8 and 9: Clay Therapy

As the children developed the mastery of clay work, there was more fun and enjoyment as story after story came out through their sculptures. For the first time, they were curious and interested in the other children’s sculptures.

Children displayed more coherence and support, and were able to be helped and in turn help each other.

This happened mostly because some children would cry when they were making the sculptures. Those who were overwhelmed by emotions would be seen individually until they settled down and then went back to the group to continue working. They would be concentrating on their work in such a way that they were relaxed and enjoying the cool, soft clay. At some stages some children would succumb to sleep only to be woken up by others or the therapist to encourage them to continue working.

On the other side of the clinic the control group was receiving a normal, traditional intervention program as commonly given by the clinic sisters. Their sessions were conducted by the clinic sister who would sit down with the therapist after the sessions to discuss the sessions and the children's responses.

Session 10 and 11: Clay Therapy

Stein and Sunkenberg (1994), stated that group activities improve socialization by encouraging interactions with peers. During the group activities on clay therapy, children shared jokes and activities, which had a positive bearing on increasing their self-esteem. In these tenth and eleventh sessions, which were the sixth and seventh sessions of psychotherapy, children were now more focused and enjoying their play.

Sculpting continued, and the subjects were no longer concerned with their hands getting "dirty". It was at this stage that the group leader became aware that the children were coming to terms with their trauma. More "soft" and "gentle" sculptures were made by the subjects at this stage. They made sculptures such as shields or huge rocks that they believed represented their protection. Behind these shields or rocks were clay-made people taking shelter.

One sculpture that showed acceptance and healing was that of two people who were embracing each other. The subject said that she has forgiven her parents who were blaming her and accusing her of “looking for it”. Most of the subjects verbalized that men should not be “painted” with the same brush. They accepted, for the first time in therapy, support from their parents and gave permission for the therapist to tell their parents about their trauma. Parents were invited to the session as both the therapist and the children disclosed to them. The therapist took this opportunity to discuss termination of sessions at a later stage with both the children and their parents.

Session 12: Clay Therapy

As sessions continued children indicated that they enjoyed making these shelter or protection sculptures and verbalized that they felt comfortable and in control. The burden on their shoulders had eased after the disclosure to their parents, who promised support. To them, it was a feeling of relief from their troubles and fears. As they indicated, the shields and rocks are means to protect them from any imminent attacks.

When they were asked about the shields and rocks, various responses were given. Some indicated that they thought they were not sure of their safety while others pointed out that they thought they needed to take more precautionary measures in the future. Those who had blamed their parents indicated that parents were actually protective and the children should play a more prominent role in protecting themselves and be more vigilant at all times.

Intervention sessions were successful, but there was one thirteen (13) year old child who, throughout the sessions, showed less positive response to treatment. She was always approaching the clay with tears in her eyes and her sculptures were mostly weird. They were huge sculptures with swords or guns at times, an indication of anger and fighting.

During an individual interview, this child said that she does not have a father. She indicated that she had been sexually molested by her mother's boyfriend. To make her situation worse, the mother did not believe her. She accused her (the daughter) of trying to destroy her (the mother's) relationship with her man. She accused the daughter of not being appreciative of the help and "many sacrifices" on the part of the boyfriend. The perpetrator (boyfriend) always takes the children to school and fetches them on his way home from work because he starts work late and returns home early. According to the subject, this is where and when the sexual abuse takes place.

The mother was invited separately (with her daughter), to a session so that a compromise regarding their misunderstanding could be reached. During the first session the mother was not cooperative and accused the daughter of trying to manipulate her. She felt that the daughter should leave her house as "she is now a woman who wants to dictate to her about who should come to the house and who should not". Improvement was, however, achieved after a few individual sessions that at some stages included the subject.

As the therapist/group leader, I indicated to the groups that sessions were soon going to be terminated. We agreed that we would invite parents to discuss the termination of sessions once more. We mutually agreed even though the majority made it clear that they were still enjoying the clay. I made it clear to them that they would have the same tests again in the last session.

Session 13 and 14: Psychometric assessment

As the sessions were wrapped up, children were requested to undergo psychometric testing again. The same tests that were given in the second and third sessions were given once again. Discussions regarding termination of sessions were held with the health care centre sister, children in the control group and their parents. All participants were then subjected to psychometric testing as per their first participation.

These tests were going to be scored in the same way as in the second and third session's tests. A comparison and analysis of scores will be discussed in the next chapter.

The health care centre sister, the parents, and the subjects were told that sessions would be terminated as they were deemed to be on their way to full recovery. The parents were, however, warned to monitor their children closely, at home, at school and in their social relationships, and to watch out for any signs of relapse. If these should occur, the child should be brought back to the clinic sister. If the clinic sister, the parent or the child feels that she wants to see the therapist, the sister will make an appointment for the therapist to visit. Mutual agreement was then reached to have sessions terminated in both the experimental and the control groups.

There is an outreach program at the clinic that is run by a multi disciplinary team from an academic hospital. This team visits the clinic once a month and does assessments and intervention. A discussion was held with the thirteen year old subject and her mother to suggest referring them to the team. This was done with the anticipation that they would be able to complete sessions and therefore complete their mutual understanding and healing. They agreed to the referral. A confidential referral letter was sent to the team with a requisition for feedback on completion of the sessions, so as to be satisfied that the child and the mother were taken care of.

3.6 ETHICAL CONSIDERATIONS

Participants were all minors and therefore extra care was taken in order to safeguard their identities. This was more pressing because sexual abuse is still seen as taboo in most communities and cultures. Once a child is known to have been sexually abused, degrading remarks in most instances are passed leading to some humiliation (Bacigalupe, 2001).

Permission to undertake this research was obtained from the Department of Health and Education through the officer-in-charge of the health care centre. In keeping with governmental regulations, all channels for permission to interview were followed, and relevant binding forms completed. Relevant nursing personnel were tasked by the head of the health care centre to help identify children.

Permission to see the children was obtained from their parents as well, who then signed consent forms. They were advised that participation in the study could be terminated at any time once they felt uncomfortable. Children and their parents were assured that termination of participation would not disadvantage them from receiving proper care and treatment at the health care centre. Participants were also reassured that the researcher has no relationship with the health care centre other than for the purpose of the research study.

Participants were also told that their identity would be kept confidential at all times in order to protect them from stigmatisation or name-calling, at all stages during and after the study.

The research process was explained to them, e.g. assessment instruments, and audio recording. They were made aware that even though they had disclosed their names on the audio cassette, names would not appear anywhere in the report and/or dissertation.

It was made known to them that a copy of the report/dissertation may be given to the following departments as a requirement after granting permission to conduct the study:

- Social Welfare
- Health
- Education.

Signed consent forms were then requested and obtained from participants and their parents or guardians.

3.7 SUMMARY

The main focus of this chapter was on research methodology. The research process followed a pre-test and post-test method, after which clay therapy was conducted on the experimental group, whilst the control group received routine therapeutic interventions offered at the clinic. Results for these interventions are discussed in the next chapter.

CHAPTER 4
ANALYSIS AND INTERPRETATION OF DATA

4.1 INTRODUCTION

The aim of this research was to evaluate a group treatment programme of female teenage children who have survived child abuse. Participants in this research were pre- and post-tested on three emotional factors that were observed during the clinical interviews with the subjects, namely;

- Self-esteem
- Depression
- Anxiety

The pre- and post-test results will be presented according to each of these emotional factors, for each of the two groups, i.e. the experimental and the control groups respectively.

4.2 PRESENTATION OF DATA

4.2.1 The psychological well-being questionnaire: Pre-intervention

Table1: Frequency distribution table on psychological well-being questionnaire:

Experimental group

Severity	*Respondents*
Mild	2
Moderate	4
Severe	14
Profound	0

Control group

Mild	2
Moderate	5
Severe	13
Profound	0

Of the forty subjects interviewed, all of them showed pathological behavior both in the experimental and control groups. There were constant thoughts of suicide, feelings of hopelessness, being unable to manage the demands of everyday life, difficulty in forming warm and lasting relationships with others, and crying tendencies. These responses therefore gave a pathologically oriented clinical impression.

4.2.2 The psychological well-being questionnaire: Post intervention

Table2: Frequency distribution table on psychological well-being questionnaire:

Experimental group

Severity	***Respondents***
Mild	0
Moderate	1
Severe	1
Profound	18

Control group

Mild	0
Moderate	2
Severe	5
Profound	13

The experimental group was then subjected to an intervention programme while the control group received a routine intervention at the health care centre. After the intervention programme the two groups were subjected to the same clinical assessment and psychometric assessments as before the intervention. This was done so as to measure the effect of the intervention programme on their current pathological conditions.

The above table indicates that a total of eighteen (18) subjects from the experimental group showed a profound (i.e. remarkably high) psychological functioning after the program. (It should be noted that the use of the word *"profound"* in this research is different from the *'disease state'* i.e. where it means gross physiological abnormality.) In this group, one subject in each of the categories, namely, severe (i.e. higher) and moderate (i.e. moderately high), showed recovery from their pathological condition.

In the same way, thirteen (13) were seen to have recovered profoundly (i.e. remarkably high) from the control group. Five and two in this group were found to have recovered severely (i.e. higher) and moderately (i.e. moderately high) respectively.

Traditional psychological intervention programmes post sexual abuse indicated desired recovery effects on the victims. The clay therapy programme, however, proved to be more effective. This is seen by the number of victims that displayed signs of improvement during the application of this programme.

Inferential statistics were generated in order to indicate the significance of the recovery of the victims after the intervention program. The tables and graphs in the sections that follow, show results of quantitative analysis of data.

4.2.3 Self-Esteem

Low self-esteem is one of the most common signs that was identified during the clinical interview with the subjects. This necessitated in-depth attention in order to assist subjects improve their level of self esteem.

The assertiveness scale data analysis gave the figures below and these figures are shown in the table with their means before the intervention programme and after the intervention programme. Reflected in the brackets are the standard errors and the mean change in the extreme column.

Table 3: Pre and Post-test mean scores for self-esteem

	Before intervention	Post intervention	Mean change
Experimental	31.05 (1.32)	58.85 (0.63)	27.8
Control	29.9 (1.48)	35.65 (1.83)	5.75

The above figures show that the experimental group shows a mean of 31.05 before the intervention programme with the standard error of 1.32 in brackets. This suggests the presence of low self-esteem that resulted from the sexual victimization. The same signs of low self-esteem have been identified in the control group before the intervention programme as well, a mean of 29.9 with a standard error of 1.48 in brackets.

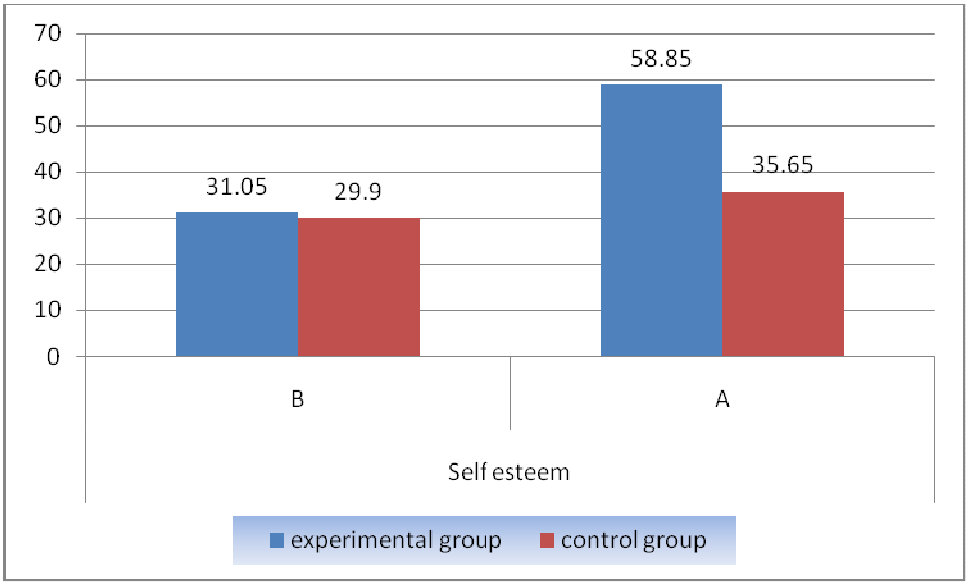
After four weeks of the intervention programme, a significant improvement in self-esteem on the part on the experimental group was marked. A mean of 58.85 with a standard error of 0.63 in brackets was now obtained. The same can be said with the control group, although the intensity of the improvement is less than that of the experimental group.

The difference in the improvement in self-esteem between the two groups is significant (i.e. 27.8 – 5.75 = 22.05). This therefore suggests the achievement of the desired effects of the treatment. Improvement in self-esteem post

intervention has been shown on the graph below (Figure 1). This graph illustrates the difference between the experimental and the control group.

Figure1: Graphical presentation of Pre and Post-test mean scores for self esteem

NB: B = PRE-TEST A = POST-TEST



4.2.4 Depression

The second prominent theme identified during the clinical interview with the victims was depression. The figures reflected in the table below were generated during data analysis and are also reflected on the graph.

Child sufferers of sexual abuse showed high levels of depression in both the experimental and the control groups. During therapeutic intervention the two modalities (i.e. the traditional modality given by the clinic staff and the clay modality rendered by the therapist) were employed. These modalities indicated a positive impact or an improvement of depression in both the participating groups as illustrated below:

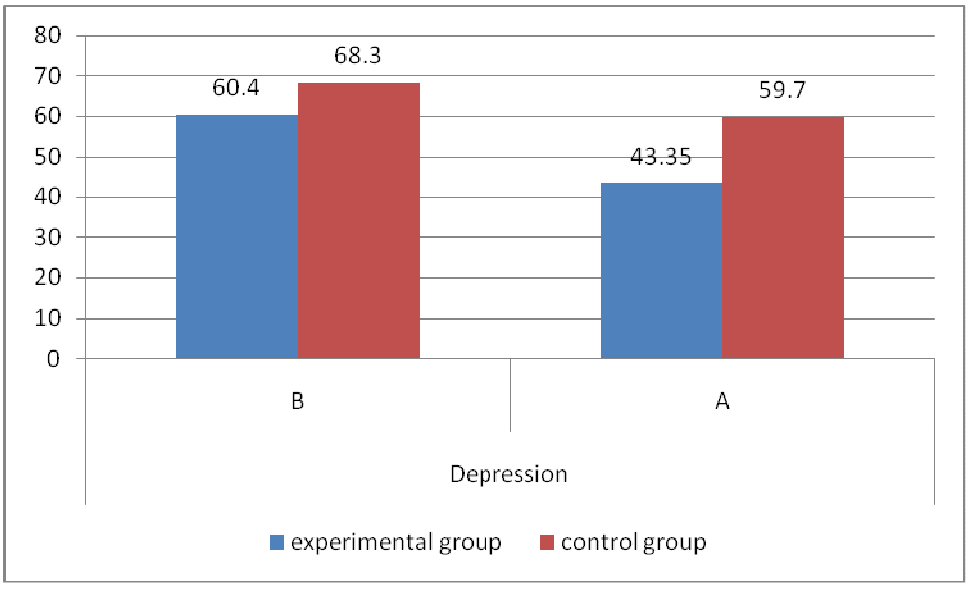
Table 4: Pre and Post-test mean scores for depression

	Before intervention	Post intervention	Mean change
Experimental	60.4 (1.12)	43.35 (1.13)	-17.05
Control	68.3 (2.23)	59.7 (1.51)	-8.6

The above table shows the means with standard errors in brackets and the mean changes. The mean change signifies a significant decline in depression (-17.05 – -8.6 = -8.45). The significant change suggests that the intervention programme has a positive effect on the victims, thus confirming the significant decline in depression. This has been illustrated in Figure 2 below and provides clarity on the change in both the experimental and control groups.

Figure 2: Graphical presentation of Pre and Post-test mean scores for depression

NB: B = PRE-TEST A = POST-TEST



4.2.5 Anxiety

Anxiety can be in the form of panic attacks and various phobias that are debilitating. If any one of these conditions causes a significant impairment in the normal daily social functioning of the victim, then the condition is pathological (American Psychiatric Association, 2003). Anxiety expressed by the subjects during the clinical interviews was regarding the uncertainty about the perpetrators. Some of them had not yet been incarcerated, others were out on bail. Subjects also expressed fear of not knowing how to behave around males.

Statistical analysis suggested an increased level of anxiety from both the experimental and the control groups. The two groups differed significantly in their levels of anxiety before and after intervention programmes.

It is noted that in as much as the traditional treatment modality yielded positive results, the clay therapy results were significantly more positive in comparison. In their four weeks of therapy, subjects in the experimental group appear to have gained more control of their anxious tendencies than those in the control group.

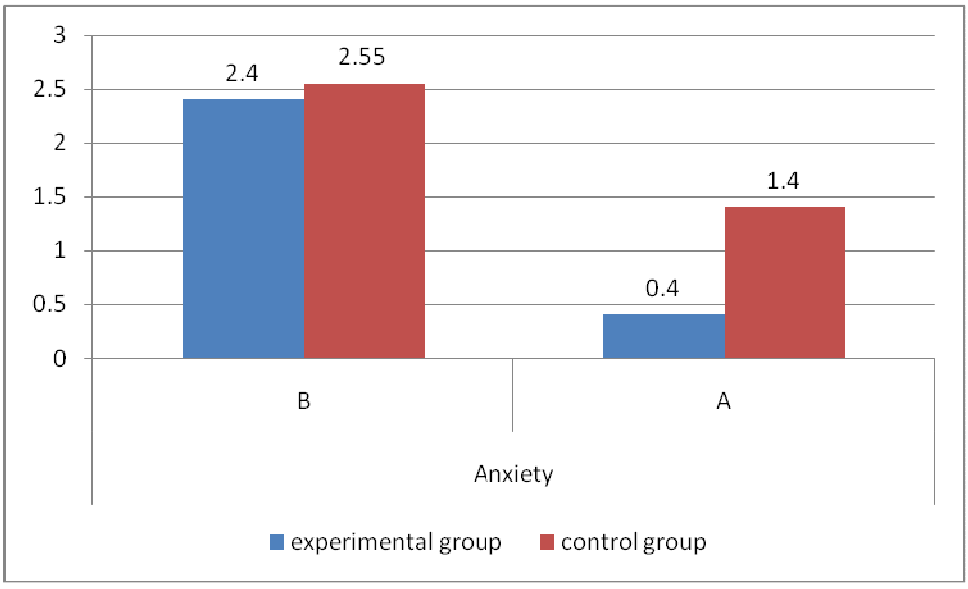
Table 5: Pre and Post-test mean scores for anxiety

	Before intervention	Post intervention	Mean
Experimental	2.4 (0.11)	0.4 (0.11)	-2
Control	2.55 (0.11)	1.4 (0.15)	-1.15

Figure 3 illustrates how anxiety has subsided after therapeutic intervention post sexual abuse. It continues to suggest that clay therapy proved to be more effective when compared to the traditional programme.

Figure 3: Graphical presentation of Pre and Post-test mean scores for anxiety

NB: B = PRE-TEST A = POST-TEST



4.3 DISCUSSION OF RESULTS

4.3.1 Introduction

The average differences in scores were used to determine if the programme had an effect on the sexually molested children's self-esteem, depression and anxiety.

These differences in scores were calculated by continuously subtracting the pre-scores from the post-scores. A positive difference in scores means that the group in general achieved higher marks with the post-scores than during the pre-scores. (A negative difference in scores thus means the opposite).

Since the programme aims to better self-esteem, in this case one would expect a positive difference in scores with the subjects in the experimental group.

The programme further aims to lessen depression and anxiety. The experimental group should obtain a negative difference in scores for these two variables.

In order to test whether the average difference in scores between the experimental and control groups differ significantly, the Mann Whitney U-test was used. This non-parametric test was used since both groups were small and there was doubt about the assumption that normal scores did exist. The 1%-mark of significance was used.

4.3.2 Summary of findings

Self-esteem

According to the results in Table 3 a higher average difference in score was obtained between the experimental group (27.8) and the control group (5.75) with regard to self-esteem. Since the purpose of the programme was to better self-esteem, it can be expected that higher post-scores than pre-scores will be obtained.

In order to determine whether there is a significant statistical difference between the two average difference scores, the Mann Whitney U-test was used. A z-value of 5.2024 has been obtained, which is significant on the 1%-level. Thus the null hypothesis can be rejected in this case, which shows that the programme was of value to the self-esteem of the children in the experimental group (in comparison with those in the control group).

This indicates that people who have been sexually abused can be assisted in order to be able to deal with effects of the trauma. The intervention programme yielded increased coping skills to the extent that they can positively assimilate their experience and have fewer negative effects. Clay therapy intervention appears to yield higher recovery effects than the traditional intervention programmes.

Depression

According to the results in Table 4 a higher average difference in score was obtained between the experimental group (-17.05) and the control group (-8.6) with regard to depression. Since the purpose of the programme was to lessen depression, it can be expected that higher pre-scores than post-scores will be obtained.

In order to determine whether there is a significant statistical difference between the two average difference scores, the Mann Whitney U-test was used. A z-value of -2.6135 has been obtained, which is significant on the 1%-level.

There is a significant difference in the level of depression experienced by subjects before and after the intervention programme. This implies that the null hypothesis can be rejected and that people who had some form of an intervention, experience less depression than those who have not.

The experimental group, however, shows higher improvement with their depression than the control group (i.e. -17.8>-8.6). This group has been assisted to cope with the expected depression that goes with having been sexually abused.

It can also be assumed that the intervention assisted the victims in getting back to a normal way of functioning than if they had not received any form of intervention.

Research has shown that people, especially adolescents, who have been sexually assaulted, seemed to cope better if they have had an opportunity to deal with that experience in a caring, non-judgmental context. It can therefore be assumed that this sample group felt understood and non-judged. This contributed to their recovery. In most cases children that are sexually abused find it hard to cope with trauma (Finkelhor, 1986). The effects of their experience are exacerbated by numerous factors as indicated by Finkelhor (1986), which include feelings of being betrayed by people they trust (adults) and know, and the stigmatization of sexual abuse. In most cases sexual abuse is inflicted on children forcefully, leaving sufferers with physical and emotional scars.

The treatment that they endure from different agencies such as the police stations, health care centers, and the courts of law sometimes worsens their trauma. In some cases, family members are not supportive, which makes matters even worse.

Anxiety

Anxiety is commonly found in individuals that have undergone a traumatic experience such as sexual abuse. Following abuse, individuals usually suffer constant and debilitating fears. They usually anticipate danger or bad news for them or significant others. These feelings cause a significant disruption in their social lives as well as their normal daily functioning.

The results in Table 5 show that a higher average difference in score was obtained between the experimental group (-2) and the control group (-1.15) with regard to anxiety. Since the purpose of the programme was to allay anxiety, it can be expected that higher pre-scores than post-scores will be obtained.

In order to determine whether there is a significant statistical difference between the two average difference scores, the Mann Whitney U-test (already discussed) was used. A Z-value of -3.4645 has been obtained, which is significant on the 1%-level. Thus the null hypothesis can be rejected in this case, which shows that the programme was of value to the anxiety of the children in the experimental group (in comparison with those in the control group).

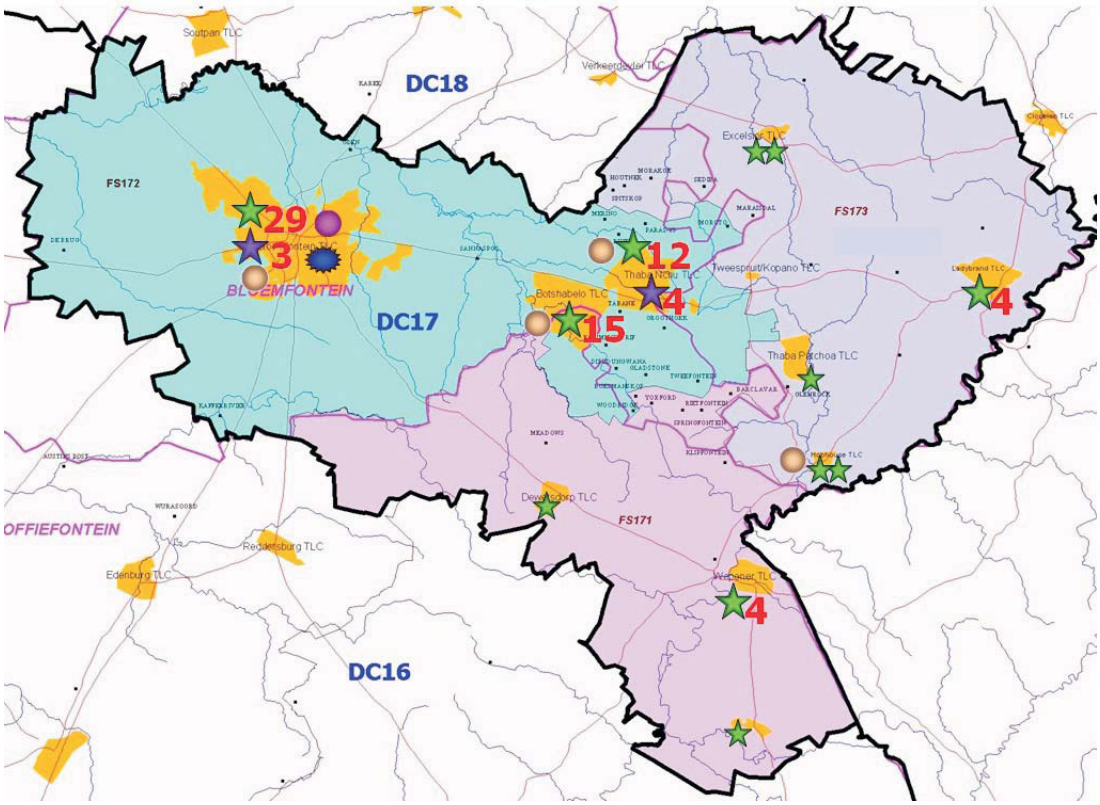
These test results indicate recovery from the psychological conditions within both the experimental and the control group. The significantly higher difference of -0.85 suggests that victims especially in the experimental group have recovered from their constant fears, anticipation of eminent danger and exclusion from interacting with others. This huge difference in the anxiety improvement suggests as well that the programme had remarkable results, more so than the traditional therapies used at the health care centre.

CHAPTER 5
CONCLUSION AND RECOMMENDATIONS

5.1 INTRODUCTION

This research study was conducted in the Motheo district in the Free State Province, in South Africa. The district has a total population of 755 521 (Annual Performance Plan 08/2009) and a population of 39 434 adolescent girls (Free State Stats 2008). Although the Motheo district is being developed, poverty is still one of the challenges faced by the population in this area. Unemployment, illiteracy, and increasing numbers of child sexual abuse are some of the general concerns amongst the communities.

Figure 4: The Motheo District Map



5.2 DISCUSSION

Sherwood (2004), asserts that research has shown that a human-being's body cells are affected by what they think and feel, which leads to psychological pathologies. Particular feelings affect our psychological well-being in different ways. These can either be negative or positive. The thinking and feeling of being abused sexually leads to trauma.

In order to reach clients that are pathologically inclined, it can be easier and more effective to focus on the totality of the client, that is, the body and mind. Traditional modalities of psychotherapeutic interventions are mind based, consisting of reflections, conversations and words which makes it difficult to access the client if either the therapist or the client is unable to command the language, so that they both understand each other (Sherwood, 2004).

Body based psychotherapy such as clay therapy works on the body. It touches and restructures the mind and holistically manages the client (Sherwood, 2004). Dalley (1993), states that most children experience difficulty articulating their feelings, thoughts and concerns. Clay therapy is therefore a powerful medium that can be useful in working with children, especially young children, that have been sexually abused. It is a medium that helps therapists break the barriers created by the survivors, thus bringing to the surface suppressed emotions and feelings. Oaklander (1988), states that clay seems to be able to penetrate the protective armour, i.e. the barrier in the child. It is at the same time friendly in as far as time is concerned when it is given to clients. Clients will take their time working with clay, beating it and making it softer to suit their own needs.

The high incidence of child sexual abuse, as well as the challenges with regard to the availability of therapists, and the demands on the few therapists that are available, have necessitated group therapy approaches in addition to individual therapies. Ryan (2007), states that a non-directive therapy approach is helpful in clients that have suffered emotional damages. It gives victims the time and privacy they need to address deeper levels of mental and

personal experiences using symbolic play. Symbolic play is a natural vehicle children use to assimilate and express their personal experiences. Sexually abused children actively direct their own process of symbolic re-enactment of personally meaningful experiences, thus emotionally individualizing and personalizing play therapy sessions.

It is imperative that survivors of sexual abuse receive help irrespective of their language or cultural orientation. Clay therapy allows for healing to occur even though clients may have language or cultural challenges. They are able to make contact with their etheric bodies, i.e. through expressing themselves non-verbally and therefore attain healing (Sherwood, 2004).

Clay therapy, therefore, gives survivors of sexual abuse an opportunity to penetrate, layer upon layer, the deepest levels of their feelings. It can bring to the surface that which is unknown with a power and clarity that is awesome (Sherwood, 2004). One of the defence mechanisms that adolescent survivors of sexual abuse employ is to suppress the painful trauma experienced. These suppressed feelings and emotions unfortunately return to haunt them and affect normal functioning at a later stage in their lives if not addressed properly.

In this research the experimental group used clay to form shapes that were symbolic of their feelings. This process was repeated until they had exhausted their negative emotions. The pattern of recovery is evident across the three identified factors, i.e. self-esteem, depression, and anxiety. Clay therapy modality is, therefore, understood better by clients seeking psychological help irrespective of their literacy status because it involves actions more than words, hence the significant recovery pattern.

5.3 STRENGTHS FROM THIS STUDY

The intervention program was given for eight sessions. This is taken as brief therapeutic intervention. Brief therapies are more effective and helpful with

clients of low socio-economic status simply because some of them lack funds for daily trips to see the therapists, most of which are located in urban and peri-urban areas. The subjects for this research were all from a rural area.

The sample was taken from children of scholastic standing between grade 3 and grade 8. Their home languages ranged between South Sotho, Setswana, and Xhosa. Children are usually not as eloquent as adults in expressing their feelings in therapy. Clay therapy was, therefore, the correct modality for them. It allowed for minimal communication. Feelings were expressed through shapes that were created by the survivors. In some cases strong emotions were evoked by simply working with clay (e.g. a few clients cried throughout some of these sessions).

South Africa is made up of nine provinces and the provinces are further divided into districts. Through poverty, politics, e.g. forced removals, faction fights, etc., and societal factors such as the migrant labour system, marriages, and others, people have migrated from their places of origin, so that one finds mixed cultural groups all over the country. A therapeutic modality that reaches a varied number of clients is more acceptable.

The programme could be extended to other districts, however this did not happen because of limited resources. The programme requires a skilled therapist who would be able to deal with the strong emotions that are evoked during the programme and yet be able to keep the rest of the group going. At the time of this research, the therapist was the only psychologist working with the experimental group. While this may seem a disadvantage, it is not, because more than one client can work with the therapist at the same time. Confidentiality is maintained in such therapy because the subjects do not have to talk about their feelings in the group, if they do not want to.

The strengths of this modality can be summarized as follows:

- The brief intervention approach yields positive outcomes within a shorter period of intervention.

- In comparison to traditional modalities, clay therapy modality was more effective.
- Clay therapy modality showed no language barriers; all the girls grasped activities well and fast, even though they were from different cultural groups.
- Clay activities showed an impact on the physical body, which may be a tonic to body aches and fatigue.
- A significant positive response of the subjects was observed in all the factors assessed, namely, self-esteem, depression, and anxiety.
- Playing with clay is culture friendly because no level of education is needed to master the art of playing. This makes clay therapy much easier to be integrated in child therapies.

5.4 CONCLUSION

Sexual trauma on children is an ongoing challenge that seems to be fueled by multiple reasons. It is a daunting task to eradicate this crime. The initiative by governments and non-governmental organizations to curb this crime needs to be supported. All governmental institutions that serve the best interests of the child need to work together, e.g. health clinics, social welfare offices, police services, courts of law, etc.

The ever rising incidence of child sexual abuse poses a challenge to health professionals, e.g. psychologists. The challenge lies in dealing with a large number of clients, through limited resources. Psychologists are compelled to continuously improve traditional therapeutic approaches and formulate new therapeutic modalities in order to minimize complications.

Clay therapy is a modality that is comprehensive and user-friendly when working with children. In most cases, children, especially adolescents, are too scared to talk about their traumas. Their feelings then get buried in the unconscious. Sherwood (2004), states that clay therapy has a subtle way of reaching the deepest turmoil, thoughts and feelings and brings them to the

expressive channel. Clay relaxes and tires children, as they fall asleep midway in therapy. The healing effects of clay become noticed within few sessions of instruction with children in therapy. This is demonstrated through their clay creations and openness to talk about their unpleasant experiences, when describing these creations.

5.5 RECOMMENDATIONS

More health professionals should be trained to practice clay therapy with children, especially the children that have deep-seated feelings of trauma.

Research of the same nature as this one can be repeated for adults that tend to bury their feelings, or rather, that find it hard to talk about their feelings, in order to help them release negative energy.

It would be interesting to see the outcome of the same study, if the control group had been exposed to traditional therapeutic modalities carried out by a psychologist, instead of nurses and social workers, as happened in this study.

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ANNEXURE 1

PSYCHOLOGICAL WELL-BEING QUESTIONNAIRE (Ryff, 1995)

Circle the number that best describes your present agreement or disagreement with each statement.	**Strongly Disagree**	**Disagree Some-what**	**Disagree Slightly**	**Agree**	**Agree Slightly**	**Agree Some-what**	**Strongly Agree**
1. I tend to be influenced by people with strong opinions.	-1	-2	-3	0	+1	+2	+3
2. I think it is important to have new experiences that challenge how you think about yourself and the world.	-1	-2	-3	0	+1	+2	+3
3. In general I feel I am in charge of the situation in which I live.	-1	-2	-3	0	+1	+2	+3
4. I live life one day at a time and am really pleased with how things have turned out.	-1	-2	-3	0	+1	+2	+3
5. Maintaining close relationships has been difficult and frustrating for me.	-1	-2	-3	0	+1	+2	+3
6. When I look at the story of my life, I am pleased with how things have turned out.	-1	-2	-3	0	+1	+2	+3
7. I have confidence in my opinions, even if they are contrary to general consensus.	-1	-2	-3	0	+1	+2	+3
8. For me, life has been a continuous process of learning, changing and growth.	-1	-2	-3	0	+1	+2	+3
9. The demands of everyday life often get me down.	-1	-2	-3	0	+1	+2	+3
10. Some people wander aimlessly through life, but I am not one of them.	-1	-2	-3	0	+1	+2	+3

11. People would describe me as a giving person, willing to share my time with others.	-1	-2	-3	0	+1	+2	+3
12. I like most aspects of my personality.	-1	-2	-3	0	+1	+2	+3
13. I judge myself by what I think is important, not by the values of what others think is important.	-1	-2	-3	0	+1	+2	+3
14. I gave up trying to make big improvements or changes in my life a long time ago.	-1	-2	-3	0	+1	+2	+3
15. I am quite good at managing the many responsibilities of my daily life.	-1	-2	-3	0	+1	+2	+3
16. I sometimes feel as if I should give up on life.	-1	-2	-3	0	+1	+2	+3
17. I have not experienced any warm and trusting relationships with others.	-1	-2	-3	0	+1	+2	+3
18. In many ways, I feel disappointed about my achievements in life.	-1	-2	-3	0	+1	+2	+3

ANNEXURE 2

AN ASSERTIVENESS QUIZ

Before learning how to develop your assertiveness, it is important to take a few moments to get some idea of where you are right now. Answer the questions below honestly. They will help you gain some insights about your current level of assertiveness.

Assign a number to each item using this scale:

ALWAYS NEVER
5 4 3 2 1

_____ I ask others to do things without feeling guilty or anxious.

_____ When someone asks me to do something I don't want to do, I say "no" without feeling guilty or anxious.

_____ I am comfortable when speaking to a large group of people.

_____ I confidently express my honest opinions to authority figures (such as my boss).

_____ When I experience powerful feelings (anger, frustration, disappointment, etc.), I verbalize them easily.

_____ When I express anger, I do so without blaming others for "making me mad."

_____ I am comfortable speaking up in a group situation.

_____ If I disagree with the majority opinion in a meeting, I can "stick to my guns" without feeling uncomfortable or being abrasive.

_____ When I make a mistake, I will acknowledge it.

_____ I tell others when their behavior creates a problem for me.

_____ Meeting new people in social situations is something I do with ease and comfort.

_____ When discussing my beliefs, I do so without labeling the opinions of others as "crazy," "stupid," "ridiculous," "irrational."

_____ I assume that most people are competent and trustworthy and do not have difficulty delegating tasks to others.

_____ When considering doing something I have never done, I feel confident I can learn to do it.

_____ I believe my needs are as important as those of others and I am entitled to have my needs satisfied.

ANNEXURE 3

DEPRESSION SELF RATING SCALES

Risk Factors

- **Age** – The most common age of onset of depression is in the late 20's. There is an increased risk in the elderly that appears to be associated with an increasing prevalence of physical illness. There is evidence that the prevalence of depression is increasing in the 15 - 19 year age group.
- **Sex** – The female : male ratio ranges from 2:1 to 3:1 in all cultures

  Depression may be becoming more frequent amongst men. Men may present with a slightly different pattern from women (e.g. more aggression and substance abuse)
- **Genetics** – Depression is 1.5 to 3 times as common amongst those with a first- degree relative with depression than among the general population.
- **Stress** – About 80% of depressive illnesses appear to have been precipitated by stressful life events.
- **Physical illness** – Depression is often associated with physical illnesses such as HIV/AIDS, cancer, cardiac disease, diabetes and Parkinson's disease.
- **Hormonal Changes** – Women may be vulnerable to depression due to changing hormone levels, as in postpartum depression.
- **Alcohol, Nicotine, and Drug Abuse** – These substances may contribute to depression.
- **Diet**-Symptoms of depression may be caused by deficiencies in folic acid and vitamin B-12.

Suicide

Depression is a serious illness that, if left untreated, can result in an accelerated course of more frequent and severe episodes over time. It can lead to a downward spiral of disability, dependency, and suicide.

Certain warning signs may indicate serious depression and any threat of suicide should be taken seriously. If you see any of the following danger signs contact a doctor, mental health clinic, or suicide hotline immediately. *

- Pacing, agitated behaviour, frequent mood changes
- Actions or threats of physical harm or violence
- Threats or talk of death or suicide
- Withdrawal from activities and relationships
- Giving away prized possessions or saying goodbye to friends
- A sudden brightening of mood after a period of severe depression
- Unusually risky behaviour

*** Depression and Anxiety Support Group**
Tel: (011) 783-1474/6

Management of Depression

Depression is treated by:
- medication (pharmacotherapy)
- physical therapies such as ECT (electroconvulsive therapy)
- psychotherapy

- The best treatment for depression is usually a combination of pharmacotherapy and psychotherapy.
- The use of antidepressants is the mainstay of management of depression in primary care.
- 70% - 80% of patients will respond to an **adequate dose** of antidepressant medication.

Acute treatment
Some improvement can usually be seen within the first 10 days to two weeks of treatment, but it takes up to 6 - 8 weeks before the patient feels "back to normal".

Continuation treatment
This is the time taken to consolidate the response. The same drug should be used in the dose that was effective at the end of the acute phase i.e. the dose that gets you well keeps you well. The patient should be **free of symptoms** for 6 months to a year before the treatment is reduced with a view to discontinuation (WHO recommendations).

Non response
If, after 6 - 8 weeks of treatment there is no response to the medication, the dose can be increased or the antidepressant can be changed.

Prevention
Medication may need to be continued indefinitely in some patients with:
Recurrent depressive episodes
Severe episodes of depression
Prolonged episodes of depression
Chronic major depression

Zung Self Rating Scale

Name _____

Age _____ Sex _____

Date _____

		None OR a little of the time	Some of the time	Good part of the time	Most OR all of the time	TOTAL
1.	I feel downhearted, blue and sad	1	2	3	4	
2.	Morning is when I feel the best	4	3	2	1	
3.	I have crying spells or feel like it	1	2	3	4	
4.	I have trouble sleeping through the night	1	2	3	4	
5.	I eat as much as I used to	4	3	2	1	
6.	I enjoy looking at, talking to, and being with attractive men/women	4	3	2	1	
7.	I notice that I am losing weight	1	2	3	4	
8.	I have trouble with constipation	1	2	3	4	
9.	My heart beats faster than usual	1	2	3	4	
10.	I get tired for no reason	1	2	3	4	
11.	My mind is as clear as it used to be	4	3	2	1	
12.	I find it easy to do the things I used to do	4	3	2	1	
13.	I am restless and can't keep still	1	2	3	4	
14.	I feel hopeful about the future	4	3	2	1	
15.	I am more irritable than usual	1	2	3	4	
16.	I find it easy to make decisions	4	3	2	1	
17.	I feel that I am useful and needed	4	3	2	1	
18.	My life is pretty full	4	3	2	1	
19.	I feel that others would be better off if I were dead	1	2	3	4	
20.	I still enjoy the things I used to do	4	3	2	1	
					SDS Raw Score	
					SDS Index	

Interpretation of self rating scale results

Conversion of Raw Scores to SDS Index

$$\text{Index} = \frac{\text{Raw Score Total}}{\text{Maximum Score of 80}} \times 100$$

Raw Score	SDS Index	Raw Score	SDS Index	Raw Score	SDS Index
20	25	40	50	60	75
21	26	41	51	61	76
22	28	42	53	62	78
23	29	43	54	63	79
24	30	44	55	64	80
25	31	45	56	65	81
26	33	46	58	66	83
27	34	47	59	67	84
28	35	48	60	68	85
29	36	49	61	69	86
30	38	50	63	70	88
31	39	51	64	71	89
32	40	52	65	72	90
33	41	53	66	73	91
34	43	54	68	74	92
35	44	55	69	75	94
36	45	56	70	76	95
37	46	57	71	77	96
38	48	58	73	78	98
39	49	59	74	79	99
				80	100

The SDS Index can be interpreted as follows:

SDS Index	Equivalent Clinical Global Impressions
Below 50	Within normal range, no psychopathology
50-59	Presence of minimal to mild depression
60-69	Presence of moderate to marked depression
70 and over	Presence of severe to extreme depression

Contact your doctor if you are concerned with with your SDS index score

ANNEXURE 4

ANXIETY RATING SCALE

Hamilton Anxiety Rating Scale[1]

Instructions: This checklist is to assist the psychiatrist in evaluating each patient as to their degree of anxiety and pathological condition. (Mark the appropriate rating).

NONE = **0** MILD = **1** MODERATE = **2** SEVERE = **3** SEVERE, GROSSLY DISABLING = **4**

Symptom		Rating	Symptom		Rating
Anxious mood	Worries, anticipation of the worst, fearful anticipation, irritability.	☐	**Somatic (sensory)**	Tinnitus, blurring of vision, hot and cold flushes, feelings of weakness, picking sensation.	☐
Tension	Feelings of tension, fatigability, startle response, moved to tears easily, trembling, feelings of restlessness, inability to relax.	☐	**Cardiovascular symptoms**	Tachycardia, palpitations, pain in chest, throbbing of vessels, fainting feelings, missing beat.	☐
Fears	Of dark, of strangers, of being left alone, of animals, of traffic, of crowds.	☐	**Respiratory symptoms**	Pressure or constriction in chest, choking feelings, sighing, dyspnea.	☐
Insomnia	Difficulty in falling asleep, broken sleep, unsatisfying sleep and fatigue on waking, dreams, nightmares, night-terrors.	☐	**Gastrointestinal symptoms**	Difficulty in swallowing, wind, abdominal pain, burning sensations, abdominal fullness, nausea, vomiting, borborygmi, looseness of bowels, loss of weight, constipation.	☐
Intellectual (cognitive)	Difficulty in concentration, poor memory.	☐	**Genitourinary symptoms**	Frequency of micturition, urgency of micturition, amenorrhea, menorrhagia, development of frigidity, premature ejaculation, loss of libido, impotence.	☐
Depressed mood	Loss of interest, lack of pleasure in hobbies, depression, early waking, diurnal swing.	☐			
Somatic (muscular)	Pains and aches, twitching, stiffness, myoclonic jerks, grinding of teeth, unsteady voice, increased muscular tone.	☐	**Behaviour at interview**	Fidgeting, restlessness or pacing, tremor of hands, furrowed brow, strained face, sighing or rapid respiration, facial pallor, swallowing, belching, brisk tendon jerks, dilated pupils, exophthalmos.	☐
Autonomic symptoms	Dry mouth, flushing, pallor, tendency to sweat, giddiness, tension headache, raising of hair.	☐			

ADDITIONAL COMMENTS: _____

_____

_____ Investigator's signature: _____

...from the Hexal gallery

Sandoz SA (Pty) Ltd., 2 Steel Road, Spartan, Kempton Park, 1619.
Tel: (011) 929-9000. Fax: (011) 929-9296. Co. Reg. No.: 1990/001979/07

CNS

Reference: 1. Comprehensive Textbook of Psychiatry/VI. 1995 Maryland Williams & Wilkins

HEXAL

ANNEXURE 5

REQUEST TO PARTICIPATE IN A RESEARCH STUDY

I am currently conducting a research study with the University of Zululand, department of Psychology, for my PhD studies. This study is aimed at developing an intervention program that may benefit child victims of sexual abuse especially female adolescents.

Participants therefore are those female adolescent children who have been sexually abused. Their participation will help to provide an instrument that may help them and other victims of sexual abuse.

Their participation is voluntary and all ethical considerations will be respected and adhered to and these include but not limited to:

- Confidentiality
- Respect their participation and withdrawal at any time they wish to.
- Refrain from using their name anywhere in the research document
- Their participation or withdrawal will not influence any rendering of service to them from the Health Care Centre.

In order for your child to take part in the study your permission is kindly requested. Should you be able to give permission to the participation of your child please sign below:

I _____ the Parent/Guardian (please circle what is appropriate) of _____ give my unconditional permission to have her take part in this study.

Signed on the: _____ at 02/02/2008.

Witness: _____ Date: 02/02/2008.

(Researcher)

Witness: _____ Date: 02/02/2008.

(Health Care Centre Nursing Sister)