What is child sexual abuse?

Child sexual abuse is defined broadly in the Children's Act and includes sexual molestation, sexually assaulting a child, using a child for sexual gratification, deliberately exposing a child to sexual activity or pornography, or the commercial sexual exploitation of a child.[1]

The Sexual Offences Amendment Act distinguishes between consensual and non-consensual sexual offences:

- Non-consensual sexual acts constitute rape or sexual assault regardless of the age of the persons involved.
- Children can only legally consent to sex from the age of 16.
- Consensual sex acts between an adult and child aged 12 – 15 years; or between a child aged 16 – 17 years and another child who is more than two years younger, is defined as statutory rape, if there is penetration, or statutory sexual assault if there is no penetration.
- Children younger than 12 years are too young to consent to sex; therefore, any sexual act with a young child constitutes either rape or sexual assault.

Why is it important to understand child sexual abuse in context?

Efforts to prevent and treat child sexual abuse, need to recognise that the broader patterns of violence in South Africa and current limitations of prevention and therapeutic programmes culminate in unrecognised and untreated childhood trauma.

Violence is pervasive

Violence permeates the daily, lived experience of large segments of South African society, and poor communities are particularly plagued by high levels of violent crime. Living in violent environments may provoke chronic fear, anxiety and insecurity. Many children are exposed to violence in their homes, schools or communities – either as victims of violence or as innocent bystanders.

A significant proportion of violence against children takes place in the home, where the offender is someone the child knows and trusts. Child maltreatment is widespread, with 42% of children reporting some form of maltreatment (sexual, physical and emotional abuse, and neglect).[7] Intimate partner violence is also pervasive – with more than one-third (38%) of women living in Gauteng experiencing physical and/or sexual intimate partner violence with even higher levels of emotional/economic abuse (46%).[8]

Social and cultural norms can increase risk

Societal and cultural norms further contribute to children's vulnerability. CSA has a distinctly gendered nature, as dominant patriarchal constructions legitimise male control over women and children, and promote notions of male sexual entitlement. Children are socialised not to question authority, allowing sexual violence to occur without much resistance from children and women, and impunity by men. In this context, disclosure is particularly difficult for children and when they do disclose, they are often met with disbelief, blame or silencing to protect known offenders.

Poor access to critical services

While government policies show strong commitment to protect children from harm, few sexually abused children are able to access appropriate therapeutic support.[9] Anecdotal reports indicate that therapeutic services for abused children are insufficient to meet the demand, and children are placed on lengthy waiting lists to access services. Most services are concentrated in urban centres, and service provider responses are not necessarily appropriate to facilitate healing and recovery for traumatised children.[10]

The police services and criminal justice system are similarly under-resourced, and offenders often remain at large or court cases are protracted, resulting in secondary trauma and ongoing risk for the affected child and family.

Case study 1: The offender is present in the family's environment

Pretty (not her real name) is an 18-year-old female participant in the Isibindi-Childline residential therapeutic programme. When she was 17 she was raped by an older man living in the area. She lives with four siblings and their caregiver. The family struggles to make ends meet.

Pretty absconds from school and often stays away from home for a few days without informing her caregiver. She has shared with the CYCW her desire to leave her community as she fears seeing the offender again. Pretty's caregiver reports that she is also very careful when she walks alone. She has on occasion met the offender, who intimidates her. The offender has apparently raped other girls in the community and was arrested, but has been repeatedly released on bail.

The caregiver shares more about the impact: *"…even the neighbours knew that she was infected by the virus and how she got it… We've became the laughing stock of the neighbourhood… the children at school would call her bad names because of her seemingly deteriorating health. She was a very beautiful and healthy child before the incident…"*

About the Children's Institute

The Children's Institute is a leader in child policy research and advocacy in South Africa. The Institute is based at the University of Cape Town. The CI aims to contribute to policies, laws and interventions that promote equality and improve the conditions of all children in South Africa, through research, advocacy, education and technical support.

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How can services to traumatised children and families be strengthened?

Effective services and support is essential to ensure that children and families benefit from available services, and to enable better mental health outcomes for children and families in South Africa.

1. Ensure safe environments for sexually abused children

Continuous exposure to risk or harm is detrimental to the psychological well-being of traumatised children and undermines therapeutic support. In many cases, perpetrators are not held accountable and continue to pose a threat to children's safety. This is due to failures of the criminal justice system, which often lead to secondary victimisation and undermine children's right to protection. These constraints are further outlined in the Children's Institute's Child Abuse Tracking Study report (forthcoming).

2. Review sexual abuse treatment and intervention responses

Traumatised children are entitled to access quality therapeutic support in a timely manner. The multi-faceted and continuous nature of trauma is a key factor affecting child outcomes and the efficacy of the therapeutic programmes included in the evaluation. It is therefore critical to review the design, content and impact of existing therapeutic programmes in South Africa. Therapeutic approaches showing effectiveness in addressing complex and continuous trauma in other LMIC contexts should be tested in South Africa.

3. Build capacity to respond to continuous and complex trauma

Many social service practitioners providing services to children were not adequately skilled to respond to trauma and CSA. There is an urgent need to improve practitioners' capacity to identify and respond appropriately to continuous, complex and inter-generational trauma. It is also essential to clarify specific roles and responsibilities for different cadres of social service and mental health practitioners to ensure effective collaboration to improve outcomes for children. The use of para-professionals to deliver mental health programmes is showing potential in low-income settings[17], and should be explored in the South African context to address resource constraints.

Social workers acknowledged a need for further training and support to develop competence in CSA case management. A key question for consideration is whether social workers should develop a specialisation in child protection and child trauma.

4. Implement community- and family-based responses

Trauma is often inter-generational, and in several cases family or community members were involved in the sexual abuse. It is therefore necessary to adopt a social-ecological approach and design therapeutic programmes that include caregivers, families and communities. This includes the provision of community-based mental health services for children and families, and greater investment in parenting programmes which are showing promise in improving parenting practices and reducing risky behaviours in children and caregivers in LMIC settings.[18] The scale-up of parenting programmes in both homes and other settings should be explored, and should be sensitive to children's care arrangements in the South African context.

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Research brief

Helping children recover from trauma

Strengthening therapeutic responses for victims of Child Sexual Abuse in the South African context

Violence against children is widespread, and the impact of violence on children extends beyond the physical injuries to have lasting psychosocial consequences.

The Children's Act outlines government's obligation to prevent violence against children, protect child victims from further harm, and support and treat children who have experienced violence to restore them to physical and psychological well-being. Early access to therapeutic support for traumatised children helps mitigate negative effects such as violence and risky behaviour, depression, anxiety and suicide, and ensure better outcomes in the long term. But little is known about current models of therapeutic care for child sexual abuse (CSA) victims in South Africa, or their efficacy in facilitating psychological recovery. This research brief examines a local, innovative, therapeutic programme for sexually abused children living in rural areas, and considers what kind of therapeutic responses are appropriate in low- and middle-income countries (LMIC).

What is the extent of child sexual abuse in South Africa?

Child sexual abuse is a pervasive problem affecting the health, social and psychological well-being of children globally, cutting across the divides of race and class, and affecting large numbers of children in South Africa. The first national prevalence study estimates that between 17 and 35%, or one in every three young people had experienced some form of sexual violation during their lives,[2] and that girls and boys are equally at risk of exploitation and non-contact abuse;[3] however, girls are more at risk of sexual assault.

What is the impact of child sexual abuse?

Sexual abuse has lasting impacts on the child

CSA has a profound impact on the child from immediate physical trauma to long-term psychological distress. Psychological responses associated with CSA include emotional distress, depression, anxiety – including post-traumatic stress disorder (PTSD), self-harming behaviours, substance abuse, eating disorders and personality disorders.[4] CSA is also associated with an increase in behavioural problems, poor school performance, sexual risk-taking behaviour, and often leads to re-victimisation of the child.[5] In boys, it may increase the risk of violent and anti-social behaviour.[6]

Child sexual abuse impacts on parents and caregivers

CSA has intergenerational consequences. Exposure to trauma can result in caregivers feeling overwhelmed, depressed and anxious, which can compromise their capacity to parent effectively. Caregivers' ability to provide nurturing care and support is also influenced by their own experiences of trauma, such as child maltreatment and intimate partner violence. And their child's trauma is likely to trigger a re-experience of their own trauma.

Between 17 and 35% of young South Africans have experienced some form of sexual abuse

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PROGRAMME TO SUPPORT PRO-POOR POLICY DEVELOPMENT

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A short-term residential programme for children in rural areas

Programme design

In response to these challenges, the National Association of Child and Youth Care Workers (NACCW) and Childline South Africa in collaboration with Department of Social Development (DSD), have developed a residential therapeutic programme for sexually abused children. The programme is part of the Isibindi "Circles of Courage" model, which aims to develop a workforce of community-based child and youth care workers (CYCWs) to respond to the overwhelming needs of vulnerable children. CYCWs generally make a valuable contribution to supporting and responding to the daily needs of vulnerable children and their families, using a developmental approach.

Local departments of social development provide standard psychosocial support services that usually include home visits, counselling and psycho-educational support for children and caregivers. Anecdotal reports indicate that public-sector therapeutic services for abused children are insufficient to meet the demand and are not easily accessible in rural areas.

In response, the short-term intensive, residential programme was introduced in 2007 to provide therapeutic intervention and follow-up support to sexually abused children. The partnership's multi-disciplinary model combines the counselling and therapeutic skills of the Childline therapists with the social support and life-space care offered by the Isibindi CYCWs. The CYCWs are present before, during and after the residential programme, providing responsive child care and support, and modelling and mentoring to caregivers. The CYCW provides a vital element of continuity for the child and caregiver. CYCWs also liaise with DSD social workers and other services to ensure the child's safety and appropriate care, and re-integration into home and community life.

The seven-day programme provides a unique approach to treatment, including individual and group-based sessions, drawing on play-therapy modalities, debriefing, the person-centred approach and psycho-educational therapy. A 12-week aftercare programme is implemented by CYCWs to reinforce the therapeutic gains made with the child and caregiver during the programme.

The residential therapeutic programmes in KwaZulu-Natal and the Eastern Cape were recently evaluated. A sample of children participating in the programme (the intervention group) and those receiving usual, state-provided care (the comparison group) were followed over a 10-month period. The emerging findings identify some positive outcomes, as well as challenges and constraints of the programme.

What do we know about therapeutic programmes in the South African setting?

Current therapeutic practices for victims of CSA are variable in South Africa: Where children have access to specialised therapeutic services, little is known about the programme theory, or programme effectiveness. Standard child protection services offer general psychosocial support services that may include home visits, counselling and psycho-educational support.[13] However, little information is available on the nature and extent of services delivered in response to need, or their effectiveness to reduce trauma symptoms and child behaviour problems.

A key challenge is the severe shortage of social service and mental health professionals. For example, the largely rural Eastern Cape province is unable to reach the national norm of one social worker to 3,000 clients. In the 2013/14 financial year, only 1,663 social workers were employed through public funds in the Eastern Cape: slightly over 1,400 were employed by the Department and the remainder by NGOs.[14] Many of these professionals serve a range of vulnerable groups including children, and perform multiple functions. Further research is therefore needed to determine what constitutes effective mental health responses to CSA in low-resource settings, where social services and mental health services are thinly stretched and where large numbers of children face multiple adversities.

Positive outcomes

Children in the Isibindi programme reported abuse earlier than those children in the comparison group. This finding may point to the positive and supportive relationship and value that the CYCW brings within the life space of the child. Many intervention group children and caregivers reported feeling supported and heard, and felt that their well-being had improved, during and after the residential programme.

In addition, primary school children (7 – 12-years-old) showed improvements in behavioural outcomes that may be due to the programme. But the same improvements were not evident for adolescents receiving the programme. These findings suggest that the residential programme with the after-care component may be better suited for younger children, who are more dependent on family support, than for adolescents. The valuable role of the CYCW and their ability to build meaningful relationships within the family environment is key.

Critical challenges and constraints

While children showed some behavioural improvement, no significant change in post-traumatic stress and depressive symptoms was found that can be attributed to the intervention. This suggests that the intervention, in its current design, is not sufficient to improve mental health outcomes. Several factors contributed to these outcomes for children participating in the evaluation.

Children exposed to continuous risk and multiple traumas

Exposure to violence and trauma remained high within homes, schools and communities. Violence was not confined to a single traumatic incident. Instead, children were exposed to multiple traumas and persistent fear and anxiety were common emotions expressed by children. The continued presence of the perpetrator further compromised the safety of children in their homes and communities, and ongoing exposure to the perpetrator is a major deterrent to psychological recovery.

In other words, children and their families experienced multiple incidents and forms of trauma, with ongoing exposure to trauma and "real" danger where perpetrators remained in the child's environment. This lends itself to the concept of *continuous traumatic stress* rather than PTSD (where the emphasis is on traumas that occurred in the past and where no real threat of present danger exists).[15]

Abuse by trusted persons is damaging

In South Africa, children are most at risk of sexual abuse by a person they know within their home or the home of someone trusted. School settings are particularly risky with girls at risk of violation by teachers due to their positon of power. When perpetrators are known to the child, it exacerbates the trauma and is likely to prolong the healing process. These forms of sexual abuse may lead to *complex trauma*[16] when the interpersonal trauma is recurrent and perpetrated by a caregiver. The impacts are often severe and multifaceted.

Shifting perceptions of child trauma and redesigning therapeutic responses accordingly to better meet the needs of traumatised children and their families is therefore critical.

Case study 2: Intergenerational effects undermines caregiver support

Ayanda (not her real name) is a 13-year-old girl, participating in the Isibindi-Childline residential therapeutic programme. She was sexually abused at a young age. Ayanda's mother is in a violent relationship with an older man who supports her financially. Her mother also abuses alcohol and drugs as a means of numbing her pain.

Ayanda and her mother appear to have a difficult relationship, and the mother blames Ayanda for the abuse. Subsequently, her mother discloses her own sexual abuse as a child and describes the difficult relationship between herself and her grandmother, who blamed and beat her after disclosure.

Her mother shares her current state of mind: *"Eish, it is hard… (pause) Sometimes I think of killing my children because of what happened to me. Now it is happening to Ayanda… (crying). I did not plan to have her. I lost both my parents and I was then abused. Now they (her children) are abused as well. What did I do to the Lord? (silence, crying)… I even think about killing myself…"*

Intergenerational trauma and compromised parenting

Intergenerational trauma was evident, with caregivers experiencing re-traumatisation when their child was abused. The parent-child relationship was adversely affected in these cases, compromising the caregiver's ability to provide nurturing care and support. There was a higher turnover of caregivers over time in the intervention group, indicating that changes in care arrangements are common in particularly vulnerable families in South Africa. Low levels of caregiver nurturing and support, and several cases of harsh parenting were evident.

These factors, such as exposure to trauma, may undermine caregivers' ability to be emotionally available and support the child effectively, compromising the child's recovery process. This creates a vicious cycle, where caregivers' responses are inappropriate and may even be harmful, further intensifying trauma responses in the child and worsening the psychological and behavioural consequences in the child.

Inadequate social service response to trauma

Social service practitioners (in both the intervention and comparison group) provided limited therapeutic care and support to traumatised children and families. Social workers and CYCWs indicated several common challenges that hampered their delivery of quality services. These included:

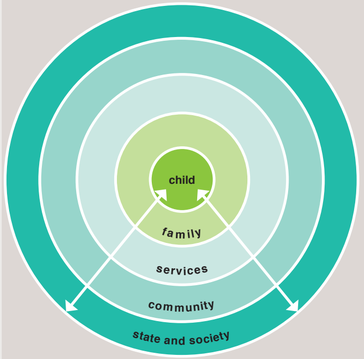
- Limited knowledge and experience of how trauma effects child development, and how best to support traumatised children.
- Poor supervision and guidance, poor case management and poor development of child protection plans were key concerns for social workers in the comparison group.
- Personal trauma – CYCWs particularly noted how their own experiences of trauma affected their capacity to support traumatised children.

These findings support other evidence that social service practitioners need capacity development and support to enable appropriate and timely service responses to meet children's social and therapeutic needs.

A key challenge is the severe shortage of social service and mental health professionals

What models could work in low-resource settings?

Dominant Western models generally provide therapeutic support on an individual basis for sustained periods, depending on the individual needs of the client. These models follow evidence-based treatment protocols after a comprehensive assessment of trauma impact, and where cases are complex, multi-disciplinary teams of professionals collaborate to offer structured services. To date mental health interventions in LMIC have followed Westernised approaches, yet have shown limited efficacy, raising questions about the feasibility and appropriateness of these models in low-resource settings. There are, however, a few innovative approaches being tested in LMIC.



Violence is prevalent in children's homes and communities, therefore services need to extend beyond therapeutic support for the child and address the complex interplay of risk and protective factors in the family and wider community.

A task-shifting approach using para-professionals is showing potential

The Zambian case

The use of trauma-focused cognitive behaviour therapy (TF-CBT) to address trauma symptoms in HIV-affected children and their families was tested in a low-resourced setting in Zambia.[11] The intervention was delivered over 11 weeks: Sessions included a trained lay counsellor working with the child, caregiver, and the family together, following a task-shifting model. The treatment model showed symptom reduction for trauma and stress-related symptoms, although the follow-up period was only one month. Nevertheless, the use of TF-CBT is an evidence-based practice worth considering for the treatment of traumatised children in the South African setting. A task-shifting approach using para-professionals with limited formal mental health training is also proving to be effective in evidence-based interventions implemented in other settings in LMIC. [12]

Case study 3: Recurrent trauma

Sandiswa (not her real name) is a 15-year-old girl receiving child protection services from the local Department of Social Development. She disclosed sexual abuse by her uncle at the age of seven years, although the case was only reported to the police nine years later. The uncle was arrested and imprisoned. Sandiswa has significant learning problems as she is in the fourth grade.

Prior to the follow-up interview, Sandiswa gave birth to a baby. She initially indicated that her boyfriend was the father, but later disclosed that the father was her caregiver's boyfriend. Sandiswa believed that she was in a consensual relationship with her caregiver's boyfriend. This news caused great turmoil within the family and a social worker was called in to intervene. Subsequently, Sandiswa and her baby were removed from the caregiver's home and temporarily placed in the care of the maternal grandmother. A case of statutory rape was opened against the caregiver's boyfriend. After these events, Sandiswa was referred to a psychologist for therapeutic support.