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DECLARATION

I declare that *A Journey to healing: Exploring clients' experience of services in a clinic dealing with child sexual abuse* is my own work and that all the sources cited have been indicated and acknowledged by means of complete references.

CATHERINE NICOLAIDES

_____ day of _____ 2012

ACKNOWLEDGEMENTS

I can do all things through Christ who strengthens me.

PHILIPPIANS 4:13

To those who have guided me on this journey:

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ABSTRACT

This research served to explore the client's experiences of services in a clinic dealing with child sexual abuse and related issues. Addressing the issue of therapeutic interventions in clinics dealing with sexual abuse victims and their caregivers – looking at how the clients experience these treatments and services and how they have made 'meaning' of these on their journey to healing, is something that needs to be explored in greater depth. The aim therefore of this research is to gain insight into understanding the clients' experiences of the therapeutic services. This study will be of specific importance due to the fact that to date no literature has been identified particularly from a South African perspective on how clients make meaning of these therapeutic services at such an agency, making it difficult to compare the findings. Much of the research identified has focused on the interventions in cases of sexual abuse and have thus typically been one-sided in approach, subsequently ignoring the voices of the child victims of sexual abuse and the non-offending caregivers. The client's experience of the therapeutic interventions will be reviewed within the context of the Teddy Bear Clinic. An interpretive phenomenological approach was used to focus on the understanding of the participant's subjective experiences and meanings of the therapeutic interventions. The research utilised a qualitative framework which privileged first-person descriptions as the primary sources of subjective meaning.

Two case studies in an organisation in Johannesburg were investigated. The case studies comprised the child victim of abuse and the non-offending care-givers that participated with the child in the therapeutic process. Therefore two children and two caregivers were included in each case study. The recruitment of participants was, to a large extent, dependent on the assistance offered by the counsellors at the Teddy Bear Clinic. Therapeutic counsellors at the Teddy Bear Clinic identified a list of clients that had just terminated or were exiting the therapeutic process and not in need of further interventions, and fit the criteria as stipulated by the researcher.

Data was gathered through semi-structured interviews of each participant. The analysis was carried out using thematic analysis which revealed the meaning of their experiences. The following themes emerged through the analysis and were used to explore the client's experience and assignment of meaning to the therapeutic services: (1) background influences. Various sub-themes emerged from this theme: (1a) shame, guilt and fear of punishment (1b) developmental stages, (1c) relationship with stepmother, (1d) legal issues, (1e) marital and parenting difficulties, (1f) outside support structures and (1g) previous relationship with counsellor. The second main theme included; (2) the voices of children and caregivers on the therapeutic experience. The various sub-themes that emerged from this were; (2a) the therapeutic relationship, (2b) the role of the therapist, (2c) being kept in the loop – feedback and introductions, (2d) clarification and support for the caregiver (2e) giving back – peer support groups, and (2f) teddy bears and the therapeutic process. Thus the main findings that emerged from this study involves 'background

influences', that clients present to the medico-legal clinic for rape or sexual abuse. However, background influences have a profound effect on the therapeutic relationship and the experience of the clinic's services, as seen in the interrelationships that are interwoven with the presenting problem. A second finding emerging from the voices of the children and caregivers foresee that services could be improved in the following ways. Providing feedback and clarification of the therapeutic process; receiving an introductory brochure which highlights what services the clinic provides and resources available to the clients. Caregiver and peer support groups was another very important element that the clients expressed as a necessary and vital part of the services and interventions that the clinic could offer the clients. Finally, a positive element to the therapeutic interventions which helped the children cope and eased the caregivers anxiety were found to be the handing out of teddy bears which is symbolic of the Teddy Bear Clinic and should continue to be a cornerstone of the therapeutic intervention and introduction to the clinic.

The study, while achieving its goal of providing some understanding of how the clients experience these interventions at this medico-legal clinic, highlights the need for further exploration of how clients experience these services and interventions at other clinics dealing with sexual abuse, particularly from a South African perspective.

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CHAPTER ONE: OVERVIEW AND RATIONALE

1.1 Introduction: Framing the Research

1.1.1 Statement of the problem

Addressing the issue of therapeutic interventions in clinics dealing with sexual abuse and related issues with regard to victims and their caregivers – how the clients experience these treatments and services and how they have made ‘meaning’ of these on their journey to healing, needs to be explored in greater depth. To date no qualitative research has been identified in the literature on how clients experience these therapeutic interventions, particularly within the South African context. Interventions have typically been one-sided, ignoring the voices of the child victims of sexual abuse and the non-offending caregivers. Thus, the motivation for this study is that research has not afforded the client and caregiver a voice in how these therapeutic interventions are experienced and how the clients have made ‘meaning’ of these.

The present study, which is influenced by the researcher’s volunteer work experience within a medico-legal organization dealing with child sexual abuse and related issues, aims to give a voice to the clients’ subjective experiences on their journey to healing. Service evaluation will be reviewed from the perspective of the Teddy Bear Clinic and is the focus of this study.

Childhood sexual abuse is a complex life experience, not a diagnosis or a disorder. An array of sexual activities is covered by the expression ‘child sexual abuse’.

Childhood sexual abuse has been defined as oral-genital, genital and anal touch with a child, non-touching abuse such as voyeurism, sexual penetration, prostitution, pornography, and acts where a child is forced, coerced, or encouraged to perform these acts upon an adult (Substance Abuse and Mental Health Services Administration [SAMHSA], 2000).

The different types of sexual abuse ensure that there will be a range of outcomes. Some of these outcomes include psychiatric disorders, dysfunctional behaviours, neurobiological dysregulation, depression, post-traumatic stress disorder and dysthymia. In addition, the age and gender of

the child, the age and gender of the perpetrator, and the number, frequency and duration of the abuse experience all appear to influence outcomes. Thus sexually abused children make up a very heterogeneous group with many degrees of abuse. Child sexual abuse occurs across all socio-economic and ethnic groups (Finkelhor, 1995). Non-offending caregivers also experience significant costs and losses as a result of disclosures of sexual abuse by their children. Research indicates that caregivers go through stages of grief: denial, anger, bargaining, depression and sadness (Healthyplace.com. (2008) Grief stages when a parent learns of a child's abuse). Other significant costs and losses experienced by non-offending parents are in the areas of relationships, finance, job performance, and living situation (Massat & Lundy, 1998).

As can be seen, the complex array of criteria that one has to consider in the experience of child sexual abuse is vast. There are many evidence-based treatment models and intervention strategies in place to deal with child sexual abuse, but for the most part these represent small-scale, clinic based studies with limited follow-up. None report on how the clients experience these interventions and treatments. It is from this standpoint and the researcher's work experience in a clinic dealing with sexual abuse and related matters, that the researcher will explore how victims of child sexual abuse and their non-offending caregivers experience these interventions, and on how they have made 'meaning' of these on their journey to healing.

This study is a qualitative research study, using an interpretive phenomenological approach to explore the participants' experiences of services within a medico-legal clinic. The subjective meaning of experience tends to be minimized, diminished or accorded less significance in research (Goldner, Penn, Sheinberg, Walker, 1990). A study in terms of a phenomenological interpretive framework can shed light on the client's experience within the therapeutic intervention process. This study places emphasis on the emotional and performance elements of people's experiences. Interpretative data methods will be used; namely interviews which enable the researcher to carry out an in-depth examination of the data through thematic analysis. The themes discovered will serve to enhance the reader's understanding of the client's experience of therapeutic interventions.

1.1.2 Contextualizing the Research

When allegations of child sexual abuse are made, two types of assessments are typically conducted: forensic and clinical assessments (Swenson & Hanson, 1998; Spies, 2006). A forensic assessment includes a determination of whether the child was sexually abused. Specifics of the incident, current safety of the child, risk of further maltreatment (i.e. whether the alleged offender still resides in the home and/or current placement of the child), and the ability of the non-offending caregiver to be supportive and protective of the child are evaluated. Forensic assessments may be conducted by law enforcement officials, child protection workers and/or mental health professionals. A clinical assessment involves a comprehensive evaluation of the impact of the sexual abuse on the child and family. Obtaining a clear picture of the child and family's symptom pattern aids in individual treatment planning and provides a means of evaluating treatment effectiveness. The treatment of sexually abused children and their families is complex. Treatment plans need to be individualized on the basis of the clinical presentation of the child and the context in which treatment will proceed. Multi-modal treatment (individual, family, group, pharmacological) and different levels of care may be required for different children or for the same child at different times (Saywitz, Mannarino, Berliner & Cohen, 2000).

Working with caregivers in one form or another is essential. Including parents as part of the treatment interventions enables them to manage externalizing symptoms with behavioural strategies, to monitor children's symptoms, to develop strategies for preventing revictimisation and to normalise family functioning. Involvement in treatment helps parents control their own distress and reframe their own attributional errors so that they can support the child's coping (Saywitz et al., 2000). The purpose therefore of the clinical assessment is to obtain an accurate picture of the child and family's current functioning. A comprehensive multi-faceted assessment includes multiple methods (e.g. direct observation, interviews, self-report questionnaires), and multiple respondent information (i.e. teachers, day-care workers, previous therapists, child protection workers) (Saywitz et al., 2000). Intervention in sexual abuse cases and related issues has several important purposes, among them to treat the psychological consequences of abuse experiences and to promote healthy development, thereby reducing the risk of long-term negative outcomes. It also assesses risk to children and assesses the safety of the environment to establish a

safe family environment, and to identify sexual offenders and hold them accountable and/or protect the community (Berliner, 2003).

In many instances the painful experience of sexual abuse is not the act itself, but often the uncaring attitude displayed by the confidantes and professionals themselves which can add to the child's pain (Pollock & Farmer, 2005). Therefore, an important aspect to consider in the therapy with child sexual abuse victims is the relationship between therapist and client. Safeguarding the therapeutic boundaries is an integral and particularly important component in the development and maintenance of the therapeutic relationship (Briere, 1992). Therefore, therapeutic boundaries with sexual abuse victims are very important in the therapeutic context. Child abuse victims have learned to deny their own feelings in relationships in order to please others (Briere, 1996; Walker, 1992). Participation in therapy can make clients particularly vulnerable because of the power differential in the relationship and because of previous experiences with those in power positions. The maintenance of therapeutic boundaries especially at the beginning of therapy is extremely important as it ensures that a professional relationship is maintained (Briere, 1996). The lack of literature based on the experiences of the sexually abused child and their caregivers who have been recipients of these therapeutic interventions emphasises a need for further exploration.

This study aims to explore the clients' experience of services in a medico-legal clinic, and hopes to elicit and describe the experiences of the participants in a way that will evoke an awareness of the issues that come up. This will add knowledge of the clients' experiences and lend a deeper understanding to how the interventions impacted the individuals on their journey to healing. A profile of the Teddy Bear Clinic follows so that the reader has a clear understanding of the context of this organisation.

1.1.2.1 The Teddy Bear Clinic

The medico-legal clinic seeks to balance the demands of child protection, legal prosecution and children's physical and mental health by offering coordinated services to victims. The goals of the programme model are to improve efficiency of investigation and prevent further trauma to victims and their families.

The Teddy Bear Clinic for Abused children (TTBC) originated in 1989 in response to an urgent need for medical examination of sexually abused children, a need that arose as more and more children were being empowered to disclose details of their abuse. The Teddy Bear Clinic is an outpatient facility of the Johannesburg Hospital and the Department of Pediatrics. It offers a variety of support services to sexually abused children, their families and the child protection system. The clinic has established branches at the courts in Soweto, Johannesburg, Krugersdorp and Randfontein.

The Functions of the clinic include:

- Medical: the clinic provides forensic medical examinations to assess physical evidence of sexual abuse in suspected child abuse cases by trained doctors. However, often there is no medical evidence of abuse, but this in no way rules out the possibility that abuse has occurred. The clinic provides:
- Therapeutic: counselling and support for abused children and their families.
- Court Support: 'kidz court' support, which prepares the child for the legal proceedings and the legal process.
- Safe and Friendly Environment (S.A.F.E.) for children's project: a psycho-educational programme which educates children on abuse.
- Research, training and development.
- Education department: work in collaboration with the education department to create awareness of abuse, disclosure and reporting.
- Re-evaluation and changing certain psychological models to suit context and culture.
- Proper rehabilitation facilities, diversion programmes and skills programmes.
- Public awareness of what constitutes abuse and the legal and moral responsibility to report it (www.ttbc.ac.org).

Among the objectives of the clinic are to:

- Embrace democratic principles.

- Provide expert medico-legal examinations, necessary treatment assessment, case management and support to survivors of child abuse within the criminal justice system.
- Recognise the emotional impact of the abuse on the child and family, community and society.
- Provide support and healing.

To provide support through the criminal justice process by providing:

- Forensic medical examinations
- Forensic assessments
- Counselling
- Psychological testing
- A youth sexual offenders programme: providing early intervention for children who abuse other children (www.ttbc.org.za.Teddy Bear Clinic, 2010).

The work experience of the researcher as an intake counsellor, was to ensure informed consent forms had been signed and to obtain the clients' psycho-social history from the non-offending caregiver and inform him/her of confidentiality within the clinic and what this means. The intake counsellor records the detailed and precise reasons why the caregiver brought the child to the clinic and then prepares the child for the medical examination. After the examination, the clinic team meet in case conference to discuss medical results, psycho-social history and make the necessary referrals. The intake counsellor is responsible for case management until the file is closed.

1.1.3 Purpose of the research

The research aims are to explore how clients experience the services offered by the Teddy Bear Clinic, and what they felt was beneficial or not about these services on their journey to healing from abuse. Thus the aims are to provide an in-depth description of the subjective experiences of the clients who had received therapeutic interventions at the clinic. Attending to subjective experiences, the research attempts to understand the emotional and performative dimensions of these experiences.

In line with this approach the interpretation of the researcher is also acknowledged as part of the research understanding. This qualitative study which is based on an interpretive phenomenological approach will hopefully contribute to our knowledge of how participants experience the services within the Teddy Bear Clinic. The themes that are evoked will contribute to the rich and detailed descriptions, of the experiences of the clients thereby 'providing them a platform for their voices to be heard. With regards to services within this agency the descriptions from the findings will provide direction for attending to the clinic's services according to the themes that come up.

1.1.4 Goals of the research

- To obtain in depth understanding and the meanings of the experiences of the sexually abused victims and caregivers who were also recipients of the services.
- To gain insight into the negative and positive experiences of the process.
- To gain insight into what clients felt could have been handled differently from their perspective.
- To provide research findings that will contribute to a larger scale evaluation of the services provided by the Teddy Bear Clinic.

1.2 Conclusion

This study consists of five interdependent chapters which all work together to bring the study together as a whole.

Chapter One: Introduces the reader to the necessary background information with regard to sexual abuse and related occurrences, as this will enhance his/her experience throughout the succeeding chapters. A basic groundwork provides the reader with insight into the necessity for the study. However, this would not be possible in the absence of a thorough study of the available literature.

Chapter Two: Aims to explore current literature with regard to sexual abuse. This exploration will include the influence of various contexts that relate to the factors that contribute to sexual abuse and the effects thereof. Sexual abuse is not a phenomenon that presents itself in isolation. Rather, a variety of factors have been

noted to impact this phenomenon, and it should be taken into consideration that all these aspects are inextricably intertwined. Finally, the literature will offset service evaluation and the complexities of assessment, showing the need for hearing the voices of the clients who experience these interventions, as to whether they were beneficial or not. These experiences will be discussed within a phenomenological interpretive approach, providing the reader with a thorough understanding of the client's experiences of these interventions in rich and in-depth detail.

Chapter Three: Follows with a description of the methodology chosen for this specific study, which enables the researcher to conduct the study and analyse the data sufficiently. In order to ensure that all the processes conducted are ethical in nature, ethical considerations will be discussed in detail.

Chapter Four: Aims to provide the reader with an in-depth understanding of the participants' experiences, utilising thematic analysis. The personal accounts of the participants will be explored by means of emerging themes, enabling the researcher to identify existent as well as novel themes. The complexity of these themes will be discussed in an attempt to personalise the experiences of the participants.

Chapter Five: Aspires to present the reader with a clear and concise discussion as portrayed by the findings of the study. The discussion proceeds within a framework of current literature, identifying themes that concur with existent studies. Novel themes as well as those that are presented in opposition with literature will add to the richness of the study. Applicable recommendations are made in an attempt to guide future research.

In the following chapter the literature on the topic is reviewed.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

In this chapter, child sexual abuse and related issues, along with a description of associating factors, will be defined and discussed with a view to enrich the comprehension of child sexual abuse and interventions received by the victims and their caregivers. The evaluation of sexual abuse and related issues is often complicated. Non-specific behavioural changes are the presenting symptoms, prompting an evaluation and leading the caregiver, teacher or social worker to consider possible sexual abuse (Spies, 2006). Societal influences, cultural factors, family dynamics, and developmental problems are all inextricably intertwined, and deserve adequate attention when attempting to gain a thorough understanding of child sexual abuse (Spies, 2006). Service evaluation will also be evaluated from a review of the literature and is to be the focus of this study whereby the researcher will attempt to gain a rich, in-depth understanding of how victims and their caregivers experience these therapeutic interventions on their journey to healing.

2.2 Definitions of sexual abuse

There are many forms of child abuse, namely: physical abuse; emotional abuse; neglect; and sexual abuse. For the purpose of this study the researcher will focus on sexual abuse and elaborate further on this definition. De Panfilis and Salus (1992), point out that sexual abuse includes a wide range of behaviours such as fondling of a child's genitals, intercourse, rape, sodomy, exhibitionism, and commercial exploitation through prostitution or the production of pornographic materials. To be considered sexual abuse, these acts have to be committed by a person responsible for the care of the child, e.g. a parent, babysitter, day-care provider or other person responsible for the child. Sexual assault is usually defined as sexual acts committed by a person who is not responsible for the care of the child. Loffel (1996) claims that sexual abuse is a major problem in our society:

Child abuse and child sexual abuses are social constructs which reflect constantly shifting and developing attitudes toward children and their development. The definitions currently in use tend to be broad and inclusive of a wide range of actions and omissions considered detrimental to children. Even though these broad

definitions have problems, they are preferred as they draw attention to a range of factors which can interfere with the development of children (pg. 4).

Loffel (1996, p.4) defines sexual abuse as any act occurring between two people who are at different developmental stages which are for the sexual gratification of the person at the more advanced developmental stage.' Faller (1993) notes, that such an act may or may not involve physical contact. Studies recognise that one definition of child abuse cannot serve all purposes. For example, a definition that would increase awareness differs from that of service provision and the definition for legal purposes differs from that of research (World Health Organisation, 1999).

A definition of sexual abuse for the purpose of this study is: sexual abuse of children refers to sexual behaviour between a child and an adult or between two children when one of them is significantly older or uses coercion (Smith, 2002). Forms of child sexual abuse include asking or pressuring a child to engage in sexual activities (regardless of outcome), indecent exposure of genitals to a child, engaging the child in the display of pornographic material, actual sexual contact with a child, physical contact with the child's genitals, viewing of child's genitalia without physical contact or using a child to produce pornographic material (Faller, 1993).

Newton (2001) concludes that sexual abuse may be described operationally as:

- Any contact or interaction between a child and an adult or someone in a position of authority and control over the child.
- The perpetrators, by design or neglect, abdicate or violate societal responsibilities they have towards the child in favour of their own sexual gratification.
- The contact involves sexual stimulation of a child or the sexual stimulation and gratification of an adult.
- The child, although involved, is not developmentally mature enough to understand the meaning of the sexual interaction.
- Although involved, the child cannot give informed consent.
- Sexual abuse is not specific to any developmental phase of a child.

2.2.1 Legal definitions

The broad operational definitions given above, need to be placed within the context of the law. This process is complicated, as there are a number of laws governing the abuse and neglect of children (Pienaar, 1996). The definitions of abuse used in official government studies as noted are based on laws, and these government definitions are needed for more than just research purposes. They are also needed for purposes like determining whether or not suspected abuse should be reported, investigated and substantiated, which can then lead to action by social service agencies or the courts. A child is defined as any boy or girl who is under the age of 16. According to Pienaar (1996) crimes against children can be divided into two main groups:

1. Common Law Crimes are prohibited actions that are declared a crime by a particular act. Rape is a common law offence in South Africa. A male having unlawful and intentional sexual intercourse with a female without her consent. Intercourse with a girl under 12 years of age is considered statutory rape.

2. Sexual abuse crimes

Incest: The unlawful and intentional sexual intercourse between male and female persons who are prohibited from marrying each other because they are related within the prohibited degrees of consanguinity, affinity or adoptive relationship, e.g. siblings, parents, step-parents and step-siblings.

Indecent assault: The unlawful and intentional assault of another with the object of committing an indecent act, for example fondling, masturbation and oral sex.

Abduction: The unlawful and intentional removal of an unmarried minor from the control of his or her parents or guardian in order to enable someone to marry him/her to have sexual intercourse with him/her.

Public indecency: The unlawful, intentional public performance of an act which tends to expose private parts.

Crimen Injuria: The unlawful and intentional violation of the dignity or privacy of another. It is used in the prosecution of certain instances, one of them being sexual abuse offences against children.

2.2.2 The Criminal Law (Sexual Offences and Related Matters Amendment, Act 32 of 2007)

Sexual abuse crimes fit under specific stipulations as set out by the Sexual Offences Act.

Section 3 of the Sexual Offences Act deals with the issues of rape.

Sections 15 and 16 of the Sexual Offences Act deal with sexual activities with children, this section prohibits carnal intercourse or immoral or indecent acts with youths, below a certain age. Children under the age of sixteen cannot engage in consensual sexual activities. The law states that children cannot consent to these acts. The children participants in this study are under the age of sixteen and in accordance with the Criminal Law (Sexual Offences and Related Matters Amendment Act, No 32 of 2007) any sexual activities between children within this specific age group are regarded as offences.

Section 54 deals with the mandatory obligation of adults to report any unlawful sexual contact with children.

Section 23 deals with any sexual offences against mentally disabled children.

2.3 Prevalence of child sexual abuse in South Africa

The incidence of child sexual abuse is a social problem throughout the world. A number of surveys have pointed to the significance of the incidence of child abuse (Sholevar, 2003; Sher, 2002; Thompson-Cooper, 2001). Due to the enormity of the problem, coupled with challenging social dynamics, more abuse is becoming apparent. A survey of child sexual abuse in ten countries by Finkelhor (1994) indicates that child sexual abuse is an international problem. The evidence from Finkelhor (1994) indicates the wide extent and the gravity of this abuse. Studies

show that girls experience higher rates of sexual violence than boys; although in the recent past the number of boys is increasing. According to UNICEF's state of the World's children report 2011, evidence from eleven developing countries show a broad spread of experience of sexual or physical violence against females aged fifteen to nineteen, making this a cause for grave concern (AMPCAN, 2012). Finkelhor and Jones (2004) at the Crimes Against Children Research Centre have been pursuing the trends in child maltreatment statistics and have found a national decline in the incidence of both physical and sexual abuse. These researchers noted that the factors that may be influencing the reporting and investigation of cases are prevention efforts, detention and treatment of perpetrators, all of which may be decreasing the number of children who are harmed by sexual abuse. Statistics on the prevalence of child sexual abuse emanate primarily from retrospective accounts by adults and can be roughly divided into studies using clinical and those using nonclinical samples. According to Putnam (2003) the prevalence figures vary widely due to a function of the selection and response rates, the definition uses, and the method (e.g. self-report versus structured interviews), and thus may in fact not be impacting the actual amount of child sexual abuse cases.

With regard to the context, South Africa has one of the highest rates of sexual crime in the world, with the rape ratio for female children in the twelve to seventeen year old category (471 per 100 000 female population) being more than double the international ratio (Collings & Wiles, 2006). Jewkes, Levin, Mbananga and Bradshaw (2002) point out that in the period 1996 to 1998, rape was the most common reported crime against children, with evidence to suggest that the incidence of child rape is on the increase. The Child protection Units of the South African Police Service in 1996 identified 19 805 cases of crimes against children younger than eighteen. Of these, 7968 were child sexual abuse, rape 7363, sodomy 480 and 125 incest (Pienaar, 1996). Larsen, Chapman and Armstrong (1998) found among clinical samples of 99 children who had been sexually abused in Kwazulu-Natal, South Africa, that 60.4% experienced rape or attempted rape, 77.7% anal penetration, 4.4% rape and anal penetration, 3.3% rape and battering, 16.5% sexual molestation while 7.7% were uncertain. The categories of these most often overlap with other offences.

These statistics do not include those cases reported to and investigated by welfare agencies. Statistics on rates of child abuse and neglect are controversial; all statistics on the incidence and prevalence of child abuse and neglect are disputed by some expert. The reason for this is that complex and subtle scientific issues are involved in studies that generate these statistics. For example, there are important controversies about how to define abuse and neglect and this is also true for official government studies and any other research studies (Hopper, 2012). Therefore these statistics represent just a small proportion of cases and the problem is much bigger than the data indicate. Given the nature and scope of child sexual abuse, it is unclear how accurate these findings are for sexual abuse, especially in South Africa. The increase in abuse from the South African context could be because of higher environmental stressors faced by children and families in our society (Jewkes et al., 2002).

In recent years, there has been an improvement in awareness and a question that is always asked, is whether there is an increase in the actual instances of abuse, or if there is an increase in the reported cases. It seems that both are happening, but regardless of this debate professionals are faced with an ever increasing demand for knowledge and skills to keep up with the increasing demand for intervention in child abuse cases. In many cases assessment and treatment techniques have been under close examination and professionals have been challenged to demonstrate the effectiveness of their work (Swenson & Hanson, 1998). Unfortunately little is known about the effectiveness of the many agencies and programmes nationwide which utilize interventions to treat sexual abuse.

2.4 The impact of child sexual abuse

All sexual abuse is harmful in one way or another, and the trauma does not end when the abuse stops. Studies indicate that early sexual involvement with adults exposes the child to premature sexualisation and may have long-term effects; however healing is possible (Bass & Davis, 2008; Maltz, 2003; Briere, 1996; Finkelhor, 1995). According to Veltcamp and Miller (1994) the greater the level of aggression in the abuse, the more traumatic the effects will be; child sexual abuse is an expression of power and authority, the adult has all the power and authority over

the child and uses these to meet his own needs. A child internalises experiences of self in relation to others during childhood. The internalisation process can be defined as the integration and processing of the meaning of outer experiences as they relate to the self. Therefore a child who has been sexually abused will internalize information that will influence that child's behaviour and impact the child's life in various ways (Wieland, 1997).

- **Loss and powerlessness:** The most pervasive consequences of the trauma of sexual abuse are the overwhelming sense of loss felt by the child (Doyle, 1994). The developmental stage during which the abuse occurs is significant as it will be in this stage that the child may be adversely affected. Also when the child is never sure when the next abuse event will take place the child lives in a continuous state of fear and anxiety. When children are sexually abused, their natural sexual capacity is taken; they never have the capacity to explore their own sexuality naturally. Sexually abused children lose their personal power, their right to say no and their sense of control in the world (Bass & Davis, 2008).
- **Low self-esteem:** Sexually abused children experience low self-esteem as a constant feeling of worthlessness and often struggle with feelings of inadequacy and self-doubt. Victims internalize these feelings as being 'damaged' in some way, which may lead to behaviour reflecting helplessness and aggression (Crosson-Tower, 2005; Maltz & Holman, 1987).
- **Anger and hostility:** Anger can be viewed as a natural response to abuse. Children do not often express their anger to the perpetrator; many repress this anger leading to depression and self-destruction. Others are prone to angry outbursts, aggression and cause conflict in many situations without being provoked (Sher, 2002). Their anger is often indistinct and at times inappropriate in the context of the situation. Hall and Loyd (1993) indicate that this anger is a set of complex responses to the abusive experience, the abuser and other potentially protective adults, especially the non-abusive parent, who failed to protect them or allowed the abuse to take place.
- **Guilt and shame:** These children often experience intense feelings of guilt or shame as they feel that they were responsible for the abuse. All this guilt and shame may characterise the surface of deep emotional pain. The pain,

accompanied by guilt and shame has long-term effects and no time limit regarding its existence. Because of this, the victim may deny or even forget that the abuse took place, which explains why so many adult survivors are unaware of the fact that they were abused as children (Bass & Davis, 2008).

Avoidance of intimacy: Emotional or physical intimacy or closeness reminds the sexually abused child of the context of the abuse. Often socialization causes them too much discomfort and they avoid social interaction even into adulthood because of their feelings of being different or spoiled (Bass & Davis, 2008; Maltz, 2003; Sher, 2002).

- Pseudo-maturity or development regression: Child sexual abuse victims may find it difficult to relate to their own peer groups, and demonstrate developmental stages, that are incongruent with their age. Walker (1992) states that sexually abused children's capacity for play and spontaneity is reduced; these children have been forced into sexual acts that they were not ready for and this emotional demand of taking on adult responsibilities makes it impossible for them to relate to their peers. The opposite could also occur, whereby the child victim regresses in development, e.g. bedwetting, fear of sleeping alone or thumb-sucking (Crosson-Tower, 2005; Brand & Alexander, 2003).
- Inappropriate sexual behaviour: Many sexually abused children have difficulty differentiating between affection and sex (Bass & Davis, 2008; Maltz, 2003; Hall & Lloyd, 1993). The impact of sexual abuse is seen when children show behaviour such as sexual preoccupation and repetitive sexual behaviour, for example, masturbation or compulsive sexual play. To add to this, these children show developmentally inappropriate knowledge and interest in sexual activities (Spies, 2006).
- Self-destructive behaviour and dissociation: Frequent sexual activity, self-mutilation, suicide attempts and dysfunctional eating patterns can be defined as deliberately self-destructive behaviour. People feel guilty for the sexual abuse and try to punish themselves through self-harming activities. Gilmartin (1994); Swartz and Cohn (1996) note that up to two-thirds of women with eating disorders have experienced sexual abuse. Dissociation occurs in

sexually abused children when the trauma of the sexual abuse cannot be prevented, escaped or endured (Maltz, 2003; Sher, 2002).

- Stealing and lying: When children are told never to talk about the abuse, or do not want people to know what is really going on at home or elsewhere, they become very good at lying. Some children, who experience low self-worth, will tell lies about themselves as a means of creating a sense of self-worth, while others steal insignificant objects to create a sense of security. Some of these children were bribed with material items by their abusers to continue with the abuse. Bass and Davis (2008) state that stealing is a way of challenging authority, and this becomes an attempt to take back what was stolen from them.

Professionals working with these children also need to be aware of the impact that abuse has on the development of the child.

2.5 The developmental aspects associated with child sexual abuse

No conclusive pattern of symptoms appears to be associated with sexual abuse. Thus, symptoms differ across age groups, and data suggest that the response to sexual abuse may be gradual and/or delayed. Before any treatment programme with abused children and their families is considered, comprehensive assessments are necessary. Depending on the developmental stage of the child, the effects of abuse differ. Smith, Cowie and Blades (2003) define development as 'the process by which an organism grows and changes through its life span' (p.5). They further state that the most dramatic developmental changes in humans occur in infancy and childhood. Smith et al. (2003) indicate that the developmental phase is related to age and the following distinctive phases are identified:

- Infancy – birth to 18 months
- Toddlerhood – 18 months to 3 years
- Primary School years (middle childhood) 6 to 12 years
- Adolescence – 13 to 19 years

Reynolds (1992) and Garbarino and Stott (1989) emphasize that the developmental phases are interlinked and dependent upon each other. Garbarino and Stott (1989)

claim, that the major task of childhood is maintaining the capacity for continued development. Gary (2003) notes that, developmental tasks need to be mastered in order for children to move on to the next developmental phase. Developmental tasks are defined as problems that arise at certain periods in an individual's life: infancy, toddlerhood, middle childhood and adolescence and if these are mastered then the child can move on to the next developmental phase. Erikson hypothesized that successful achievement of these tasks leads to happiness and a greater probability of success with future tasks (Berk, 2006). Failure leads to unhappiness, societal disapproval and difficulty with later developmental tasks (Gary, 2003).

Children who are sexually abused undergo major interruptions in their development and in their view of themselves and the world. This results in significant emotional and behavioural changes which indicate their attempts to cope with these events (Fouche & Yssel, 2006). Sexually abused children have often experienced a world of secrecy, silence and isolation. Once children have disclosed the abuse or after it has been discovered by accident, the path towards healing can be difficult (Fouche & Yssel, 2006). Within the therapeutic intervention process, the normal emotional development of children has to be taken into account. In the therapeutic context the therapist must be aware of the progressive developmental milestones. In order to facilitate a healing process, it is vital that professionals have knowledge of these while working within a therapeutic context (Fouche & Yssel, 2006). Children who experience trauma often regress (revert to earlier behaviour patterns). It is possible to provide the child with opportunities to master these aspects to be able to once again function at an age appropriate level (Fouche & Yssel, 2006).

It is essential to understand that children have certain emotional developmental tasks which they need to address for optimal growth and functioning. Meyer and Van Ede (1998) note Erikson's eight stages of the child's lifespan. Each stage is characterised by a crisis, that is, a situation in which the individual must orient himself according to two opposing poles. Meyer and Van Ede (1998) note that each stage is brought about by a specific way of interacting between the individual and society. The solution of each crisis lies in the fusion of the two poles. This results in a new life situation from which the two opposing poles of the next stage arise (Fouche & Yssel, 2006). Within the therapeutic intervention process, the normal emotional development of children needs to be taken into account. Children who experience

trauma may regress to earlier behaviour patterns. If the therapist is aware of the developmental milestones, it is possible to provide opportunities to the child to master these aspects so that they are able to function at an age-appropriate level. For the purposes of this paper only five of the eight stages will be discussed as the participants in this study are in the late childhood to early adolescent stage.

1. Basic trust versus mistrust (synthesis: hope)

In this stage, typically the first year of the child's life, children must develop a feeling of basic trust, at the same time they must overcome a feeling of basic mistrust. The quality of the child's relationship with the mother is of prime importance in the development of trust. As children interact with the environment they become more active as their motor and physical development proceed. A healthy synthesis between basic trust and mistrust permits children to deal with new situations. Within the therapeutic situation, establishing an emotionally safe relationship in a non-threatening environment provides the child with an opportunity to experience trust and to handle issues around mistrust and anxiety caused by the trauma the child experienced (Fouche & Yssel, 2006).

2. Autonomy versus shame and guilt (synthesis: willpower)

In this stage which relates to the second year of life, the child has the task of developing a sense of autonomy (independence) and at the same time, overcoming feelings of shame and doubt. Physical maturation enables children to have greater autonomy and to follow their own will. This independence and freedom however also brings them into contact with rules which, in turn leads to possible failure and the associated shame and doubting of their own abilities. The conflict between freedom and discipline is essential for development of the child's moral conscience (Meyer & Van Ede, 1998). In therapy it is important to give children opportunities to make limited choices so that they are able to experience a sense of control and independence, and to gain awareness of the effects of their actions. When children make choices and experience the effects of their choices, it is easier for them to take responsibility for their behaviour (Fouche & Yssel, 2006).

3. Initiative versus guilt (synthesis: purpose)

This stage lasts between approximately the ages of three and six years old. It is characterised by the task of learning initiative, while at the same time overcoming feelings of guilt. Children's greater freedom of movement and autonomy enable them to act more independently than before, so that they can now begin to explore their world with a new sense of purpose. Their contact with society can bring them into situations in which they act against society's rules and intrude on other people's domain, which may leave them feeling guilty. Balanced development leads to the synthesis of purpose, which is characterised by the ability to strive for goals purposefully and confidently, without feeling guilty and without taking initiative that could be upsetting to others (Meyer & Van Ede, 1998). By establishing boundaries in the therapeutic situation and providing fun creative media to work with, the therapist encourages the child to take initiative and experience purpose. The therapist helps the child to work with the set boundaries and experience guilt free fun (Fouche & Yssel, 2006).

4. Industry versus inferiority (synthesis: competence)

This stage starts from the age of six and lasts until the beginning of puberty, covering the primary school years. The tendencies of the previous stage are continued with renewed vigour or strength. Children aim to master certain skills required for adult life and society helps them by providing schooling. Achieving success becomes important to the child. The opportunity to achieve success is an important part of education, since it helps the child to avoid feelings of inadequacy (Meyer & Van Ede, 1998). In the therapeutic setting, children can be exposed to activities that build on their sense of self-worth and pride. Providing age-appropriate media challenges them to achieve mastery and success and to compete against themselves, thereby strengthening the value they attach to their own abilities (Fouche & Yssel, 2006).

5. Identity versus role confusion (synthesis: reliability)

The adolescent's identity crisis is the central problem of this stage. Adolescents have the task of acquiring a sense of identity. This sense consists of three components, identified by the questions:

- Who am I?

- To which group(s) do I belong?
- What do I wish to achieve (Fouche & Yssel, 2006, p. 244)

The internal cause of this crisis lies in the physical and psychological changes that begin with puberty. In order to solve their identity crisis, adolescents try out various possibilities. The ideal solution to the identity crisis lies in the synthesis of the two poles of 'identity' and 'identity or role confusion', which Erikson calls reliability (Meyer & Van Ede, 1998). This means that individuals should be sure of their identity, but should also know and accept that there are other identity choices which they could have made (Meyer & Van Ede, 1998). Adolescents who have experienced trauma may have great difficulty establishing a realistic and healthy identity, and may be troubled by negative internalisations. Wieland (1997) differentiates between internalisation resulting from all abuse experiences, where the abuse experience consists of intrusions, self-related threats and acts of abuse and non-protection; sexual abuse by someone close, where the abuse experience of entanglements and distorted family boundaries lead to these internalisations; and extreme sexual abuse, the message perceived by the child during the abuse experience were, that sexualised behaviour brings attention and sensual pleasure or negative experience, distorted messages and a distortion of reality. Internalisations such as 'I am damaged', 'I am powerless', 'I am bad/guilty', 'I am responsible' and 'I feel chaotic' are common among victims of sexual abuse (Fouche & Yssel, 2006, p.244). It is essential that all aspects of a child's emotional development be taken into consideration to provide the child with opportunities to handle his or her trauma and to understand the way he or she experienced the abuse (Fouche & Yssel, 2006). The complexity in the attempt to understand and intervene in child sexual abuse from the therapeutic context is difficult. An understanding of how the child reacts to the sexual abuse is imperative so that the professional dealing with the child may be cautious and tentative as to how he/she attempts these interventions based on the child's age and development.

2.6 Cognitive distortions – children's reaction to sexual abuse

People make significant assumptions about themselves, others, the environment, and the future based on childhood learning. Because the experience of children who

are abused is often negative, these assumptions and self-perceptions reflect an overestimation of the degree of danger or adversity in the world. Chronic self-perceptions of helplessness and hopelessness, impaired trust, self-blame, and low self-esteem make up some of these cognitive distortions. These cognitive alterations often continue into adolescence and adulthood (Elliot & Briere, 1994).

Children under the age of eight years

Children in this age group cannot reason hypothetically, so do not understand 'intention' and will not necessarily identify the perpetrator as 'bad'. As these children have concrete thinking skills they can easily be manipulated through curiosity or fear and are thus susceptible to the belief that the perpetrator may have supernatural powers (Berk, 2003). According to Piaget, children between four and eight years old define right and wrong based on obedience to rules and authority (Newman & Newman, 2003). They are therefore more likely not to intentionally disclose the abuse verbally or be prompted to lie about whether the abuse occurred or not, because of their obedience to the authority of the perpetrator. On a cognitive level children in this age group are still largely egocentric and may have strong feelings of guilt, as they usually reason that they were responsible for what happened or that they should have been able to stop or prevent the abuse from happening (Fouche & Yssel, 2006).

Children between eight and twelve years of age

According to Piaget, children in this age group are becoming less egocentric and begin to realise that other people may have different perspectives from their own (Newman & Newman, 2003). They are able to understand their own sexual behaviour and that the behaviour of the perpetrator is wrong. The child still takes everything personally, and may think that he or she is not good by being engaged in 'bad' behaviour (Berk, 2003). The child in this age group may be swayed into staying silent because of what the consequences could mean for him- or herself or for the perpetrator (Keuhnle, 1996). Sexually abused children may realise the wrongfulness of sexual exploitation but follow the instruction of adults to please them or to avoid punishment (Keuhnle, 1996). If the child is with the perpetrator, or if the perpetrator threatens the child, the child most likely will not disclose the abuse. If the child's

relationship with a non-offending parent is supportive, the likelihood of disclosure is better (Fouche & Yssel, 2006).

Children between the ages of twelve and fifteen

Children in this age group develop their ability for abstract thinking and are able to hypothesise (Berk, 2006). The sexually abused child is now able to begin to understand the concept of abuse and may think about the consequence of the sexual abuse for him- or herself, as well as for the perpetrator. Children in this age group may be capable of independently instigating a false allegation for reasons of attention, revenge or to escape an emotionally or physically abusive family situation (Fouche & Yssel, 2006). In the therapeutic context it is vital that professionals have a clear understanding of how sexual abuse may affect the child's cognitions, however looking at the child's family and environmental context is also essential in helping the child and family cope with the trauma.

2.7 Family dynamics of abuse

Within the family system, children learn how to cope in their personal world and within this system children learn who they are, what to expect from the world, how to satisfy their needs and take cognisance of intergenerational boundaries between family members as well as understanding what the roles are within this system (Spies, 2006). The child becomes aware of boundaries within the family that need to be respected and as such the individual background histories of the marital couple influences their family life (Becvar & Becvar, 2000).

Abusive parents tend to be apathetic, incompetent, irresponsible or emotionally withdrawn and are critical or uncommunicative (Wolfe, 1999). The family atmosphere tends to be chaotic with people moving in and out. It has been stated that mothers who were neglected as children are depressed or feel hopeless (Wolfe, 1999). Fathers are usually not involved in their children's lives; many have abandoned their children or do not give enough financial or emotional support (Dubowitz, 1999). Abusive families tend to be socially isolated, lack social support which makes it harder for these families to cope with difficult circumstances (Dubowitz, 1999). Sexual abuse in the family context is a display of the perpetrator's personality

pathology. The behaviour of the perpetrator wreaks psychological havoc not only in the victim, but also in the family unit. Sholevar (2003) notes that sexually abusive behaviour may develop when coping mechanisms of the family can no longer survive family conflicts, thereby violating the integrity of the system. The family continues with its malfunctioning relationships and erratic communication patterns which are further burdened by the abusive behaviour (Becvar & Becvar, 2000). The following issues are relevant when working with these families. Crosson-Tower (2005); Soothill and Francis (2002); Sheinberg and Fraenkel (2001); Lew (1990); Bass and Davis (2008) and Maltz and Holman (1987) have found:

- Parents who abuse their children have themselves been reared within families where abuse occurred. Parents may have been victims of abuse on a physical, emotional or sexual level; the child accepts the abuse as a binding family rule and may displace it later to their own family.
- Parents who commit sexual abuse tend to come from families that functioned in isolation and were characterised by poor parent-child relationships. Little love and affection and knowledge regarding sex, and sexual relationships was extended to children and sex was often viewed as taboo.
- Abuse of power – this is the primary treatment issue in incest. Aggressive rather than caring use of power by the strong against the weak is a family norm. The offender and others in the family will continue abusing their power until they are stopped. At the same time being unaware of the underlying feelings of powerlessness in those concerned, as these are likely to have contributed to the abuse. This is also exacerbated by the intervention of outside authorities if not dealt with in the appropriate way (SgROI, 1982).
- Fear of authority – because the family's own power is unequal they perceive external authority as threatening, they tend to deal with their own fears by avoidance of contact, or anxiety, suspicion, evasiveness, denial or hostility (SgROI, 1982).
- Isolation – the family often withdraws from broader society, and the more powerful members block any efforts of those who are weaker to form coalitions outside of the family. The offender sets himself up as the only outlet of communication with outsiders (SgROI, 1982).

- Lack of empathy – family members are typically insensitive and unresponsive to the needs and feelings of others. This is due to a persistent pattern of denial and lack of ability to communicate (Sgroi, 1982). Sexual abuse as a ‘family secret’ is a factor of incestuous relationships. Family members experience a high degree of emotional pressure to maintain the family secret and each member may also have a very special reason for maintaining the family in its current form (Crosson-Tower, 2005; Crisma, Bascelli, Paci & Romito, 2004; Spies, 1997). While family dynamics are relevant in the understanding of how sexual abuse impacts the child and the family as a whole, an overview of the wider environmental factors are also important to gain a holistic view of the dynamics within and around these families.

2.8 Ecological view

The American Psychologist, Urie Bronfenbrenner, expressed frustration with the traditional ways of understanding child development. Most developmental theories focused on the immediate settings of the individual and they ignored wider societal effects on how children develop (Smith, Cowie & Blades, 2003). Smith et al. (2003) confirm that Bronfenbrenner’s emphasis is on the importance of studying ‘development-in-context’. The main drive of Bronfenbrenner’s ecological model is the adaptation between the individual and his or her environment. Colton, Sanders and Williams (2001) note that the individual plays a dynamic role in influencing the environment, which in turn wields an influence on the individual which takes into account previous influence, and so on. It is a combined cycle of influence between the changing individual and the changing environment (Berk, 2006).

A disparate number of abused children come from large, poor or single parent families, which tend to be under stress and have trouble meeting children’s needs. They live in crowded conditions, in high risk neighbourhoods and may move frequently (Dubowitz, 1999; Sedlak & Broadhurst, 1996). It is important to understand children from their micro system, for example, home, parents and siblings, school, teachers and peers. Meso system for example, the inter-relational among two or more settings in which the person actively participates. Exo-system, these are events that occur that affect or are affected by what happens in the setting containing the developing person for example, parents’ work environments which

may affect the parents' behaviour at home, therefore influence the quality of parental care. Macro-system, this is the organisation of social institutions in the society or sub-culture in which the individual functions, for example, laws, regulations and rules and belief systems (Bronfenbrenner & Morris, 1988). All of the above are important for the context of therapeutic intervention.

The developmental assessment of children should therefore incorporate factors of the macro-system as they have a significant impact on the child in his or her situation (Berk, 2006). Colton et al. (2005) summarise the practice value of this 'A consideration of the macro-system for an individual child is important because it calls upon the practitioner to locate his or her practice in the widest possible political and social contexts, and can serve as a secure basis for developing anti-discriminatory practice' (p.51). While acknowledging the family and environmental contexts influencing sexual abuse, it is also important to consider the cultural factors that play a role in abuse.

2.9 Cultural factors

Due to South Africa's complex history of colonisation, industrialisation and marginalisation, the conditions for interpersonal and criminal violence of multiple kinds has been allowed to thrive (Beinart, 1992). Social upheaval and instability, through conflict and war also contribute to increases in child abuse and neglect (World Health Organisation, 2010). One of the difficulties in defining child abuse in the African context is that cultural attitudes toward abuse vary a great deal, for example, the importance of male domination and female subservience is emphasized as being the root of child sexual abuse. Also socio-economic factors and political instability have had drastic effects on the position of the child in African society (Lachman, 1996). Background conditions beyond the control of families or caretakers, such as poverty, inaccessible healthcare, inadequate nutrition, and the unavailability of education can be contributing factors to child abuse. Therefore an awareness of cultural factors must remain high as they influence all aspects of abuse from the occurrence and definition, through to its treatment and successful prevention and also to increasing public awareness. Definitions must therefore consider the cultural environment in which sexual abuse occurs.

In the years since democratisation in South Africa, violence of various types has become a particular area of individual and collective anxiety, political interest and media coverage in the country. Therefore sexual violence in particular has become a highly politicised issue (Posel, 2005).

According to McKendrick and Hoffman (1990) a key factor in child abuse in South Africa has been the breakdown in family structure. They state that when a nation becomes severely polluted by violence, the corrosive effects perforate all layers of society, damaging national institutions, community life, and family living, so that no individual within the society remains untouched by its insidious presence (McKendrick & Hoffman, 1990). In recent years, the seriousness of the HIV/AIDS epidemic and a growing interest in masculinities has also been brought to the fore with regard to sexual violence against girls and women (Hunter, 2005; Morrell, 2001). Studies by Jewkes, Penn-Kekana, Levin, Ratsaka and Schrieber (2001); Sideris (2004); Wood and Jewkes, (2001) on youth sexuality, focus on violence experienced by many South African girls and women within their sexual relationships. In some African cultures violence prevails through notions of legitimacy Nordstrom and Robben (1995). Harvey and Gow (1994) point out that violence in sexual relationships is due to social breakdown. However, violence can also be seen as an aspect of everyday living, a form of communication that arranges lives and subjectivities and that it is productive of relationships, especially in relation to gender. In particular violence assists in the organisation of inequality within sexual relationships; it is used as a means to live out certain gender positioning that privileges some men by associating them with particular forms of power (Nordstrom & Robben, 1995; Harvey & Gow, 1994).

Bourdieu (2001) described hierarchy in some African cultures as a form of 'symbolic' violence, that is, in many settings, cultural assumptions, for example, that men should control and protect 'their' women and be the main decision makers within households, which creates stresses that lead to violence (Sideris, 2004). As can be seen, multiple factors have to be considered in the therapeutic context. Professionals dealing with child sexual abuse are faced with complex interactions that have to be weaved into the therapeutic process. Understanding the subjective experiences of the child and caregiver will give insight into how they have perceived these services and the meanings they have attached to them. It therefore goes without saying, how

important it is to consider the role of the non-offending caregiver in the therapeutic process and how they can contribute to the child's recovery. The non-offending caregiver is often left devastated and dealing with his/her own losses that come with the child's disclosure.

2.10 The role of the caregiver

Children's reactions to and recovery from sexual abuse vary, depending on the nature of the sexual abuse. The way the caregiver reacts to the child when the child discloses is important to his or her recovery (Mash & Wolfe, 2005). An unsupportive or over-reactive parental response results in greater trauma (Doyle, 1994). Hooper and Koprowska (2004) and Roberts (2004) indicate that there is evidence that a history of child abuse can affect the mother-child relationship. Caregivers to the sexually abused child need to be aware of the need for skills training and experience to cope with the demands and challenges that face these children (Geldard & Geldard, 2002). According to Pollock and Farmer (2005) most caregivers have little or no knowledge of sexual abuse to support the child. Caregivers indicate that they have a need to nurture these children; to help them; to try to change their destructive behaviour because of the abuse; and to speak out against the person who abused their child. However, when they responded to these needs, they found that children became aggressive and/or withdrew from the family system (Geldard & Geldard, 2002).

When caregivers' express hostility towards the abuser, it may contribute to the victim's already low sense of self-worth, as they tend to feel responsible for the abuse. If the abuser was a parent who was also the only one to attend to their emotional needs despite the abuse, the child may still regard that parent as special in his or her life and may even prefer to return to that relationship (Pollock & Farmer, 2005). These researchers also suggest that it is of greater importance to the sexually abused child if caregivers understand the life and survival skills of a sexually abused child. Thereby minimizing the mistakes caregivers carelessly make during their interactions with their children, which helps to contribute to their healing.

2.11 How the caregiver experiences the child's sexual abuse disclosure

How caregivers deal with the disclosure of their child's sexual abuse is significant. However, not much literature has focused on what the caregiver experiences when he/she finds out that their child has been sexually abused. This is particularly relevant especially since it is the non-offending caregivers who will be helping the child recover from abuse. If the caregiver has not been taken care of and given support and a space to grieve for his/her child then he/she will be ineffective in helping their child deal with the trauma. When a parent/caregiver learns of their child's sexual abuse a series of grief stages follow. The progressive stages of grief apply to non-offending parents or family members. These stages of grief are observed in most parents who are dealing with the sexual abuse of their child (www.childrenscenter.com. Ways to support a caregiver when their child has been the victim of sexual abuse, n.d.). However, it is necessary to note here that not all non-offending parents/caregivers experience these stages of grief in this order.

- Denial – the initial reaction for most parents is some denial of the abuse. Over time as the facts of the abuse unfold and conversations occur, the caregiver usually experiences
- Anger – this anger could be directed towards the perpetrator, child or parental self. The caregiver realises the enormity of the 'losses' that they will face as a secondary victim of their child's sexual abuse. Non-offending parents appear to suffer more losses than the child. For example, if the perpetrator is a step-parent or live-in-partner, the relationship is likely to end and as a result the non-offending parent faces loss of companionship and finances.
- Bargaining – as greater acceptance of the sexual abuse occurs, they accept the fact that the sexual abuse occurred but begin to struggle with the level of impact the sexual abuse had on the child and family and their need for recovery. Bargaining occurs when parents look and hope for a fast and less painful recovery. By doing this they may try to minimise the impact of the sexual abuse and unintentionally give the child the message that it will all go away.
- Depression or sadness – as parents move through this stage, they come to realise the extent of changes and degree of impact on the child and family

resulting from the sexual abuse. In this stage they acknowledge that recovery could be a long-term process and that the sexual abuse is not going to go away. Non-offending parents appear to experience the effects of this stage to a greater degree than parents of extra familial sexual abuse.

- Acceptance - parents who enter this stage are accepting of the facts and the impact of the sexual abuse. Recovery and healing processes are no longer feared by the parents. If parents can reach this final stage, they can acknowledge that their child and family can survive the losses, changes and recovery process (www.childrenscenter.com. Ways to support a caregiver when their child has been the victim of sexual abuse, n.d.). A view of service evaluation will be described according to the literature available.

2.12 Service evaluation

Exploring the experiences of victims and their caregivers who were recipients of therapeutic interventions at a medico-legal clinic and how these were perceived by them, is what will be considered and explored further in this study as a vast number of experimental studies investigates statistics, interventions and treatments dealing with child sexual abuse victims, but none on how the clients experience these interventions.

With regard to research on service evaluation the study methods of investigating child sexual abuse have been criticised (Walton, 2001; Wells, 1994). Critics claim excessive and complex legal proceedings harm, rather than help child victims (Jenson, Jacobson, Unrau & Robinson, 1996). Such proceedings are often regarded as additional abuse which includes multiple interviews and medical examinations with victims, removal of children from their living environments, and extended criminal court proceedings (Jenson et al. 1996). The most painful experience of sexual abuse is not always the act itself, but often the uncaring attitude displayed by the confidantes, which may include professionals. This attitude contributes to feelings of guilt and denial, and the child might change an earlier story about the sexual abuse as a result (Spies, 2006). This emphasises the importance of studies that explore the clients' experience of services within these agencies.

It was established that inter-agency coordination is one way of reducing the trauma experienced by children during the investigation process (Wells, 1994). Multi-disciplinary teams are based on the assumption that a coordinated effort among various professionals is a more effective method of investigating child sexual abuse (Steele, 1992). In incidents of child sexual abuse, the interview with the child is typically the most valuable part of the medical evaluation. Elicited history is frequently the only diagnostic information that is uncovered. Additionally, if it is done in a sensitive and knowledgeable manner, the history-taking process can be the first step in the healing process for the child who is sexually traumatized. The professionals of the inter-disciplinary team need to demonstrate an open, non-judgemental, and caring attitude toward the child; the willingness to support the child must be demonstrated as the evaluation unfolds (Giardino & Giardino, 2008). Interviewing the caregiver/s is also crucial in this process. Understanding the dynamics within the family of the child that has been sexually abused allows for greater understanding and therefore a more holistic approach to the therapeutic intervention process. Families are central to child safety and well-being, and therefore need support. All families benefit from information, guidance and help in connecting with resources. For families with inadequate resources, or those facing additional challenges, the need for support and assistance is even greater (Pollock & Farmer, 2005). The effectiveness of both family support and family preservation services depends on the skills and ability of service providers, to work closely with families from different cultures and ethnic backgrounds. Support interventions need to provide optimal care and assistance to families with children. Practitioners must strive to be culturally competent ensuring that services are respectful of and compassionate with the cultural strengths and needs of the family (Goode, Haywood, Wells & Rhee, 2009). If parents are provided with services and support they are empowered to change their lives and help their children heal from the abuse.

Authorities agree that more than three-fourths of physical examinations of children suspected of having been sexually abused are without conclusive findings of sexual abuse. Heger, Ticson, Velasquez & Bernier (2002) conducted a comprehensive study that included a review of physical examinations performed on 2,384 children evaluated for suspected child sexual abuse. They found that overall, only 4% of the children had abnormal findings. It was concluded then, by Heger et al. (2002) that in

cases of suspected child sexual abuse physical findings in the examinations are not likely to be discovered. There are many reasons for this, firstly, the child and family typically know the perpetrators, and physical force is often not a major component as in adult sexual assaults. Secondly, disclosure of the abuse frequently is delayed, and evaluations may be performed weeks to months after the abusive contact. Finally, mucous membranes that compose the genital structures heal rapidly and, often, without obvious scarring (Giardino & Giardino, 2008). The general approach to the physical examination follows the standard examination techniques for a comprehensive physical examination (that is, complete head-to-toe approach). In this way children receive the messages that their whole bodies and health are important (Giardino & Giardino, 2008). Due to the complexity of evaluation and the skill required to accurately identify and interpret examination findings, it is of utmost importance then to standardize training of medical professionals who carry out suspected child sexual abuse evaluations, thereby avoiding on-going trauma or re-examination of the already traumatized child (Giardino & Giardino, 2008).

Much progress has been made in understanding the prevalence and impact of sexual abuse on children. Treatment programmes are continually changing and evolving and many are still in their developmental stages (Mash & Wolfe, 2005). Owing to the dynamics involved in child sexual abuse, the different types of trauma imposed on the child, the nature of the offence and the resilience of the child, it is thus understandable that having a comprehensive treatment programme is almost impossible (Fouche & Yssel, 2006). More often than not, an eclectic approach, using a combination of different strategies, is applied in the therapeutic context. Treatment of the child sexual abuse victim can be divided into three groups, namely crisis intervention, short-term intervention and long-term intervention.

Crisis intervention strategies are implemented immediately after the trauma while short-term intervention consists of therapy sessions spread over three to six months. Long-term intervention consists of therapy sessions spread over a longer period, usually more than six months. The Teddy Bear Clinic Deals with all three intervention strategies, namely medical examinations required for medico-legal purposes, after a child discloses sexual abuse or because of accidental disclosure of allegations of sexual abuse. They also offer short-term and long-term therapy for the child,

counselling for caregivers, offender treatment programmes and court support services.

It is apparent that there is a serious lack of service evaluation in the mental health sector, while such evaluation should be an integral part of practice. Programme planning today frequently focuses on patients' immediate requirements and ignores future service needs. Aspects of continuity of care, the client's access to needed programmes over time as well as their ability to establish therapeutic relationships with caregivers, have been jeopardised (Bachrach, 1996). It is therefore vital to evaluate services and programme evaluations (Neigher & Shulberg, 1982). It is also necessary to have meaningful and valid measures by which to assess service outcome. What this study will attempt is to bring to light the themes relevant to the research topic. Thus, exploring how the clients have made meaning of these experiences of the therapeutic services received at the Teddy Bear Clinic, to gain an in-depth understanding of whether the services in this agency lived up to the client's expectations. To do this, the researcher has to consider the voice of the victim and the non-offending caregiver regarding how they perceive these interventions.

2.13 Understanding the sexually abused child from the child's perspective (giving a voice to the sexually abused child)

Article 12 in the UN Convention on the Rights of the Child states that children have the right to say what they think should happen when adults are making decisions that affect them and that their opinions should be taken into account. James and James (1999) confirm that listening to the voices of children has become a stated demand both within and outside the academic world. Children are persons and not property; children have the right to be heard, to privacy and to be represented legally (James & James, 1999). It is with this in mind that the researcher would like to give a voice to the children, to hear from them with regard to how they experienced the therapeutic interventions of the Teddy Bear Clinic. It is noteworthy that the professional role-players have to act on what is in the best interest of the child, listening to what the children have to say will not refute the professional integrity of the professional but rather give a platform for the child to be heard as a recipient of these interventions.

According to the New Children's Bill (Section 75) passed in June 2005 and what is now known as the Children's Act (No 38 of 2005). In terms of Section 6 (2), it states that all proceedings, actions or decisions in a matter concerning a child must

- Respect the child's inherent dignity.
- Treat the child fairly and equitably.
- Protect the child from unfair discrimination on any ground.
- Recognize a child's need for development, engaging in play and other recreational activities appropriate to the child's age.
- Recognize a child's disability and create an enabling environment to respond to the special needs that such a child has.

As Franklin (2002) explains, a legal right is an entitlement which is acknowledged and enforced by an existing law in a specific state; legal rights are the de facto rights which children possess. A moral right is a claim for a right which it is believed children should possess by virtue of their common humanity. Franklin (2002) notes that welfare rights highlight the provision for children's welfare needs and their protection, including their rights to education, health, shelter and a minimum standard of living. Liberty rights focus on children's rights to self-determination, implying that children should enjoy greater freedom and rights in decision making. Children are worthy of human dignity and respect (Bill of Rights Section (7)). By being sexually abused children's human dignity is seriously violated. Section (9) implies that discrimination against children, by virtue of their age is unacceptable. It further implies that regardless of the child's age his or her views, wishes and feelings should be given serious consideration. Section (12) has specific relevance in cases of physical, emotional and sexual abuse. When a child is abused his or her dignity is not respected or ever acknowledged. Abuse further threatens a child's right to life. Abuse in any form is a direct violation of Section (12) as a whole. In Section (28), subsection (2), it is stated that a child's best interests are of paramount importance. Children need to be allowed to participate in their own lives and be heard in order to be able to determine their best interests. Children need to be informed of issues that affect them in order to be able to portray their wishes and feelings. If children are given the opportunity to make decisions while being guided and protected, they will be able to make informed decisions as adults (Kruger & Spies, 2006).

2.14 Conclusion

The United Nations Convention on the Rights of the Child stressed the importance of listening to children and of taking their wishes and feelings into account. Making sense of children's development is an essential part, both of listening to children and facilitating their participation in decision making (Schofield, 2005). Many professional role-players are of the opinion that the child's right to be heard contradicts his or her right to be protected (Schofield, 2005). Listening to children when making decisions that affect their lives is simply about offering them the right to contribute views; it is about understanding children's point of view as well as their developmental needs, striving to make sense of what their lives have meant to them and seeing the world through their eyes. This research has considered the voices of the children who have been recipients of the clinics services and whether they felt these were of benefit to them or not.

As can be seen with the vast amount of studies done on intervention and prevention (Finkelhor, 1994; Harvey & Gow, 1994; Jenson et al. 1996; Loffel, 1996; Pollock & Farmer, 2005; Spies, 2006; & Wieland, 1997) but not many if any studies, on how child victims and their caregivers experienced these and whether they felt that these treatments and services were successful in helping them cope and deal with the effects of sexual abuse. Although child sexual abuse has become more visible as an area of professional concern, its management continues to prove complex and problematic. From the therapeutic perspective, despite the numerous treatment models available, there is a need for the assessment of the indicators for, and efficacy of family, group and individual approaches, as well as for the further development of appropriate techniques in all these areas of treatment. Behind these uncertainties there is intense controversy over the best way to understand child sexual abuse. A prominent issue that has become evident from the above-mentioned research is that there is a multitude of explanations that enable people to understand sexual abuse and related issues from different contexts, and many more on treatment models and the efficacy of these. The literature on child sexual abuse is diverse and wide, and covers many different aspects of it. However the current literature survey for this study revealed little if any research which has addressed how sexual abuse victims and their caregivers experience these therapeutic interventions and whether they felt that these were beneficial to them or not. Thus,

giving a voice to the victims and the non-offending caregivers on how they experience these interventions is lacking in the literature, especially within the South African context and it is for this reason that this study will focus on exploring the experiences of clients who were recipients of these services, thereby gaining a rich and in-depth understanding of these from their perspective.

An attempt will be made to broaden the understanding of their experiences by means of thematic analysis, the method of which will receive adequate attention in the chapter that follows. The following chapter describes the research design, method of data collection and thematic analysis.

CHAPTER THREE: METHODOLOGY

3.1 Introduction

This chapter gives a description of the research process. A summary of the research design, namely qualitative research, and thereafter a description of phenomenological methodology will be given in introducing an interpretive phenomenological approach. Of significance in this chapter are issues of sampling, method of data collection and method of analysis; namely thematic analysis which will be discussed in depth. Thereafter issues of validity and measures of trustworthiness will be discussed. Finally, ethical considerations will be put forward.

3.2 Research design

Mouton (2001) defines a research design as a plan or blueprints of how an individual intends to conduct their study. A design offers a set of guidelines, instructions and framework of how the researcher intends putting these goals into practice (Mouton, 1996). The research method used in this study was qualitative in nature and employed an interpretive phenomenological approach, with the emphasis placed on the lived experience. More specifically, how the participants came to make sense of their experiences with regard to therapeutic interventions.

3.2.1 Qualitative research

Qualitative research is not a positivistic scientific form of conducting research (Braun & Clarke, 2006). It is a research strategy that presents the data in the form of language rather than the quantification in the collection and the analysis of data (Bryman, 2001). It is based on flexible explorative methods because this allows the researcher to change the data progressively so that a deeper understanding of what is being investigated can be achieved. First-hand experience of the object under investigation produces the best data which involves the use of small samples of people (Miles & Huberman, 1994). The purpose of the interpretive phenomenological approach is to study the 'experiential life of participants' and to describe in rich detail the different ways the clients' (child sexual abuse victims and their non-offending caregivers) describe their experiences of the services within the Teddy Bear Clinic.

3.2.2 Interpretive paradigm

According to Terre Blanche, Kelly & Durrheim (2006) a number of research approaches fall within the ambit of qualitative approaches; these are divided into interpretive, social constructionist and narrative approaches. This research fits within the interpretive paradigm. This paradigm accepts multiple realities. There are many realities as there are participants and meanings are constructed by the participants and researcher. It therefore allows for the researchers' reality to be taken into account, thereby acknowledging this influence in the research and interpretation (Morrow 2007). The multiple realities mean that there is no objectivity as each individual has their own subjective view. In keeping with the aims of the study, the approach allows for the individual experiences of the participants to be explored.

The interpretive paradigm embraces the characteristic features of phenomenology and hermeneutics. Hermeneutics, which is the work of interpretation, is 'the methodological meaning of phenomenological description' (Heidegger, as cited in Denzin, 1984a, p.8). Hermeneutics in the interpretive paradigm gives priority to the world of the first-person, or subjective experience (Schwandt, 1994). Upholding the interpretive method of 'verstehen' – translated literally as 'to understand' (Schwandt, 1994), a position of empathic understanding is adopted. To understand clients' experience of the therapeutic context (Kelly, 1999, p. 405) requires then the framing of experience using participants' own terms of reference. Through a detailed examination of a text, all that is known about a phenomenon is 'revealed' and 'engulfed' through interpretation (Denzin, 1984a, p.8; Neuman, 1994). The 'hermeneutic circle', a term used by Gadamer (as cited in Stahl, n.d.) reflects this understanding of the circularity of the text; that is, in the interpretation of the text, the meanings of structures should be considered in relation to the meaning of the whole (Kelly, 1999), or what Denzin (1984a, p. 8) calls the 'interpreted totality'. The focus of interpretation is on the uniqueness and distinctiveness of thoughts, feelings and meanings of the clients' experience of the therapeutic interventions at the Teddy Bear Clinic. Language construes relations of parts to wholes within its own text, between itself and its context.

3.2.3 Phenomenology

The specific theoretical paradigm informing this research is phenomenology, which fits into the above described paradigm. Phenomenology may be considered a subset of interpretivism. Phenomenology is dedicated to describing the structures of experience as they present themselves to consciousness, without recourse to theory, deduction or assumptions from other disciplines such as the natural sciences. Phenomenology is both a philosophy and a research method. The purpose of phenomenological research is to describe experience as they are lived in phenomenological terms (Welman, Kruger & Mitchell, 2005). In order to reveal the layers of subjective meaning, a phenomenological approach privileges the subjective perspective, according this with greater significance than objective reality (Rossman & Rallis, 2003). Thus the broad question that phenomenologists want to answer is 'What is the meaning of one's lived experience?' All phenomenologists agree that there are multiple realities, and the subjective reality of each individual is important and as such the interpretive paradigm allows for the exploration of the individual participants' experience and accounts for the influence of the researcher (Mackey, 2005). Descriptive phenomenology, which is another form of phenomenology, is different to interpretive phenomenology. Within descriptive phenomenology 'bracketing' is necessary to ensure that the interpretation is free of bias (West, 1996). This term, refers to suspending one's own natural views or attitudes in order that these do not influence one's description of experience. The idea of 'bracketing' was seen as imperfect by interpretive phenomenologists, and 'reflexivity' became the essence of this approach. 'Reflexivity' or being able to reflect upon the researcher's own personal standpoint and to acknowledge how this shapes the research is seen as a plausible alternative to 'bracketing' (Willig, 2008a).

3.2.4 Interpretive phenomenology

The focus of phenomenological research is people's experience in regard to a phenomenon and how they interpret that experience. It is from this standpoint that an interpretive approach was chosen for this study. Heidegger questioned the possibility of any knowledge outside of an interpretive stance, whilst grounding this stance in the lived world – the world of things, people, relationships and language. 'Meaning' is thus of fundamental importance here, because for interpretive phenomenologists...

‘Consciousness makes possible the world as such, not in the sense that it makes possible the existence of the world, but in the sense that it makes possible a significant world’ (Drummond, 2007, p.61).

Interpretive phenomenology as advocated by Heidegger is informed by hermeneutics a method for bringing out and making manifest what is normally hidden in human experience and human relations and by the idea that interpretation is evident in all forms of description: the approach does not bracket assumptions, that is, attempting to ensure that the interpretation is free of bias (West, 1996) as does descriptive phenomenology. Rather it uses them to arrive at a better understanding (Willig, 2008a). Interpretive research assumes that the researchers’ own presuppositions are essential in guiding research. The researcher’s own interpretations as a former intake counsellor at the Teddy Bear Clinic will influence the research as the researcher has to interpret participants’ mental and emotional states from what they say. By being interested in examining how they think about what is happening to them, the researcher also diverges in deciding how this thinking can best be studied (Benner, 1994). As such constantly reflecting on one’s own standpoint is essential in interpretive phenomenological research.

The interpretation of the experiences provided by the participants in relation to various contexts is essential. Interpretive research makes sense of people’s experiences by interacting with them and listening carefully to what they tell us. It relies on first-hand accounts, describes what it sees in rich detail and the findings are presented in engaging and sometimes evocative language. As such language becomes one of the major roots for analysis (Lopez, 2004). Working in this tradition involves understanding in context and the researcher is the primary instrument of how information is collected and analyzed (Lopez, 2004). It involves collecting the data in the form of verbal reports such as interviews or written accounts. The analysis consists of different formats of interpreting these experiential accounts and the researcher adopts an insider view by talking to participants or observing behaviour in a subjective way.

To this end, interpretive phenomenological approaches are concerned with human lived experience and posit that experience can be understood through an examination of the meanings which people impress upon it. These meanings in turn,

may illuminate the embodied cognitive-affective and existential domains of psychology. This approach requires a combination of phenomenological and hermeneutic insights (Smith, Flowers & Larkin, 2009). The interpretive approach is thus well suited to explore experiences, gain deeper understandings and to make meaning of the participants' experiences.

3.3 Research methodology

3.3.1 Case studies

The case studies consisted of the child victim of abuse and the non-offending caregivers that participated with the child in the therapeutic process. Thus all members of the case study were recipients of the agencies services. Case studies were used so that a large amount of information could be generated about a few participants. Thus provision was made for the researcher to obtain greater depth and more detail on the subject that was studied which is in line with the aims and theoretical approach of this particular study (Neuman, 2000). The researcher focuses on the person's subjective world, which has no meaning in generalizing and is only valid in the system being investigated (Neuman, 2000).

3.3.2. Participants

Qualitative research often requires smaller sample sizes than quantitative research, and interpretive phenomenological research, being involved with the description of an experience, does not lend itself to large randomised sampling methods.

The purpose of qualitative research is 'to gain an understanding of the nature and form of phenomena, to unpack meanings, to develop explanations or to generate ideas, concepts and theories' (Ritchie, Lewis & Elam, 2003). Selecting participants therefore is based on inclusion of 'constituencies, events, processes' and characteristics that shed light on the phenomena under investigation. Purposive sampling was used as the research had a specific purpose (Van Vuuren & Maree, 2002) and because the researcher is studying unique cases that are especially informative about the topic being explored (Terre Blanche & Kelly, 2002).

The sample fell within a difficult-to-reach population and the particular cases chosen were ideal for obtaining an in-depth investigation (Neuman, 2000). A small number of

cases were identified by the clinic's professionals as likely participants for this study. These participants had to be willing to describe their experiences and they had to have undergone and completed the therapeutic services at the clinic before they could become participants in this study. The children taking part in the study had to be within a specified age group, making it a population difficult to reach. Taking cognisance of the key features of qualitative sampling outlined by Ritchie et al. (2003), the aim initially was to recruit clients who were (i) fluent in English, (ii) were recipients of the clinic's therapeutic process (iii) the children participants had to be between 12 and 16 years old and the reason for this is that in this age group children are more cognitively developed and able to express emotions and feelings in a descriptive way and recall detail of experiences. Also regarding the legal definition as stipulated in Section 14 (1) (9) of the Sexual Offences Act , which states that any adult is prohibited from having or attempting to have sexual intercourse with a child below the age of 16. Therefore including the child in the study below the age of 16 years fits the criteria for the purpose of this study. (iv) The adult participants must be the non-offending caregivers who were part of the therapeutic intervention process and (v) were identified by the clinic counsellors as having terminated the therapeutic process and not in need of further intervention (prior to participation).

The criteria were set out to explore the clients' experiences and to gain a rich understanding of the content. Fluency in English was a requirement in order to preserve the element of first-person accounts. As a common medium of exchange, it also facilitated the researcher's interactions with the participants. The eventual sample reflected a convenience sample approach, one which relies on ease of access to participants and the characteristics specified above, rather than based on a clear sampling strategy (Ritchie et al. 2003). The recruitment of participants was, to a large extent, dependent on the assistance offered by the counsellors at the Teddy Bear Clinic. Therapeutic counsellors at the Teddy Bear Clinic identified a list of clients that had just terminated or were exiting the therapeutic process and not in need of further interventions, and that fit the criteria as stipulated. These clients were asked (by the clinic counsellors) if they would be interested in participating in the study at an initial face-to-face interview which included the clinic counsellor and the researcher. Here the researcher explained the study in detail and obtained informed consent from the non-offending caregiver/s and legal guardians of the

children and separate assent was obtained for the children, before the one-on-one interviews were conducted.

The participants were interviewed until saturation was reached, that is, sampling continues until the researcher recognises no new data were forthcoming – a point of data or information redundancy, or nothing new is heard in the case of interviewing and for thematic development and theorising (Lincoln & Guba, 2000). The final decision about sample numbers was based on evidence of data saturation. Four case studies were eventually chosen. It is not the amount of data that is collected but rather the richness of the data and the detailed descriptions of the content that is significant.

3.3.3 The researcher's role

Certain measures to enhance trust between the researcher and participants were taken. Trust was facilitated by informing participants prior to the interview about the purpose of the study. They were informed of the results which would become available to them, that their personal identity would be protected, and that they had the right to withdraw from the study at any time. They were also informed about the approximate duration of the interview and the fact that the conversations would be audio taped, so that the interviewees were able to express themselves authentically. The interviews were conducted at the Teddy Bear Clinic. This was done to ensure comfort and security of each participant. It is noteworthy that data obtained is the participants' subjective 'truth' as it only reflects how participants found meaning in their understanding of their experiences (Becvar & Becvar, 2000). The researcher's involvement stretches further than just listening and being passive and extends to sharing in the experience of the participants (Pollio, Graves and Arfken, 2006). The researcher's involvement in the clinic and the reading of the literature relating to the topic will influence the researcher's understanding of the client's experiences. Due to the sensitive nature of the research, aspects relating to confidentiality were better contained in a one-on-one setting (Lewis, 2003). An example of the interview guide is attached as Appendix B.

3.4 Data collection procedures

3.4.1 Semi-structured interviews

Interviews were conducted with the child and non-offending caregiver separately so that no element of coercion was felt by the participants. Apart from the emphasis on subjective meaning and the exploration of a complex phenomenon such as the clinic's therapeutic interventions; the in-depth interview, according to Mishler (as cited in Banister, Burman, Parker & Tindall, 1994) is also about empowering disadvantaged groups in a manner that validates their views and gives voice to their experiences. Hayes (2000) believes that these semi-structured interviews involve a maximum degree of trust and caring between the person interviewing and the one being interviewed, with few boundaries or limitations on the content of the interview.

In upholding the epistemological stance (ways of gaining knowledge about the social world) of interpretivism, the research relied on in-depth interviews with the participants (Snape & Spencer, 2003). Generated data collection methods, such as in-depth interviews, allow the participants a 'direct and explicit opportunity to convey their own meanings and interpretations through the explanations they provide' in a spontaneous manner or when prompted by the researcher (Lewis, 2003, p. 57). The in-depth interview, although often described as a 'conversation with a purpose' (Webb & Webb, as cited in Legard, Keegan & Ward, 2004, p.138) is nevertheless an exchange between the participant and researcher, each having different roles and objectives. The present research adopts the 'travel metaphor' perspective on in-depth interviewing. The researcher and participant embark on a journey to develop meanings of stories, which are subsequently interpreted by the researcher. Kvale (as cited in Legard et al. 2003, p. 139) states that the traveller (i.e. the researcher) 'asks questions that lead the subjects to tell their stories of their lived world'. Interviews allow the story of relationships to emerge from which the listener gains access, to the teller's experiences.

According to Legard et al. (2003), the in-depth interview is defined by its key features, namely, structure combined with flexibility (set topics are covered but allow room for probes and exploration); interaction (free talk is encouraged with the interviewer picking up points in the participants' responses); depth (achieved through probing or follow-up questions to explore, penetrate and seek explanation of

the participant's meaning), as well as its generative nature (new knowledge or thoughts on the topic arise, either self-directed or guided by the researcher). To bring these features together requires face-to-face interaction between participant and researcher. 'Intuiting' as a phenomenological principle was also applied during the interview. This mode of awareness involves 'sensing; and being attuned to slight nuances to what is being conveyed by the participant' (Rose, Beeby & Parker, 1995). These nuances were noted in a journal, and were later included in the analytic process.

The interview schedule was a guide for the discussion of several topics, albeit 'not as an exact prescription of coverage' (Arthur & Nazroo, 2003, p. 123). The semi-structured approach facilitated the exploration of topics that were generated with the research question in mind. An interview guide which was drafted beforehand was used to guide the process, thereby exploring the experiences participants had with regard to the therapeutic interventions, in this way affording participants the opportunity for personal and unique expression (Williamson, Karp & Dalphin, 1977). Considerations related to length and phrasing of questions were designed to elicit a more natural and engaging interaction. Different to a fixed structure of quantitative approaches (e.g. semi-structured questionnaire), its structure encourages rather than stifles the processes of reflection and facilitates the discovery of new ideas and themes. More significantly, as Arthur and Nazroo (2003) assert, the interview guide serves as a public document that makes the research objectives and processes transparent, particularly so as participants' actual transcripts remain hidden from view. Probing questions and interjections follow the participant facilitating expression of the experience.

3.5 Data analysis

The research employed thematic analysis of content. The aspect of meaning is often referred to as thematic content, which refers to the function of language. The extracts in thematic analysis are illustrative of the analytic points the researcher makes about the data and are used to support the analysis which goes beyond the specific content, to make sense of the data and tell the reader what it does or might mean (Braun & Clarke, 2006).

Data analysis is 'the process of bringing order, structure, and meaning to the mass of collected data' (Rossman & Rallis, 2003, p. 278). It is likened to the creative processes of immersion (in relation to words and impressions of the data), incubation (allowing the data to generate mentally), gaining insight (identifying the meaning entrenched in the data) and interpretation (making sense of the findings and drawing conclusions) (Bargar & Duncan, as cited in Rossman & Rallis, 2003).

3.5.1 Thematic analysis

In line with the principles of interpretive analysis, the texts were interpreted from the perspective of empathic understanding. In upholding the interpretive-hermeneutic process, analysis results in 'thick description' of the clients' experiences of the therapeutic interventions, as well as accounting for the researcher's role in constructing this description (Rossman & Rallis 2003; Terre Blanche & Kelly 2002). The emphasis on 'thick description' provides the basis upon which meanings, values and 'rules' by which people order their daily lives are derived. Although many definitions of thematic analysis exist, it is generally defined as a method of data analysis that provides a coherent means of data organisation into thematic headings which reflect both the research question and the preoccupations of the participants as these are revealed in the (interview) data (Banister *et al.*, 1994). The approach offers an analysis that is accessible and is not attached to analytic strategy, as Braun and Clarke (2006 p.81) state. 'Thematic analysis is not bound to any pre-existing theoretical framework, and therefore it can be used within different theoretical frameworks and can be used to do different things within them.' Thematic analysis is useful with an interpretive phenomenological perspective as it allows for the researcher's influence on the analysis of the data. Thematic analysis is a search for themes that emerge as important to the description of the phenomenon (Daly, Kellehear, & Gliksman, 1997). As such the researcher becomes familiar with the data so that patterns, themes and codes can emerge. The theme may comprise a phrase or sentence that describes more subtle processes (Rossman & Rallis, 2003). Theme prevalence was measured in terms of the theme appearing across the (entire) data set. In other words, the majority of participants had to allude to an idea before it constituted a theme.

Apart from repetitions, participants' uses of metaphors were also identified (Ryan & Bernard, 2003). Although no specific analysis of metaphors was undertaken, they were used as evidence for a particular theme. Although the stages are presented as linear, step-by-step procedure, the research analysis is an iterative and reflexive process; it involves a constant moving back and forth between the entire data set. For the purpose of the thematic analysis 'patterns' and 'themes' are defined as: a pattern is recognised because of its repetitiveness and in phenomenology patterns are the regularities in the way the respondent relates to the world in different situations and at different times. An inductive or 'bottom-up' approach to analysis was conducted. This involves 'a process of coding the data without fitting it into pre-existing coding frames, or the researcher's analytic preconceptions' (Braun & Clark, 2006 p.84). Therefore, the coding process involves recognizing an important moment and encoding it prior to a process of interpretation (Boyatzis, 1998). This data-driven process allowed themes to emerge that moved beyond the specific research questions asked (Braun & Clark, 2006). This bottom-up approach suggests that general rules or classes are inferred from specific instances. Coding defines what the data are all about, that is, themes, categories or concepts that emerge from the data (Ezzy, 2002). Coding according to Rossman and Rallis (2003), constitutes the 'evidence' of a category or theme, and is thus narrower than the theme. In this manner, codes created were matched with specific data extracts. Following Braun and Clark (2006), data extracts were often coded several times according to their fit with potentially different themes.

In the present research, the latent content, namely the underlying assumptions or interpretive meanings are examined. In so doing, effort is made to 'theorise the significance of the patterns and their broader meanings and implications' (Braun & Clarke, 2006, p. 84). In this sense, the research epistemology is situated in essentialism/realism. As noted earlier, the interpretive framework privileges the individual's subjective experiences which are seen as real and as emanating from the self (Terre Blanche & Kelly, 2002). Based on the assumption that language directly and passively reflects meaning and experience, this position asserts that motivations, experience and meaning can be theorised in an uncomplicated manner (Braun & Clarke, 2006).

Meaning is not created by language alone. In speech it is accompanied by gestural, postural, proxemic, situational and paralinguistic information. The meaning of any text depends on how we connect it to some texts and events (Lemke, 1988a). Language creates three interdependent kinds of social and cultural meaning. (1) Presentational meaning refers to the function of language, for saying what is going on. (2) Orientational meaning refers to interpersonal or attitudinal constructs, which is the social, evaluative and affective stance towards the thematic content of the participants. (3) Organisational meaning includes ways in which language creates wholes and parts; it tells us which words go with what, which phrases and sentences go with which ones and how a coherent text distinguishes itself from a random sequence of sentences, phrases or words. In analysing the data collected from the interviews, the following steps (as recommended by Fereday & Muir-Cochrane, 2006, pp. 4 – 7) were followed:

3.5.2 Stages in the thematic analysis

Phase 1: Transcribing

The researcher transcribed all the audio taped conversations herself. This was done directly after the interviews so she could capture the emotions present during the interview sessions and be able to understand the meaning and context. The process of analysing the transcribed interviews began, by reading the first interview a number of times. It is in the transcribing where the researcher starts to become familiar with the data (Riessman, 1993). The left hand margin of the transcriptions was used to annotate what was regarded as interesting or significant comments from the interview with the participant. During this process it was found that some parts of the text were richer than other parts. The language used and the level of sophistication was also noted. Of importance during this initial process were the similarities, differences, amplifications and contradictions (Smith and Osborne, 2003) in what the participants talked about. 'It could even be seen as a key phase of data analysis within interpretive qualitative methodology and seen as an interpretive act where meanings are created' (Bird, 2005, p.227).

Phase 2: Familiarization and Immersion

Immersion involves 'repeated reading' of the data, and being actively involved with the data, thereby searching for meanings and patterns (Fereday & Muir-Cochrane, 2006). What the researcher had in mind was to immerse herself in the data so that she became familiar with the depth and breadth of the content. Once the researcher completed the initial reading of the first interview she went back to the beginning of the transcript and another margin was then used to document emerging themes and marking ideas for coding

Phase 3: Generating initial codes

This phase involved initial coding from the data and this was done manually, the coding of the data was done by writing notes on the texts that were analysed using highlighters or coloured pens to indicate potential patterns, these codes were then collated together within each code and this was done by copying extracts of data from individual transcripts and collating each code together in separate computer files or using file cards (Fereday & Muir-Cochrane, 2006).

Phase 4: Searching for themes

Here the researcher analysed the codes and considered how the different codes combined to form an overarching theme. This phase involved sorting the different codes into potential themes, and collating all the relevant coded data extracts within the identified themes. Here tables or mind-maps were used to sort the different codes into themes. The researcher thought about the relationship between codes, between themes, and between different levels of themes, example, main themes and sub-themes. A collection of main themes and sub-themes, and all extracts of data that have been coded in relation to these made up the bulk of this phase (Fereday & Muir-Cochrane, 2006). It is at this point that the researcher had a sense of the significance of all the individual themes.

Phase 5: Reviewing themes

In this phase the main themes were refined to establish which ones were supported by data and which ones were not. Some themes were broken down into separate themes. Once the researcher was satisfied that the themes adequately captured the contours of the coded data, the researcher moved on to the second level in this phase. Here the researcher considered the validity of individual themes in relation to

the data set and the validity of the main thematic map, which should accurately reflect the meanings evident in the data set as a whole. The entire data set was re-read at this stage to ascertain whether the themes ‘worked’ in relation to the data set and to code any additional data within themes that may have been missed in earlier coding stages (Fereday & Muir-Cochrane, 2006).

Phase 6: Defining and naming themes

Here the researcher defined and refined the themes that were presented in the analysis, i.e. identifying the ‘essence’ of what each theme is about and determining what aspects each data theme captures, and organizing these into a coherent and internally consistent account, with the accompanying ‘story’ that each theme tells (Fereday & Muir-Cochrane, 2006).

Phase 7: Producing the report

This involved the final analysis and write-up of the report, in this phase the researcher tells the story of the analysis in a concise, coherent, logical, non-repetitive account of the data within and across themes (Fereday & Muir Cochrane, 2006).

3.6 Trustworthiness of the research

As the researcher makes public her own stances, motivations, assumptions, and biases, the researcher gains a level of honesty that contributes to the trustworthiness (rigour) of the study (Morrow, 2007). Lincoln and Guba (1985) state that to attain trustworthiness the following strategies must be used; observation, peer debriefing, prolonged engagement and persistent observation, audit trails and member checks. Also significant are the characteristics of the researcher, who must be responsive and adaptable to changing circumstances, have a holistic approach, have professional immediacy, sensitivity, and ability to clarify and summarize (Guba & Lincoln, 1981).

Rigour was achieved in the following ways:

Balanced integration refers to the intertwining of philosophical concepts in the study methods and findings, and a balance between the voices of the study participants and the philosophical explanation (De Witt & Ploeg, 2006). In this study the

researcher accounts for the phenomenon under study through the rich material that is been collected, understanding the material in relation to theoretical questions and the literature in the field (De Witt & Ploeg, 2006). This, involved constant reflection and evaluation on the part of the researcher. The researcher gives an account of how the findings emerged through the codes and themes in the data analysis, checking the credibility of the analysis to see if the findings reflect the participants' own experiences and perceptions. Finally providing participants an opportunity to review the researcher's interpretation of the data (De Witt & Ploeg, 2006).

Openness relates to the process of accounting for the multiple decisions made throughout the study process (De Witt & Ploeg, 2006). In this study the researcher was accountable and transparent for the changes that emerged throughout the study and accounted for these in the analysis and final account. Supervision also allowed for further evaluation of the study.

Concreteness relates to usefulness of study findings (De Witt & Ploeg, 2006), that is, gaining a deeper understanding of how clients experience these services and thus providing information to the stakeholders on how these experiences were understood by their clients.

Resonance encompasses the experiential or felt effect of reading study findings upon the reader, by reading the rich and detailed description of the participants experiences to gain a deeper understanding of the 'meaning' they have ascribed to their perceived understanding.

Actualization refers to the future realization of the resonance of study findings (De Witt & Ploeg, 2006). This implies how this study will impact the reader and the changes that may be realised because of it.

3.7 Ethical considerations

Permission to do the research was obtained from:

- The Directors of 'The Teddy Bear' Clinic for sexually abused children and
- The ethics committee of the Health Services Faculty of the University of Pretoria.

According to Clandinin and Connelly (2000) ethics should be thought of in terms of relational matters. This relates to negotiating researcher-participant relationships in consideration of ethical principles to ensure safety for both parties. This section addresses the principles of informed consent, anonymity and confidentiality. The research material gathered for this study was considered private; therefore informed consent and assent for the children had to be obtained. The participants were identified by the clinic's counsellors as eligible for participation in this study, based on the research criteria as stipulated. The participants were contacted by the clinic counsellors. The procedure of the research process was described in full to each participant. The initial face-to-face interview was done with both the counsellor and the researcher, informing participants of the research study and asking participants whether they would be interested in participating. Both child and non-offending caregiver/s were interviewed separately to ensure that neither of the participants felt coerced in any way. The nature of the study was clarified, and participants were made aware that they have access to the resultant information as feedback, for further input. This pertains to informed consent. After the interviews participants were given the option to use the clinics, counsellors or psychologist if they felt that they needed to discuss anything further. A suitable referral was provided for the participants that felt that they wanted to see someone outside of the organisation.

All information obtained about the participants during the study was treated with anonymity as the ethical responsibility of the researcher and confidentiality and anonymity were assured. Respect for the identity of those participating was valued and information that may have been linked to an identifiable person was disguised by using pseudonyms (HPCSA, 2009). Any other specific identifying data was removed. This relates to the participants' privacy.

During this study the data was stored on the researcher's personal computer and a code was used to protect data from unauthorized access. On completion of the dissertation the information will be stored at the University of Pretoria in accordance with the regulations of the university. All tape recordings and private records were destroyed after completion of the study.

CHAPTER FOUR: DISCUSSION AND RESULTS

4.1 Introduction

The data analysis is presented in two parts. Part I will focus on the content of the participants lived experience. Insight into the clients' experiences of the therapeutic encounter is obtained by giving attention to the emotional and psychological dimensions. Attention to the content, therefore, is in line with the 'experience-near' end of the interpretive continuum introduced in the previous chapter (i.e. the 'lived experiences' of the client's therapeutic intervention at the Teddy Bear Clinic) (Kelly, 1999). However, an exclusive focus on content or subjective experiences suggests that the client's experiences of the therapeutic encounter are taken at face value. Whilst attention to the subjective elements illuminate the psychological reality of experience, it is necessary to shift the lens towards the 'experience-distant' pillar of the interpretive continuum to understand the process by which the participants engaged in their talk of the therapeutic encounter.

Part II addresses the question of how the participants related their narratives of the therapeutic encounter. A critical reflexive gaze on the researcher's influence on how the clients describe their stories will be illustrated. This will be done through critical reflection on the researcher's position within the interpretative framework while remaining true to the stories of the clients as well as understanding of the researcher's power within this dual interaction. The findings that emerged from the thematic analysis will be deliberated upon within the context of existent literature, aiding the researcher to determine those themes that are represented in existing studies.

4.2 Reflexivity

In this particular section the word 'I' is used to refer to the researcher as a reflexive technique (Bishop & Shepard, 2011). 'I' makes the reader aware of the role that the researcher bears on the participant's narrative accounts. In the rest of the study I use the term the researcher instead of 'I' in order to gain the distance necessary to allow for the clients experiences to be described and interpreted. The interview context provides the structured setting in which the clients (children and caregivers) talk about their experiences at the clinic. Different from the ordinary conversation the

semi-structured interview by virtue of the specific role assigned and adopted by the researcher and participants (Kvale, as cited in Legard, Keegan & Ward, 2003), power differentials are imbued in this 'dialogical' exchange (Kvale, in press). These power relations however are manifest in the interviewer not only having control over the interview, but also over the entire research process, from devising the research question; setting up the interviews, to the analysis and interpretation of the participants' stories (Banister, Burman, Parker, Taylor & Tindall, 1994). Given this dynamic, a consideration of issues of reflexivity needs to be considered with a view to making the research process visible (Banister et al. 1994). Nightingale and Cromby (1999) define reflexivity as:

Reflexivity requires an awareness of the researcher's process, and an acknowledgment of the impossibility of remaining 'outside' of one's subject matter while conducting research. Reflexivity then, urges us to explore the ways in which a researcher's involvement with a particular study influences, acts upon and informs such research (p.228).

I reflected on my reasons for wanting to explore research into the clients' experience of services within a clinic dealing with sexual abuse. Having had some exposure to the work in the sexual abuse clinic, I felt the need to continue to contribute to the clinic and the clients in the area of service evaluation. Having started out as a volunteer counsellor with little knowledge of sexual abuse, I was naturally eager to embrace any new learning that came my way. Gradually as I learned more, I wondered about my clients as I had immersed myself in only a one-sided perspective, that of a counsellor offering a service to these clients. However, what it was like for the client to receive such services was something that often plagued me. Given the stress of the work, which focuses predominately on victims of abuse (namely children), the main approach reflects a one-sided intervention which at times places the caregivers in greater danger of being neglected. Even though the children are the focus of intervention, I felt their voices are not heard in terms of how they experienced the therapeutic process and this is something that I wanted to explore. My interest as well as my need to understand the child and the caregivers who were recipients of the clinic's services, was something that I felt I had to explore. This in no way disregarded the services of the clinic, my overall dissatisfaction stemmed from what I perceived to be a power differential between the clinic professionals and

the clients. By engaging with this research, I hope to achieve an insider perspective of the voices of the children and their caregivers, with anticipation that something may be gained to assist the clinic with change regarding their services and how the process was experienced, describing strengths and weaknesses and possible changes in the clinic services.

4.3 Positioning myself

My desire to understand the subjective experiences of these clients in some ways biased my theoretical positioning. I aligned myself strongly with an interpretive framework which emphasised the importance of empathy in an interview encounter, accentuating the notion that people are the source of their thoughts, feelings and experiences and are considered real (Kelly, 1999; Terre Blanche & Durrheim, 1999). I attempted to adopt a non-judgemental, listening stance. I felt this was necessary in order to elicit responses from clients that would not be defensive and superficial (Ptacek, 1998). In some respects I wanted to believe that they would convey the 'truth' about their experience of the clinic's services. Reflecting on my own interpretations was vital however, remaining true to the stories of the clients was essential to the research. My approach, interpretive phenomenology, allowed for this, by allowing the client to tell his/her story, which is an account of events that unfolded according to their values, intentions and purposes. The 'meaning' that is made of these experiences, is a mix of what is told in the story and what the researcher brings to it from her; own store of knowing (Rossiter, 1999).

4.4 Self-representation and power

As the interviewer, the decision-making power rested with me in terms of when I contacted the participants, how I chose to set up time slots for the interviews, how I framed the questions, how I closed the interview, and most importantly, how I chose to be seen. Having adopted these structures within a framework of 'research', the participants may have seen me as an expert, having knowledge about the area of study. However, upon introducing myself to the clients, I emphasised that I was a student who was interested in learning about their experiences of how they perceived the services at the clinic. Positioning myself in this way, I felt that I may have removed some of this power differential between myself and the participants. At the end of the individual interviews with the researcher both the children were

asked how it was for them to be involved in the interview process. Their responses were:

I actually felt it quite relieving [interview] I actually could get rid of some of the stress and I could actually talk to someone and know exactly what I was saying... [Sarah]

I would just like to say thank you for everything, [interview] and to those of them who have been there with me [clinic professionals]. [Thandi]

The children seemed to value the opportunity to speak about their experiences and share their stories. They were the experts in their narratives which allowed them a platform for their voices to be heard.

This illustrates the importance of a study such as this; giving the children and caregivers a voice to be heard, thereby allowing them another space and platform to heal from the trauma. I was also aware of the social lines of difference between 'me' and 'them', as well as the notion of them as victim and me as a student psychologist with no real understanding of rape or sexual abuse, thus my own preconceived notions about sexually abused children and the non-offending caregiver, forced me to question whether I as a relatively inexperienced researcher and student would have the necessary interview skills required to tap into the emotionally vulnerable areas of these children and caregivers' lives. The interview questions and the researcher's views on sexual abuse were thus influenced by the literature review and the specific approach chosen for this study.

4.5 Research results

The analysis provides some insight into the experiences of the children and caregivers as clients of the clinic's services. The researcher's involvement stretches further than just listening, and using reflexivity. Analysis results in 'thick description' of the client's experiences of the therapeutic interventions (Rossman & Rallis, 2003). Thematic analysis is a method of data analysis that provides coherent means of data organisation into thematic headings which reflect both the research question and the preoccupations of the participants. The participants consist of two case studies, who were recipients [clients] of therapeutic services at the Teddy Bear clinic. Within each

case study the children and caregivers were interviewed separately. However, in the analysis they are combined to gain a deeper and richer understanding of their experiences at the clinic.

4.5.1 First case study: Background

In the first case study presented, Sarah and her father Joe are from Gauteng. They are a white family that come from a lower middle class status. Sarah's mother passed away when she was nine. She has three other siblings from her father's first marriage to their biological mother. She has an older sister of twenty, twin brothers who are thirteen, and Sarah, who is fourteen years old. Joe has re-married; his current wife has a son who is twelve years old. The children have been living with their father since their mother's death. Sarah contracted meningitis as a baby and because of the complications thereof, she is now cognitively challenged and is partially deaf. She attends a special school where she is learning to become a chef.

Sarah's father, Joe grew up with an alcoholic mother. As a young boy he went from foster care to foster care. This was a very unsettling period and emotionally difficult time for him. It was during this time that Joe was sexually and physically abused. When Joe went into high school, his mother rehabilitated herself and regained custody of her children, there was some stability for Joe in his adolescent years. Joe works in the construction industry and has had a stable job for the last twenty years. Joe cares deeply for his daughter and they appear to share a close relationship.

4.5.2 Presenting problem: first case study

Father and daughter presented to the Teddy Bear clinic because of two incidents. Sarah had underage sex at a special school she was attending at the time. The first incident was forced by another underage boy at her school. However, the second incident was consensual. Sarah had been living with her grandmother when this incident happened as the school she was attending then was quite a distance from her primary residence. Joe wanted her to attend the special school which was closer to Sarah's grandmother's home, as he felt that it was a superior school compared to the special school that was situated closer to their home. It was at this school that Sarah's school psychologist overheard her talking to friends about what had happened. The school psychologist called for a meeting with both Sarah and her

father. In this meeting Sarah disclosed her involvement in the underage sex with a boy who attended the same school. Sarah has since left this school and is now at a special school closer to home. Sarah presented to the clinic due to the underage sex. It was reported at the clinic that the first incident was forced which is classified as abuse and the second incident was consensual and thus unlawful sexual intercourse. According to the Sexual Offences Act the first incident in which Sarah alleged to have been forced to have sex, is classified as rape under Section 3 of the Sexual Offences Act, No 32 of (2007). Subsequent to this sexual trauma she appears to have developed symptoms of traumatic sexualisation or eroticisation as defined by Finkelhor and Browne (2008). This manifests itself, in Sarah having consensual, but still unlawful sexual intercourse with another boy at her school. This consensual but unlawful sex with children is defined under Section 15 of the Sexual Offences Act of (2007). Sarah presented to the clinic due to the fact that it is mandatory to report this consensual but unlawful sex under Section 54 of the Sexual Offences Act of (2007). This section makes it clear that there is an obligation to report any unlawful sexual contact with children as well as the mentally disabled Section 54 of the Sexual Offences Act, (2007).

The first complicating factor is that the alleged offenders are also disabled children under the law, and as a result are managed under the Child Justice Act No. 75 of (2008) in terms of their criminal capacity with regard to consensual but unlawful sex. The children have to go through a diversion programme designed to rehabilitate young sex offenders who have committed sexual offences. The aim of these interventions is firmly based on a restorative justice approach. The outcome is to open up a basket of services to these children rather than acting punitively. The children charged are mandated to go through a programme designed to rehabilitate or educate young sex offenders (Strode, Slack & Essack, 2010). A programme such as this is promulgated at the Teddy Bear clinic.

The second complicating factor is that children with disabilities are at elevated risk of abuse, particularly if the disability impairs their perceived credibility, for example if they have a cognitive disability. Feelings of a lack of belonging and meaningful participation due to their disability on the part of the person with the intellectual disability and lack of sex education compound the problem (Wattermeyer, 2006). The child's family characteristics also play a role, in the absence of one or both

parents the risk increases, some research (www.apa.org.child. Child sexual abuse: what parents should know, n.d.) found that children living with only one biological parent are at twice the risk of sexual victimization. Older children from father only families were also at risk of sexual victimization compared to other children. The parental characteristics associated with increased risk of child abuse are the parents' own history of childhood sexual abuse. A child with poor self-esteem or other vulnerable states elevates the risk of child abuse. Sarah is a child with an intellectual disability due to the meningitis she suffered as an infant, thus affecting her sense of judgement and choices. Compounding this system is the father's (Joe) own childhood sexual abuse as indicated by the above research. The lack of judgement on Sarah's part compounded by the initial sexual trauma as stipulated by Finkelhor and Browne (2008) makes the sexual acting out a high risk factor that needs to be managed if it is not to continue.

4.5.3 Second case study: Background

Thandi and Thembi are a black family from Gauteng. Thandi is a very lively and animated teenager. She describes herself as a typical teenager, mostly concerned with her peers, socialising and making future career plans. She has a very naïve and idealistic view of life and feels she is capable of achieving it all and having it all. She describes herself as 'driven'. She attends a high school in Johannesburg and is in Grade 9. She is a very ambitious young lady who aspires to do many things with her life. She hopes to be involved in journalism, dress designing, travel and cooking. She is hoping to qualify for a bursary so that she may go to university and live out her dreams. Thandi's parents are divorced. Her mother Thembi is a single parent bringing up her three children on her own. Thembi loves her career. She is a professional ICU nurse in a large government hospital. She has been a nurse for approximately nineteen years. Thandi is her youngest child. She shares a very close relationship with her daughter and is an extremely supportive and caring mother.

4.5.4 Presenting problem: Second case study

Thandi and her mother presented to the Teddy Bear Clinic because Thandi was raped. Thembi reported that the perpetrator was a stranger to her daughter who had never met or seen the rapist before the incident. At the police station Thembi asked

the police officer where she could take her daughter for counselling. The police officer referred them to the Teddy Bear Clinic.

South Africa has one of the highest rates of sexual crime in the world, with the rape ratio for female children in the 12 to 17 year old category being more than double the international ratio (Collings & Wiles, 2006). Jewkes et al. (2002) note that rape is the most common crime reported against children. Taking into consideration the cultural factors in South Africa, the seriousness of the HIV/AIDS epidemic and a growing interest in masculinities has been brought to the fore with regard to sexual violence against girls and women (Hunter, 2005; Morrell, 2001). Also in some African cultures violent practices are differentiated through prevailing notions of legitimacy. Harvey and Gow (1994) and Nordstrom and Robben (1995) point out that violence can also be seen as a dimension of everyday living, a form of communication that configures lives and subjectivities and that it is productive of relationships, especially in relation to gender. Rape is a violent act against women and girls that is not legitimised by socio-economic circumstances, gender practices or due to HIV/AIDS myths. Rape against a child violates the child's sense of self on so many levels, causing long-term physical as well as psychological harm to the child. Not all girls who have been raped are as fortunate as Thandi. Due to her close relationship with her mother she was able to tell her mother what happened, her mother sought help for her, she was supportive and caring thus enabling her to get the help that she needed.

The following themes emerged from the two case studies:

4.6 General themes across all cases

4.6.1. Background influences affecting the therapeutic experience

A number of background influences appear to affect, the therapeutic experience and these were noted across each participant although they varied. It was noted in this main theme that the background factors influence the therapeutic encounter and it is therefore necessary to include these as part of the primary findings. Literature confirms these findings, stating that various influences including the impact that sexual abuse/rape has on the child, affect the therapeutic encounter (Bass & Davis, 2008). The professional working with these children needs to have a thorough understanding and awareness of the impact that rape or abuse has on the

development of the child. The literature review also influences what the researcher brings into her understandings and interpretations. As stated by Bass and Davis (1998), treatment programmes with abused children and their caregivers have to be considered from a number of perspectives so that a comprehensive assessment may be conducted by the counsellor/therapist. In the therapeutic context the therapist/counsellor must be aware of the progressive developmental milestones of the child in order to facilitate a healing process (Fouche & Yssel, 2006). Cognitive development is another factor to keep in mind while working therapeutically. The professional should have a clear understanding of how sexual abuse/rape is comprehended in the mind of the child (Fouche & Yssel, 2006). In terms of Sarah's case her lag in maturation due to her intellectual disability influences her ability to make judgements and the right choices, for instance when she was coerced into the underage sex.

Thandi was raped at a crucial time in her developmental stage, the stage of identity formation, the impact of rape during this crucial stage may have a profound effect on Thandi. The counsellor should therefore consider the child's developmental stage during the therapeutic encounter as well as when having to implement an intervention programme and psycho-education for the child. Family dynamics have a fundamental influence on the child within the therapeutic context (Spies, 2006). The counsellor should be mindful of the child's familial context and the parental background history so that there is an understanding of the child's context and influence during therapy (Spies, 2006). If the counsellor is aware of the caregiver who is struggling emotionally then she is able to offer supportive counselling, thus enabling the caregiver to cope and deal with the child's disclosure while at the same time understanding the caregiver's personal difficulties (Geldard & Geldard, 2002). Some of these familial factors are divorce, poverty, step-parenting and own childhood traumas. These influences form the basis of the treatment programme (Spies, 2006). Therefore considering the child and caregiver's ecological context will be valuable to the counsellor when dealing with sexual abuse and rape as the multi-layered factors within the ecology of the family influences the course of therapy during and after the child has undergone the therapy (Smith, Cowie & Blades, 2003). Cultural factors within the South African context are also another factor to consider when the counsellor shares in the stories of his/her clients. Poverty, illiteracy,

language and culture influence the therapeutic process. McKendrick and Hoffman, (1990) note that breakdown in the family structure is a key factor in sexual abuse and rape. In and amongst these cultural difficulties the HIV/Aids epidemic has a crushing effect on the lives of children and caregivers who receive a positive diagnosis after the sexual abuse or rape encounter. This adds to the worry and trauma of the child and caregiver. It becomes a medical as well as a therapeutic complexity for the professional dealing with the child and caregiver. The role of the caregiver and how the caregiver responds to the child's disclosure of sexual abuse or rape also needs to be considered by the counsellor during the therapeutic process as this will influence the therapeutic process either negatively or positively (Doyle, 1994) as will be seen by the cases studied. The therapist/counsellor who explores how the caregiver deals and understands his/her child's disclosure can then be in a position to recommend supportive counselling to the caregiver who is struggling under the burden of the disclosure (www.healthyplace.com. How caregivers deal with the aftermath of their child's disclosure, n.d.). Worry about the complex legal proceedings can hamper the therapeutic process and thus affects the compliance of the caregiver and child during the therapeutic process (Walton, 2001; Wells, 1994). This is seen in both Sarah and Joe in the first case study. These background influences are part of the client's lived experience and if the researcher's aim is to stay as close and as true to these stories it is essential that they are included so that a richer, more in-depth understanding of the client's experience is described, giving a broader understanding of their stories.

4.6.1.1 Shame, guilt and fear of punishment

In the interview Sarah seemed nervous and shy as evidenced by her body language. When she was asked as to how she came to be at the clinic she looked down, avoided eye contact, was tearful and began wringing her hands as she talked about being forced to do things (under aged sex) she did not want to do. It is alleged that in the first incident she was forced into the underage sex. In the second incident Sarah consented to the sex. Her fear of punishment is at the fore of her initial experience due to her and her father's uncertainty of the law in terms of the Child Justice Act, No 75 of (2008).

No! I actually didn't [know about the Teddy Bear Clinic] we've got this psychologist at my school and cos of the incident that I had, she actually said... she asked my dad if, he would take me to the Teddy Bear Clinic, cos they would know what to do with me further and ja..

I don't want to talk about it [underage sex incident] I thought I was being judged for what I was doing. I know it was wrong..... [Sarah]

These quotes, along with the body language, suggest shame, guilt and possible fear of punishment. This sense of shame and guilt is supported by the literature as being a noted response of adolescents who have experienced trauma who may then have great difficulty establishing a realistic and healthy identity, and may be troubled by negative internalisations resulting from traumatic experiences (Wieland, 1997), as is evident in Sarah's behaviour and initial reaction to the Teddy Bear Clinic. Wieland (1997) differentiates between internalisation resulting from all abuse experiences, where the abuse experience consists of intrusions, self-related threats and acts of abuse and non-protection and distorted family boundaries, which lead to these internalisations. Internalisations such as 'I am powerless' 'I am bad / guilty' and 'I am responsible' are common among abuse victims (Fouche & Yssel, 2006: 247-262). Research indicates that the pain accompanied by guilt and shame, as well as the feelings of shame and guilt as such, if not adequately dealt with, may have long-term effects (Bass & Davis, 2008). The fact that Sarah was raped, was traumatic in itself, while as consenting to unlawful sexual intercourse added to her feelings of shame and guilt particularly as she does not seem to have the cognitive awareness of her involvement that the under-aged sex is unlawful and thus makes her liable to be charged. The dignity of the child must be preserved; they need to be well prepared to talk about it and must not at any time be forced to do so (Fouche & Yssel, 2006). Sarah's disclosure did not happen voluntarily and she was forced into disclosing what had happened by the school psychologist who overheard a conversation between Sarah and her friends. This can result in further shame and guilt (Bass & Davis, 2008). Despite the therapy there is a sense of her feelings of shame and guilt throughout the interview over what she did.

When interviewing Sarah's father there is further confirmation of the researcher's initial interpretation of the child's sense of shame and guilt. The way her parents

reacted to her disclosure could have further added to her sense of shame and guilt and fear of punishment.

'We snapped when we first heard about it, I was angry...' Sarah's father admits to handling the disclosure inappropriately in the beginning. This may have given Sarah the idea that she is a 'bad' girl, possibly causing her to feel further shame and guilt. This was not probed further as Sarah had a hard time just describing how she came to be at the clinic. The researcher was cautious due to the sensitive nature of the topic and the fact that Sarah had just completed her therapy, thus avoided asking direct questions about the incident due to ethical considerations and to prevent re-traumatisation. The interviewer was left wondering whether further counselling would be beneficial with regard to Sarah's feelings of shame and guilt.

Research alludes to the fact that the way the caregivers handle the child's disclosure will influence the outcome of therapy (Mash & Wolfe, 2005).

We snapped when we first heard about it, I was angry.....my wife on the other hand did struggle, she is the stepmother of course, from a sense of uhhhhh, ohgg, how can I put it uhmm (pause) man (pause) I don't want to say typical stepmother thing, but she was disappointed in Sarah, I think had it been her own daughter biologically, she may have handled it slightly differently....she was upset and I had to kind of guard Sarah to a point...[Joe]

Joe and his wife were angry and his wife was disappointed with Sarah when they found out what had happened. They did not deal very well with the disclosure and possibly frightened her with the possibilities of what a legal charge against her could mean. Joe's preoccupation with the law is seen in a later theme on 'legal issues'. The literature states that, how the caregiver deals with the aftermath of the child's disclosure in terms of feelings and emotions is very significant for a positive outcome to the therapeutic process (Mash & Wolfe, 2005). This is particularly relevant since it is the caregiver, who will be helping the child recover. The disclosure and reason of referral together with subsequent decisions the caregiver has to make seem daunting and overwhelming. He has to face and deal with Sarah's involvement in the underage sex incident as well as deal with how his wife reacted towards Sarah. Joe seems to be vacillating between different emotions of anger, protectiveness of his child as well as fear of punishment and legal consequences. The law dictates the

wider voice of society's influence and Joe's reaction to the situation, illustrates his fear of punishment which echo his daughter's fear of punishment. These elements are seen in the quote below.

...like an interrogation kind of a thing [Teddy Bear Clinic interview] now, uhuh [pause] and beat everyone over the head including mommy and daddy [pause]. I had been going through a difficult time with my wife.... I was angry about it of course, she is my little girl. They, [Teddy Bear Clinic professionals] are here to help her and not hit her over the head with it... [Joe]

Later in the interview with Sarah's father the same phrases and ideas are repeated in the following quote:

... uhmmm, I think it's natural as a parent to have a little bit of resistance of what's going on here now! [pause] uhuh, like an interrogation kind of a thing, now, uhuh [pause] and beat everyone over the head including mommy and daddy [pause] and at first I didn't think, it was appropriate for what we needed... [Joe]

As was mentioned, Joe and his wife did not handle the disclosure very well initially. They reacted with anger and disappointment. Mash and Wolfe (2005) state that, the caregiver's response, results in greater trauma if it is not handled correctly. According to Pollock and Farmer (2005) most caregivers have little or no knowledge of sexual abuse to support the child. Both of Sarah's parents' initial reaction to her disclosure was unsupportive as they were angry with her for participating in the underage sex. The phrase beat everyone over the head including mommy and daddy shows Joe's fear of punishment which is echoed in his daughter's comments. However, as Joe overcame his initial anger he wanted to help and support his daughter. The issues between Sarah and her stepmother seem to still remain unresolved as seen in the theme 'relationship with stepmother' and seem to have more to do with their relationship as a whole than on just the underage sex. Reflecting on all the factors within this theme it seems the child and parent echo each other when referring to fear and punishment and accompanying sense of guilt and shame surrounding the reason for referral. This confirms the importance of the reaction of the parent (Mash & Wolfe, 2005) and perhaps suggests that the parents should be included in the therapeutic process at the clinic.

Another factor to consider in the way Joe reacted to Sarah is his own childhood sexual abuse. Any of his unresolved issues relating to the abuse may have also affected his reaction as well as to how he responded to Sarah after her disclosure.

I have been through some of it and uhmmm (pause) sexual trauma as well as uhmmm [pause]. [Joe]

This incident with Sarah could be bringing up some of Joe's own feelings regarding his childhood sexual abuse, influencing how he deals with this situation, as well as how he interacts and supports Sarah. Once again, this suggests a need for parents to receive therapeutic support.

4.6.1.2 Developmental stage

Being a teenager, lacking in self-worth and struggling to form an identity may have caused Sarah to consent to sex just so that she could be liked or accepted. Erikson's developmental theory states that the adolescent's identity crisis is the central problem at this stage of their development. The internal cause of this crisis lies in the physical and psychological changes that begin with puberty. In order to solve the identity crisis, adolescents experiment with various possibilities (Meyer & Van Ede, 1998). In Piaget's cognitive developmental theory, it is stated that adolescents think differently from younger children. Their speed of information processing continues to increase. Although their thinking may remain immature in some ways, many are capable of abstract reasoning and sophisticated moral judgement as well as planning more realistically for the future (Berk, 2006). However in Sarah's case this stage may still not have been achieved due to her developmental lag. Thus she may be easily influenced by her peers to do as she has been told and to appear pleasing and compliant, which is more common for children in the formal operational stage.

As an adolescent having one's peers accept you as part of the in-group is very important and perhaps her need to be liked and accepted may have caused her to engage in an activity that she was not developmentally ready for: she was coerced into sexual intercourse and she lacked the strength and assertiveness to say 'no'.

Stand up and say 'no', it's especially hard for me...it's really hard to say 'no!' [Sarah]

There seems to be a recurring pattern in the interview with Joe which indicates that Sarah takes on her father's ideas on being punished and also takes on the example of how her mother treats her that confirm that this child easily takes on the ideas of others as her own. For example,

It was really stressful and I kept on saying, I won't go back, I won't go back. We haven't got a mother to hang onto and it's just really emotional.

This also illustrates how vulnerable she is to the influence of her peers, especially where she was urged to consent to the underage sex, for example when she says, 'for me I know it's really hard to say no'.

4.6.1.3 Relationship with stepmother

Sarah lost her mother at a crucial time in her development. She was nine years old when her mother passed away. The loss of the biological mother in this family seems to have affected all the children. However, the loss for Sarah at such a young age is particularly significant. Sarah would have been very dependent on her mother after she got ill as a baby making it likely for her to have developed an extremely close connection with her mother. The meningitis that affected her as an infant and the amount of time her mother spent nursing her child back to health and helping her cope with the difficulties may have created a stronger bond between them (Bicknell, 2011). There is a sense of Sarah's unconnected and burdened relationship with her stepmother. She seems to yearn for a closer maternal connection with her stepmother, but is struggling to develop this relationship.

She's my stepmom so ja (pause). My real mom actually passed away in 2004 [pause] so I haven't actually bonded with my stepmom and I actually would like to, and ja, [pause] I dunno. I actually don't think she is doing a good job as a mother, we don't have anyone to talk to, it's, really emotional [tearful] what mother does that. We haven't got a mother to hang onto. [Sarah]

It is apparent from the quotes above that Sarah would like to form a closer bond with her stepmother. However, in this relationship it would take both of them to work at this together (Becvar & Becvar, 2000). It does not seem that Sarah's stepmother took the opportunity to use the therapeutic space to try to develop and understand her stepdaughter. It is Sarah that uses the therapeutic space with the counsellor to

help her negotiate a better relationship but this does not seem to have happened and she is left feeling disappointed.

I took the counsellor's advice, I tried straightening it with my stepmom and I [pause], it didn't work, cos I [pause] sometimes she doesn't want to listen to me and sometimes she does. Cos I actually don't think she is actually doing a good job as a mother. [Sarah]

Again Sarah also seems to echo the views of Joe regarding his wife's role as a mother. This shows the vulnerability of this particular child finding it difficult to form her own opinions and resist what others tell her as stated in the theme above.

This theme is very prominent throughout the interview and took up much of the therapeutic space to try and resolve. It was within this holding frame that Sarah began to see her counsellor as a maternal figure where she is held, supported and understood. Here it is clearly seen how the background influences can impact the therapeutic process. It is seen here how it influences the counsellor's role. The counsellor is someone who will not give up on her, who will be there for her.

I don't want to lean back on her [stepmother] I have got other people to go and talk to like my grandmother and my counsellor. [Sarah]

Sarah talks very emotionally about her personal struggle with adjusting and coping with her stepmother, and wanting more than anything to form some kind of a bond with her. 'Maybe I will probably bond with her a lot now.' Sarah seems to hope that it will improve but it seems that the underage sex incident has disconnected this relationship even further as noted in her quote 'I tried straightening it out with my step-mom and I, it didn't work'. The absence of her mother was illustrated in the therapeutic process, as well as in their day-to-day relationship. Sarah expresses a real need for her to feel loved, wanted, accepted and understood by her replacement mother. Her stepmother's reluctance to be part of the therapeutic process may have also hampered the process of developing a connection with her and helping her overcome her feelings of shame, guilt and fear of punishment.

Sarah is now entering her teen years. Children in this transition into adolescence, struggle with role confusion and role identification (Berk, 2006). It is a developmental period marked by confusion and emotional turmoil (Berk, 2006). Teenagers are

striving for a general need for autonomy and identity. To add to Sarah's difficulties blended families are difficult to integrate into the family system, especially for children, as they have to adjust to the new system of step-parent and step-sibling (Becvar & Becvar, 2000). Most children do not have a choice of who their parents choose to marry. What may be more difficult is when the deceased parent is replaced by another. All of the children in this family are affected in some way by the loss of their mother as described by their father Joe.

It impacted my oldest daughter the most and I am busy going through hassles with her, my twin boys were much younger than Sarah and didn't really know their mother. [Joe]

Sarah's mother's death has left a void in her life as she does not experience a close relationship with her stepmother. From the interview process it is understood that most of the therapy centred on helping Sarah deal with the relationship issues between her stepmother and herself. This seems to place a lot of responsibility on the counsellor to fix the situation between them. This was interpreted by the question the researcher asked Sarah when she asked if there was anything that she found unhelpful in her experience. 'I took [counsellors] advice, it didn't work.' When clarifying the understanding of her response she said that she felt that the clinic could have helped her stepmom to connect with her. There is a paradox to this in the interpretation, as it seems as if Sarah may be yearning for the maternal connection but at the same time rejecting it, by saying she doesn't want to lean on her stepmother. She is also guarding herself in defence against a connection in case she gets hurt, abandoned, or rejected, which is illustrated by her comment on 'I have other people to lean on...' She also shows ambiguity when she says 'I haven't actually bonded with my stepmom and I actually would like to, and ja [pause] I dunno'.

Sarah gives a heartfelt illustration of the disconnected relationship she experiences with her stepmother in relating the imminent separation from her brothers who are going to boarding school. This is a loss that Sarah cannot prevent and therefore it further impacts her relationship with her stepmother, making the divide between the two of them wider.

I am trying to build a relationship with her, but she keeps on breaking it down, and I don't like it [pause], it's just really emotional to see my brothers go through this [pause] and I know it's for whatever reason that she has got, [pause] that it's a good reason [Tearful and emotional]. [Sarah]

From the quotes above it could be possible that Sarah is projecting her own denied emotions. Shepard (n.d.) notes that projection is a psychological defence mechanism where a person subconsciously denies his/her own attributes, thoughts and emotions, which are then ascribed to the outside world, usually to other people. Projection reduces anxiety by allowing the expression of the unwanted unconscious impulses or desires without letting the conscious mind recognize them as her own feelings. It seems therefore that Sarah is projecting her own feelings onto her brothers in the following quote:

Uhhh just to be part of their lives, they want to experience what Jason, experiences with his mother (pause) we haven't got a mother to hang onto. We can't talk about anything and it's just really emotional. [Sarah]

I actually don't think she is doing a good job as a mother... she is not concentrating on our needs and our wants, she only concentrates on her son [pause] and that is also very frustrating cos, my brothers really need something from her and then she says 'NO' [pause] what mother does that [pause, sigh], I don't know. [Sarah]

Sarah emphasises the sibling separation rather early in the interview. She talks of her twin brothers who will be going off to boarding school in a month's time. Sarah seems quite protective of her brothers and is struggling to understand why they have to go to boarding school. In the beginning of the interview she said that she understood why they had to go, however later on in the interview she contradicts herself by saying how angry she is with her stepmother and blames her for this separation and for the way her brothers are treated. Sarah yearns for her and her brothers to feel as loved and accepted as their stepbrother does by their stepmother. Thus the researcher senses that Sarah has projected much of her own maternal needs onto her brothers, when it seems that Sarah is the one that has a deep need for maternal love and connection.

The above extracts exemplify the impact that the loss of a primary caregiver has on a child. For Sarah, the loss of a maternal figure in her life is profound and her wish for this emptiness to be filled by her stepmother has been to no avail.

4.6.1.4 Legal issues

This theme links to the preceding theme of punishment and the fear of the legal implications which to date is still an unresolved matter. In these extracts the anxiety and concern over the unknown for Joe (caregiver) is profound as he considers the voice of wider society in the form of the law.

They [Teddy Bear Clinic] pretty much expect that it's their problem now and I must go home and forget about it [pause], but it's going to be my problem again [sigh] and I [pause] I am damn upset with them [parents of the boy] because they have not come forth... [Joe]

You are forced to go through this cos legislation can hit you over the head with this...If this happens then we are all called in again, because it has'nt been dealt with and from there it goes to an investigative court level, I believe [pause] and then she [Sarah] has to be called in again, simply because the boy's family is not responding, which I am fairly anxious about. I don't want it to go to a level where they both get charged [pause] whatever the charges of the underage sex are. [Joe]

From the extracts above one is able to identify with Joe's anxiety and concern over the unknown. His initial experience of the Teddy Bear Clinic is one of fear, trepidation and uncertainty resulting from fear of punishment as seen by the repetition of the words in the earlier theme 'interrogation, beat everyone over the head including mommy and daddy, and hit you over the head'! Joe has to sit with a lot of uncertainty, which causes anxiety and fear of punishment. Before Joe came to the clinic he was really afraid of what the experience at the clinic would be like for him. It seems that his fear is centred on being blamed and somehow punished for being a bad parent. Joe is anxious about what will happen to Sarah as well himself as the child's caregiver and worries about all the legal implications. Sarah seems to echo her father's thoughts 'I thought I would be judged, and whatever the charges of the underage sex are'. The caregiver is unaware of the unfolding legal process and the fear of the unknown can be alleviated through supportive counselling and psycho-education. Caregivers are usually not aware of the need for support or

training in dealing with sexual abuse (Geldard & Geldard, 2002). Pollock and Farmer (2005) note, that caregivers have little or no knowledge of how to support their children through these incidences. However the caregivers' own fears about being blamed and labelled prevents them from seeking support and help. It could also be Joe's anxiety that is perpetuating Sarah's guilt, shame and fear of punishment as she echoes her father's thoughts. Joe was really afraid. However, he desperately wants to help and be supportive of his daughter through this process, despite the legal and personal losses that could occur. It is evident that the caregiver does not feel he has any control over the legal process as well as no control over the boy who had sex with his daughter. This seems to be creating a lot of anxiety and frustration for him, placing a lot of responsibility on the clinic to bring closure to this case.

They [Teddy Bear Clinic] pretty much expect that it's their problem now and I must go home and forget about it [pause], and that's where I feel the Teddy Bear Clinic needs to wield their power.

Sarah and the boy as yet have not been charged with a criminal offence. The Teddy Bear Clinic does not believe in criminalizing children and therefore campaigns for the child and helps the child to understand the nature of their behaviour. A child who is engaging in sexual activity is fulfilling some other need. Sarah was involved in counselling and a diversion programme which is psycho-educational in nature, giving the child skills to make healthier choices.

Joe has many concerns as to what his role in this legal process is and where it will all lead if the alleged child and parents do not come voluntarily to the process. It is almost a year since the incident, his daughter has completed the therapeutic process and Joe is still unsure of where he stands with the case and is still waiting for closure. He seems anxious about the legal process from here onwards and does not know what is going to happen. This is causing Joe some anger and frustration toward the clinic.

I would like to know [stated firmly] because sooner or later I am gonna, someone is gonna snap somewhere, it needs to be dealt with. [Joe]

Emphasizing the need for the caregivers to be informed as to how the case is progressing through a process of feedback, Joe felt that he came to the process voluntarily so as to avoid legal action and he can't understand or control the other

party coming forward or why they have not been forced to come forward. 'I feel the Teddy Bear Clinic needs to put more pressure on these people, and deal with it.' Joe seems to vacillate between the clinic taking responsibility and it being his problem. 'They [Teddy Bear Clinic] pretty much expect that it's their problem, but it's going to be my problem'. The unknown is causing him to feel angry and powerless fearing loss of control 'snapping'. Joe has to let the clinic professionals deal with it from here onwards, however he is finding this difficult to do. He says if they do not come forward, it would mean court proceedings and a long drawn out legal process.

Research states that excessive and complex legal proceedings harm rather than help child victims and this would include caregivers (Jenson, Jacobson, Unrau & Robinson, 1996). Joe is angry and wants the boy involved in this incident to be accountable as well as his parents. At the point of this interview they have yet to take any responsibility for the incident.

4.6.1.5 Marital and parenting difficulties

In the following extracts Joe describes some of the difficulties that his wife and he are dealing with as a reconstituted couple and family. The couple's relationship is constantly re-negotiated as the children move through the different developmental stages. To add to this the couple have to find a way to negotiate and structure discipline and boundaries in the system. This couple are finding it difficult to do and with Sarah's incident, this seems to have added to the already burdened system.

Because I had been going through a difficult time with my wife, otherwise we would have been here together... [Joe]

They know more than us, I think I was probably twenty (pause), my kids know more than I do now (pause), so they got all this information without the maturity of handling that responsibility and they struggle with it...[Joe]

Sarah is not one I will let go anywhere, she has got no social boundaries that is why we are here, she is easily pushed over, pushed around and offended... [Joe]

Here again this reflects Sarah's view of herself 'I can't say no'.

In the first quote Joe implies experiencing marital problems, in the second quote he describes the difficulties of raising teenage children. In a marriage this is a difficult

developmental stage to negotiate both for parents and children (Becvar & Becvar 2000), to be experiencing these difficulties in a re-constituted family make the negotiating that much more difficult to do. In the latter extract Joe describes the difficulties of raising a special needs child, which further impacts the marital relationship. Sarah's stepmother may really be struggling in trying to understand and cope with Sarah's difficulties. Joe talks about the relationship being in trouble,

I had been going through a difficult time with my wife.

He does not mention if this is because of Sarah's disclosure or personal issues between them.

My wife did struggle, I would imagine my wife certainly, I am not being condescending at all, it's just the character that she is... [Joe]

It seems that it was a significant problem at the time and they had a hard time working through it. Joe also had difficulties with his wife over the decision to come to the Teddy Bear Clinic. She seemed aversive to the process, cautious about coming to the clinic and not knowing what the implications for them would be. Joe also mentions how his twin boys are becoming particularly difficult to discipline

My kids know more than I do now so they got all this information without the maturity of handling that responsibility...we decided to send them to boarding school to toughen them up a little bit, give them some independence. [Joe]

In Joe's opinion sending them to boarding school seems like a good option for now. Joe says it's to teach them to be hard and independent. This sounds like a contradiction; Joe wants them to go to boarding school to toughen them up and give them independence, yet at the same time he says they know too much and don't have the maturity to handle it. There is a sense of his reluctance to let them go and really emphasised that 'it won't be so bad because they will be home on weekends', making the separation easier to bear. This leaves the researcher wondering whether it was a decision the couple made together or if it was Joe's wife's decision to send Joe's boys to boarding school, something that may also have been a factor in the couple's marital difficulties at the time.

The presence of children from a previous marriage in the new blended family brings additional stressors and divided loyalties. Success in a marriage is closely

associated with how partners communicate, make decisions and deal with conflict (Papalia, Sterns, Feldman & Camp, 2002). Blended families are burdened by the baggage not carried by the 'original' family and it cannot be expected to function in the same way. Family histories can complicate present relationships (Papalia et al., 2002). Previous bonds between children and their biological parents or loyalty to an absent or dead parent may interfere with forming ties to the step-parent (Papalia et al., 2002), which is illustrated in the relationship between Sarah and her stepmother. Joe also speaks about the difficulties of parenting a child that is cognitively challenged and who struggles emotionally 'She is not one I will let go anywhere, there will always be room in our house for her til the day she dies.' All the above factors as well as the disclosure could be the reasons why the marriage may have been struggling at the time. The problem that Sarah brought into their lives could be adding to this already difficult situation, making it difficult for the parents to stand together.

The marital and children difficulties that this family had been experiencing at the time may have impacted on the positive therapeutic encounter that Sarah struggled with in the beginning of therapy and the couples divided loyalties further impacted the supportive counselling they could have received at the clinic. Joe expresses this:

Because I had been going through a difficult time with my wife otherwise we would have been here together. [Joe]

4.6.1.6 Outside support structures

Both of the caregivers in these case studies used the support of their respective churches to help them through their personal difficulties. Joe and his wife felt that they could only trust their church counsellors during this time of difficulty, possibly causing him and his wife to view the therapeutic relationship as threatening. Thembi sought out her church as a safe refuge to try and deal with her emotional pain when supportive counselling for the caregiver was not offered to her at the clinic. However, a particular sermon she went to seemed to have added to her worries and concerns for her daughter's emotional and spiritual well-being and this affected the therapeutic process.

I [Joe] always go to one of our pastors, uhmmmm or an elder that I can trust, who will be able to help in that situation, just to get them praying for the family and that, and yes, just to seek advice, cos they can even give you legal advice...

She [Sarah's stepmother] did sit with the counsellor, and uhhh the [pastoral] counsellor [pause], I don't know what they spoke about, but she obviously got support for Sarah [pause] and explaining to the counsellor what [pause], so she, she coped, her, uhhh therapy was from our church. [Joe]

This indicates that the caregivers often do not choose to go for supportive counselling even if it is offered to them and choose to get help and support through their respective churches and pastors. The counsellors dealing with caregivers that choose to use outside support structures should be mindful and respectful of their choices and to check during feedback whether they are getting the support they need and whether it is in fact helping them. If not they can recommend additional resources to support them.

It's, always important to respect the parents, background especially to religion, [pause] some views of things that were said to Sarah, I was not happy with. It would just be nice to respect our point of view sometimes [pause]. If it's okay with us before they tell a child this is okay..... I did not hundred per cent agree with everything, I am from a Christian background, but they give the basics [pause] the good that they are trying to do. [Joe]

The quotes above show how Sarah's caregivers were influenced by their belief system thus choosing to use this medium of support rather than the clinic's supportive counselling. There is a sense of Joe's reluctance to trust the therapeutic process in terms of respecting his beliefs, as well as being unsure about whether he can trust that the Teddy Bear Clinic will help prevent any further legal action. Joe also mentions a concern for him during Sarah's counselling process that he was not particularly happy about. He said that the counsellor's values and their values as a family differed, showing how different religious beliefs and values influence the therapeutic encounter (Lines, 2007). Joe found these to be in conflict with what he has taught Sarah. Joe describes his values and the counsellor's values as different and that he would have liked for the counsellor to be respectful of these and maybe to have consulted with him first, before discussing topics around sexuality and sex with Sarah. Joe's differing values and beliefs may have contributed as the reason

why he did not feel comfortable to come for supportive counselling to the clinic when the counsellor offered this to him. His views, ideals and values differed to the counsellor's in terms of his Christian values and beliefs. Joe seemed to have received the support and help he needed from the church, as did his wife who was not at all open to getting supportive counselling from the Teddy Bear Clinic.

In Thembi's case no supportive counselling was offered to her by the clinic which seems to indicate a lack of consistency on the clinic's part in terms of offering some clients supportive counselling and not to others. Thembi was left feeling burdened and struggling with her own pain around her daughter's rape. This caregiver sought out the church for support however this seemed to have added to her burden. This is illustrated in the following quote:

I am a Christian, some sermons at church, like Sunday, eh hh the theme was soul ties, and in that the pastor was explaining that uhh sex is not for people that are not married....if it happens that you have sex with this person your soul it's tied to that person and in those souls you could adopt some of the characters from these souls and they become part of you and sometimes you find yourself behaving in a strange way. So you know you hear such things and you ask yourself, [pause] here it is, this person has raped my daughter. I don't even know, even if I knew him, what is it going to do to my daughter, you know [pause] for her lifetime, ja, it really worries, it really worries. [Thembi]

The message that Thembi received from this sermon was that her daughter would never heal from the rape because her soul had been tied to the rapist's soul and that Thandi would carry around this awfulness forever. Thembi did not receive supportive counselling from the clinic, 'There is no care for me on my side as the mother, mhmmmm, that... is the only unhelpful thing.' If Thembi had received some supportive counselling at the clinic, there would have been space for to unpack this worry and concern about what the sermon could have meant and thus Thembi could have made some kind of sense out of it and therefore not have to carry around the idea of what the rape will do to her daughter's soul, thus, perpetuating her own sense of hopelessness in her daughter's journey to healing.

Understanding the values within the family of the child allows for greater understanding and therefore a more holistic approach to the therapeutic intervention

process (Lines, 2007). Caregivers are central to helping the child through the healing process, and therefore need support. All caregivers benefit from information, guidance and help in connecting with resources. For caregivers with additional challenges, the need for support is even greater (Pollock & Farmer, 2005). The effectiveness of both family support and family preservation services depends on the skills and ability of service providers, to work closely with caregivers from different cultures and ethnic backgrounds (Pollock & Farmer, 2005). Joe could have benefited from supportive therapy, as he seemed to be struggling with many different issues at the same time. The marital problems, discipline of children, worry about the legal implications of this incident all seem overwhelming for Joe. The Teddy Bear Clinic did offer and extend supportive family counselling services to Joe and his family, however he did not feel it was needed and both Sarah's caregivers chose not to use this avenue and turned to their church for the support they needed instead. Thembi on the other hand really wanted supportive counselling for herself. However, this was not offered to her. She sought refuge at church where a sermon left her feeling overly burdened and worried. Thembi's fears and concerns were never expressed to a counsellor who could help her to make sense of this and help her to alleviate her stress and worry about her child's rape. Thembi was never offered the opportunity to express her feelings in a safe, respectful atmosphere. This made it difficult to understand and support her daughter through the therapeutic experience and she was left feeling isolated and alone.

4.6.1.7 Previous relationship with counsellor

In this theme Thandi experienced a negative therapeutic encounter prior to her experience with the counsellor at the Teddy Bear Clinic. This previous experience influenced her subsequent therapeutic experience at the Teddy Bear Clinic, as she was very cautious and tentative in the early stages of her therapy.

Personally it irritated me because it was like, you know when somebody [previous counsellor at the school] insists and insists and insists, you eventually just doing it for the sake of that person to get off your back, so ja, sitting down and talking to a stranger, personally it irritated me... [Thandi]

Thandi had a negative counselling experience previously at her school. She says that she was once referred to a school counsellor as she was experiencing some

personal difficulties. The school counsellor pushed her for information and did not care to establish a relationship with her before she felt safe enough to disclose her feelings and problems.

I love talking, but not really about my problems, if I do talk about my problems, selective people, like people [pause], a person I know I can really trust, so when I got here, I said okay fine let me just give away bits and bits of my life away not everything... [Thandi]

The negative counselling experience, that Thandi had with the school counsellor made her feel unsafe and uncomfortable to open up when she first arrived at the clinic. She was tentative and sceptical about how she would be treated in the encounter with the counsellor and whether this counsellor could be trusted. So initially she told herself that she would only give away little bits of information. However Thandi's counsellor at the Teddy Bear Clinic was able to establish a safe and trusting environment very early on in the therapeutic relationship and she said she found the counselling experience at the clinic positive and effective in helping her cope and deal with the effects that the rape had on her.

Oh she [counsellor] is like [pause] honestly like my best friend like right now, and I am quite sad that I am not going to see her again. [Thandi]

This indicates the importance of the connection and relationship that is established between client and counsellor/therapist (Corey, 2005).

4.7 The voices of children and caregivers on the therapeutic experience

Article 12 in the UN Convention on the Rights of the Child states that children have the right to say what they think should happen when adults are making decisions that affect them and that their opinions should be taken into account. James (2008) confirms that listening to the voices of children has become an expressed demand both within and outside the academic world. Children are persons and not property; children have the right to be heard, to privacy and to be represented legally (James, 2008).

4.7.1 The Therapeutic relationship

In this theme Sarah's experience of the therapeutic relationship is described. She talks about her experience of the stress of being in the session with the counsellor, and her sense of feeling pressured by the counsellor as well as her sense of fear and punishment, which relates to the earlier theme of shame and punishment. How the background themes affect the relationship can be seen in the interrelationship of the themes.

It was stressful [the session], I cried a lot and I did not want to talk about anything, because I felt like I was being pressured by the lady who helped me... I did not like talking about what I did, uhmmm, and kept on saying, I won't go back, I won't go back, and they kept on pressuring me, it felt like they were pressuring me, meantime they wanted to help me. [Sarah]

About four or five sessions after that, I knew where they were coming from and I knew they wanted to help and I thought that they want to help me to never go back to what I did. [Sarah]

It was actually a nice experience, she helped me through difficult parts and uhmm, I know that she is always there for me and that she can help me, and I can basically tell her anything that I want to. [Sarah]

In time Sarah's perception of fear of punishment changed through the therapeutic process and she realised that the counsellor was there to help her, not to punish her. Sarah had no idea what the Teddy Bear Clinic stood for before her experience at the clinic. She describes feeling pressured in the first few sessions. She did not know what was going to happen to her or how much trouble she would be in. Her fear of punishment for what she had done was illustrated in the way she described her first few sessions at the clinic. Her sense of being pressured during the initial sessions with the counsellor did not allow her to open up a space to develop initial trust and rapport and this was only developed later on in her sessions with the counsellor. The way the disclosure was handled by her parents may have been the reason why Sarah was so afraid of coming to the Teddy Bear Clinic as she was afraid that she would be punished, as well as causing her to put up a defensive barrier in forming a safe and trusting relationship with her counsellor in the first few sessions.

We snapped when we first heard about it. I was angry. Like an interrogation and beat everyone over the head including mommy and daddy. [Joe]

This would explain Sarah's reluctance and fear in the first few sessions at the clinic. She also may have picked up on her father's attitudes and perceptions as the themes of punishment are echoed in the caregiver and child quotes.

Literature supports the above. Mash and Wolfe (2005) note the way disclosure is handled by both the parents and the professionals is important to the child's healing process. Pollock and Farmer (2005), state that disclosure may be accidental whether through observation by a third party, or a conscious decision. In Sarah's case a third party made the observation; the school psychologist overheard Sarah telling her friends about the sex. Sarah and her father were called in and Sarah was confronted about what the psychologist overheard. It was in this forced setting that she disclosed the underage sex. In terms of accidental disclosure, intervention may be difficult because neither the child nor the other members of the family may be willing to take it further and seek help (Spies, 2006). Sarah's father said 'I was angry about it, and angry with the young man, he was also underage'. There is a strong sense that her father was afraid and angry with Sarah after the disclosure, which made him sceptical of the clinical process initially. Sarah's stepmother was also angry and disappointed and did not want to be a part of the process at the Teddy Bear Clinic. Joe said, 'my wife did struggle, she was upset and I had to kind of guard Sarah'. Fortunately for Sarah, after her father's initial feelings of anger and fear he was willing to seek help and support Sarah especially as he did not want any legal ramifications because of this incident. Research indicates that, if a sexually abused child's personal power is respected during the disclosure the child will be more capable of making meaningful decisions (Crosson-Tower, 2005). Crosson-Tower (2005) warns professionals not to pressurise these children but rather to prepare them for the possibility of what may happen because of the disclosure.

Sarah does not describe in her interview how her parents handled her disclosure. However, her sense of fear about what could happen to her from a legal perspective with regard to the underage sex was evident. It wasn't so much what Sarah said about the disclosure that led the interviewer to believe that the disclosure was dealt with badly, but rather what her father describes in the interview that makes it clear

that the initial reactions after her disclosure were handled badly, ‘we snapped when we first heard about it, an interrogation kind of a thing and beat everyone over the head including mommy and daddy’, causing her to be fearful of the therapeutic process and professionals at the Teddy Bear Clinic, as well as fear of punishment from the police. An unsupportive or over-reactive parental response results in greater trauma (Doyle, 1994). A demonstration of support by parents in spite of the doubts they may have, could increase the possibility for further disclosure and/ or opens the way for further investigations (Doyle, 1994). The initial reaction to the child’s disclosure of an abusive experience will have an effect on the child’s sense of well-being (Doyle, 1994). Despite the difficulties of the feared therapeutic encounter as well as a badly handled disclosure, Sarah and the counsellor at the Teddy Bear Clinic were able to establish a good therapeutic relationship eventually. The counsellor used empathy, understanding and a non-judgemental attitude to build a trusting and safe environment, which allowed Sarah to begin to allow for a positive therapeutic encounter. ‘It was actually a nice experience, she helped me through difficult parts, I know that she is always there for me and that she can help me.’ She was able to explore and discuss some of her initial fears about being at the clinic as well as learn how to be more assertive and develop a more positive self-concept. Overall, Sarah describes the therapeutic intervention as positive. Fouche and Yssel (2006) state that in the therapeutic context it is imperative that professionals have a clear understanding of the child as well as the child’s family and environmental context, which is vital in helping the child and family cope with trauma.

Uhhh from the first session with the counsellor, she explained what the objective was and then I was still a little bit trepidatious [caregiver], but then I accepted and said well fine! Great! It’s here [pause] we are here to help Sarah and at the same time parallel, to get this incident sorted...I just needed the security that this was going in the right direction [pause] that it would be dealt with. [Joe]

This quote mirrors the same feat to acceptance of the process seen in Sarah’s excerpts. The caregiver was finally able to relinquish control and was willing, as was Sarah, to allow the counsellor to take control so that the process could unfold and for healing to take place.

4.7.2 The role of the therapist

Sarah's experienced the therapeutic relationship differently to Thandi. Each child entered the therapeutic relationship with a different set of expectations. Both children's background experiences affect the therapeutic relationship differently. Sarah describes her experience as:

She [counsellor] never gave up on me, she was with me through all the stages that were difficult for me, she picked me up when I was down she [counsellor] did a lot of things for me. [Sarah]

I don't want to lean back on her [stepmother], I have got other people to go and talk to like my grandmother and my counsellor. [Sarah]

It seems that the counsellor is being set up as some sort of support figure to fill the void left by her stepmother. Sarah was able to find some nurturance and maternal support with the counsellor after building a trusting relationship with her. This is indicated in the way she describes her relationship with the counsellor. She says that the counsellor never gave up on her and was there for her during the difficult times. It is as if she describes how a mother would be there for her child through all the developmental stages, during good times and bad times. A warm, trusting, and caring environment was created in the therapeutic relationship, which allowed her to express her deep feelings and concerns around the problems with her stepmother.

Sarah describes how the counsellor was there for her during the difficult times and through all the stages and that she can always come back to the counsellor whenever she needs to. Often counsellors act as surrogate mothers for children experiencing difficulties in their maternal relationships, providing a nurturing environment in the therapeutic space, which can allow for the lost or broken relationship with the mother to play out (De Jonghe, Rijnierse & Janssen, 1992). What is evident in Sarah's interaction with her counsellor is that she is provided with a safe frame for her to experience some kind of intimate connection, indicating the beneficial nature of the therapeutic relationship for children experiencing emotional difficulties.

When Sarah was asked what she found unhelpful at the clinic, she said that the problems with her stepmother were still unresolved. Despite the amount of time she

and the counsellor spent working on the relationship issues concerning her stepmother it seems that the therapy somehow failed her in this respect

I took [counsellor's] advice, I tried straightening it with my stepmom and, I, it didn't work.

For Sarah it was really important for her to have the counsellor fix the problems between her and her stepmother and this did not happen. This links to the above theme of relationship with stepmother and the difficulties Sarah has been experiencing within this relationship.

Thandi describes the therapeutic relationship as warm and trusting, which allowed her to work through the trauma of rape.

Oh she [counsellor] is like [pause] honestly like my best friend like right now, and I am quite sad that I am not going to see her again. [Thandi]

Like the day before my appointment, I would be so excited because I'd carried all this weight on my shoulders for like a week and a half, ja then come and off load here and go face the world again. [Thandi]

I feel as if nothing has ever happened, I am like myself again [pause] after a while though [pause], I feel normal again. [Thandi]

Thandi emphasises the connection and trust that was established very early with her counsellor, although both children were influenced initially by background themes that had to be overcome so that they could form a therapeutic relationship. For Thandi the previous encounter with a school counsellor made her weary and distrustful of all counsellors and her expectation of therapy was somewhat clouded until she met with the counsellor at the Teddy Bear Clinic who made her feel comfortable and safe. It seems that Thandi's biggest concern in starting the therapeutic process was of being able to trust the relationship between herself and the counsellor. She says that she usually does not feel comfortable talking about her problems. Even though she is an extrovert, Thandi finds it difficult to talk about her deep feelings as stated in the theme 'previous relationship with counsellor'. Being comfortable and feeling safe in the therapeutic process is important for all clients but for Thandi this seems to be an aspect of the counselling experience that she feels very strongly about before she can trust the therapist to talk about the rape. As

previously mentioned this may have had something to do with a previous negative experience where she found that she was not comfortable or trusting of the relationship between herself and the school counsellor.

The counsellor at the Teddy Bear Clinic took the time to build a trusting relationship with Thandi and allowed her the time and space to go at her own pace. She says she became comfortable and then began to open up.

I was assigned to a counsellor, I have not spoken to my cousins about it, so how would I feel speaking to a stranger about it... gradually then I started getting comfortable, ja then before my appointment I would be so excited... [Thandi]

Thandi's positive experience in the therapeutic relationship with the counsellor allowed her to open up and begin exploring the trauma of the rape, thereby beginning a process of healing. It shows that trust was established in this relationship with the client, helping her to make sense of the trauma. The client uses the metaphor of 'a weight on her shoulders' to describe the heaviness of the rape and how coming to the clinic allowed her a safe place to vent as well as help her to face the week ahead until she could come to therapy again. The client felt empowered and positive about this therapeutic encounter. Thandi seems to be ending her therapy on a high note. Even though she describes being sad about it coming to an end.

It is clear from what the client has described, how difficult it is for clients to feel trusting of the therapeutic space to begin to explore the difficulties and traumas of their lives. Trust is therefore a very important element that has to be established before the therapeutic process can begin (Peschken & Johnson, 1997). The counsellor has to be very respectful and safely hold the process as the client begins to unravel the chaos inside. Going at the client's pace is a way of building trust and rapport in the therapeutic alliance. Brems (2001) states, that it is very important for the counsellor to develop a sense of trust and rapport as well as safety for the client in the therapeutic space. This allows the client the containment to deal with the difficulties experienced during the trauma. The research indicates that the professionals of the inter-disciplinary team need to demonstrate an open, non-judgemental, and caring attitude toward the child and the willingness to support the child must be demonstrated throughout the process (Giardino & Giardino, 2008). It

seems therefore, that establishing trust in the therapeutic encounter is one of the most important aspects essential for a positive experience. Hearing Thandi refer to her positive therapeutic experience with such enthusiasm, one gets a sense that she is on her journey to healing. Thandi's personal characteristics like her resiliency and positivity also help the therapeutic process to work as effectively and as quickly in dealing with the rape trauma. It is evident that her positive therapeutic experience helped her to find a sense of closure to the trauma.

4.7.3 Kept in the loop – feedback and introductions

Joe notes that once the process is underway, the caregiver feels powerless and helpless to a certain extent, and there is a sense of uncertainty about the process. He has no knowledge of the unfolding process between the child and the counsellor or between the legal authorities and the management of the case in terms of outcome. Joe feels that all he wants is some sense of control over what is happening, by being 'kept in the loop' to be given periodic feedback which will allow him some sense of control and thus soothe his fears and anxieties about the legal implications. For Joe this sense of anxiety and worry seems to be mounting as no real progress has taken place with regard to the other party involved and he is anxious to put this incident behind them, so that they can move forward as a family.

I would like to know! Because sooner or later I am gonna, [pause] someone is gonna snap somewhere, [pause]. It needs to be dealt with..... the clinic should hold them more responsible... they know they have to deal with it and they haven't. [Joe]

I could have easily gone and pressed charges against this 'lighty' but I think I know how the other parents must feel [pause], but I am damn upset with them because they have not come forth, so I think it's only fair that we are kept in the loop. [Joe]

Joe feels that over and above the feedback, the clinic administrator could have made more of an effort to properly introduce the clinic team to him.

Maybe to be introduced to whoever is running the place would have been nice. To know you are welcome here and we helping you and we are on your side. I kinda did feel a little bit like they [clinic] were the government, kinda like controlling the parents and a bit of a fear factor... [Joe]

He felt it was important for him to know everyone involved in the clinic team and with whom he would be dealing with. He felt that it would have made him feel more comfortable as a client. An introduction to all the professionals within the team is an important aspect for clients. It allows them to feel welcome and less intimidated by the process. Joe feels that the initial intake session is quite overwhelming and daunting. He says that he felt a lot of emotions on the first day and could not remember everything he was told. 'Like an introductory pack, uhhh, definitely and also a kind of where you going.' Most clients who visit the Teddy Bear Clinic don't know what to expect and are usually overwhelmed and stressed by the reason they have to visit the clinic. There is a certain sense of dread, as the unknown unfolds. Caregivers are not sure of what is expected of them or what is going to happen when they arrive at the clinic. Parents are at the same time trying to shield and protect their child from further stress and trauma.

From the researcher's volunteer experience at the clinic it was observed that most caregivers are so anxious during the initial visit to the clinic that any information given at this first session is normally forgotten by the time they leave. At this initial intake session, parents have a lot to process and try to understand. It is therefore emotionally and physically draining as well as a difficult process to go through. Parents are usually struggling with their own emotions while wanting to be supportive to their child. Joe felt that some kind of pamphlet or introductory pack about what the clinic is about and what the process entails would have been something he would have appreciated after the first session particularly as his wife did not come with him in the first few sessions. Joe felt that his wife would have benefited from an introductory brochure indicating the process involved, other relevant information to help the child cope, how the clinic will support the child and family as well as any relevant telephone numbers.

The initial intake session is long and intense often the information given is forgotten in the intensity of the emotions surrounding the problem bringing the caregiver to the clinic. In this initial intake session a huge amount of background information is gathered about the child, psychosocial history, developmental milestones and problems, physical examination and assessments. After the case discussion, which is held by a multi-disciplinary team, the case is referred internally for further therapeutic intervention or externally for problems outside the scope of the Teddy

Bear Clinic's services. Joe felt that the amount of information he received at the intake session was forgotten by the time he got home and an introductory brochure would have been helpful in which he could access to read over some of the important aspects of what the process is about.

Joe's anxiety and worry about the legal implications are mentioned several times during the interview. Joe indicates how hard it is not to know what is still going to happen in the future with regard to any legal implications. Joe is placing a lot of responsibility on the shoulders of the clinic to get closure and to force the boy and his family to come forward so that this incident can be handled without any legal implications and for the family to finally have some closure.

Another issue that Joe brought up in the interview with regard to being 'kept in the loop' is the number of sessions that he was initially told Sarah would have.

She [counsellor] did point out from the start that there would be kind of like twelve sessions. I think we ran into fourteen or fifteen in the end and I kind of thought [pause] when is this gonna end, so there was a little bit of vagueness.... Also just to be on top of sessions like you know, this is where we are at [pause]. To tell you, to expect an extra two, three or four sessions, just to keep you in the loop. [Joe]

The sessions went over the estimated number of sessions indicated by the counsellor. Joe felt that the counsellor should have informed him in advance about this as he has a job and boss to answer to and he said that he could not just take the morning or afternoon off without giving notice. Joe also needed to know in advance to inform Sarah's school about time off so that he could bring her to the clinic. As a working parent relying on a salary to secure his family, the fear of losing his job because of taking extra time off without being told in advance was a real threat during this time. Joe felt that the counsellor could have kept this in mind during the therapeutic process.

Thembi echoes this pattern of the 'feedback loop' where she illustrates the lack of feedback and involvement in the therapeutic experience which recreates this pattern of worry and anxiety that Joe also feels.

I think it was going to be better if she would like, give me feedback..... at least to tell me if things are going well, if she is coping, if there are problem areas where maybe I

can get in and help. I also want to know if it is helping her, I shouldn't sit back and say, Ag, she is going through counselling so she must be okay [Thembi]

When Thembi was asked about what she felt would have been helpful and should form part of the services at the Teddy Bear Clinic, she emphasised getting feedback from the counsellor about her child's progress. She feels that this is a necessary part of the intervention process. As the mother she wants to be involved in supporting and understanding her child through this process. Thembi feels that the lack of feedback was not conducive to helping her understand and connect with her child during this time. She said as a concerned and supportive mother, being left out of the process makes her feel alienated and invisible. 'They shouldn't leave the parents out, that would be my suggestion'. Thembi says that she understands the confidentiality and boundary issues that are established between the child and counsellor and is not asking to be part of the therapeutic process. However, what she would have liked is periodic feedback as to how things are going and if she could have assisted her child between sessions in any way. This caregiver expressed her care and support for her child and would like to have been part of her child's healing process. The guidance that could have been provided by the social worker for her as caregiver would have been beneficial in understanding what her child was going through and how she could be of further help to her. Thembi says that for her it would have been a far more positive experience if she was involved at some level in the therapeutic context and through some sort of feedback and clarification process so that she could track where her daughter is emotionally. 'if there is some extra help that is needed on a particular area, that would, that would make me happy'. She also says that she would have liked to have been involved in the final session just to evaluate and get feedback of the overall process and the way forward. 'Have you [counsellor] seen an improvement in this area or that area'.

It seems evident then of the importance for the clinic to provide the caregivers with periodic feedback so that the caregiver is not left wondering what is happening until the final session is over. It is vital that the caregiver is guided through the process and progress shared at intervals. The caregivers' need for feedback is something the caregivers mentioned and not a need expressed by the children in any way. This could be an indication of the clinic's focus on the children rather than on the caregivers.

4.7.4 Caregiver support group

Davies (1995) observed that parents whose children were abused do not automatically receive post-disclosure therapeutic services. The main objective of most service providers is to protect the child and to provide services to the child. It is the researcher's view that the caregiver's feelings need to be addressed first, before they are able to become aware of the trauma and needs of the sexually abused child, and help them in their healing process.

A support group for parents who have experienced their children's abuse or rape seems to be expressed as a need for the clinic to implement. Thembi states:

Parents of victims, where they can sit and talk about their experiences, their problems, [pause] with regard to problems like that of rape. Maybe we can do this maybe we can do that, to encourage some positivity in them. That it's not the end of the world. Yes, this has happened you cannot correct it, because it has happened but looking forward, this is what we can do ourselves you know to help you keep your head up high... [Thembi]

Thembi felt very strongly about the clinic implementing a support group for the caregivers. She says as the caregiver of a child who had been through rape; it would benefit parents experiencing the pain of their children's abuse or rape to share their experiences with other parents. She emphasises not to shut the caregivers out, to attend to both the parents and victims. Pologe (2011) notes that; when people are faced with a stressful situation they prefer the company of those facing the same unpleasant event. When a victim or caregiver is able to share emotional reactions with those facing similar experiences in a support group it becomes therapeutic, leading to positive outcomes. Thembi says that sharing their stories with other parents would be a very therapeutic experience. She says that it would encourage a sense of positivity in the caregiver. The experience cannot be erased from one's memory, as it cannot be changed. However, it will allow one to look ahead with hope within the embrace of a supportive network.

4.7.5 Clarification and support for the caregiver

Thembi has unresolved feelings and emotions with regard to her daughter's rape. She is struggling with how this is going to affect her child in the long term and is left

wondering whether her child as a client at the Teddy Bear Clinic will experience any real help. Thembi is a very insightful and self-aware mother who cares for her daughter very much. As a trained, professional nurse, Thembi has an understanding of how the rape may affect her child physically. However, she feels lost and in the dark about how her child may be suffering emotionally.

I thought I was going to see, eh, a psychologist and uhh when we got here, I realized when [counsellor] introduced herself that she is a social worker and okay, I do know that social workers have done social science and they can do counselling and they can, eh, you know help and eh, I accepted it. [Thembi]

She was also like, she [counsellor] thought the rape was [pause] we knew who the perpetrator was. So she said how the policeman explained to her, she was of the impression that we knew the perpetrator. [Thembi]

So thinking is she being helped? Then that would also ease some anxiety on my side, hmmm. [Thembi]

When Thembi arrived at the Teddy Bear Clinic she was under the impression that her daughter would be seeing a psychologist, not a social worker. This made her feel uneasy and anxious she worried about this throughout the therapy process. She felt that she was not made aware of this until she had asked and there seemed to be no clarification about each member's specific job descriptions. Thembi felt uncertain about whether the social worker was qualified enough to deal with her daughter's rape trauma as well as whether her daughter would get the help that she needed. Thembi seemed reluctant to continue with the counselling. However, she continued with the process, as Thandi seemed to like the social worker. It sounds as if there was some kind of miscommunication between the police inspector who referred Thembi to the Teddy Bear Clinic and the social worker. Thembi says that when she arrived for the intake interview the social worker assumed that the perpetrator, who raped Thandi, was known to the family. This made her feel even more sceptical about the process as she had told the police that they never knew the identity of the person who raped her daughter. It would be helpful for caregivers to be well informed of the process from the onset and to be informed of the titles held by the people working at the Teddy Bear Clinic so that parents are clear about who their children are seeing as well as the process involved, allowing them to make informed decisions. For

Thembi there was so much uncertainty which made her feel unsettled and disempowered in the process. She did, however, reiterate that the social worker's professionalism was apparent throughout the therapeutic process and their subsequent interactions.

As the mother of a child who had been raped, Thembi's need for emotional support was evident throughout her interview with the researcher. She felt that she could have been considered for emotional support as she was struggling so much with her own feelings of sadness, loss and worry.

You know, when you hear such things and you ask yourself [pause] here it is! This person has raped my daughter, I don't even know, even if I knew him, what is it going to do to my daughter you know [pause] for her lifetime, ja, it really worries, it really worries. [Thembi]

It is an on-going thing, it's like every day you have got, [pause] something comes to your mind and you ask yourself have I gone through this, for how long is this going to be in my mind, is it ever going to clear off my head, it still worries me, because that is my baby, ja. [Thembi]

The rape of Thembi's child has affected her in the most fundamental way possible. She feels a great sense of loss and torment. The loss of her child's innocence and what that may mean for her daughter's future and emotional well-being is weighing heavily on her mind. This mother's own Christian values and beliefs are being questioned too and she does not seem to find solace here either. She describes a recent sermon she attended and the pastor implied that individuals who have sex with different people leave a part of themselves in the soul of the individual with whom they have had sex. 'The pastor says it's a form of soul ties that happens.' The way Thembi understood and interpreted this message made her feel even more worried and afraid for her child's emotional well-being. This encounter seems to have added to her already burdened self despite having gone to the church to find solace. Thembi is heartbroken over the idea that a part of the rapist will become a part of her child's soul and she is left wondering whether this will ultimately change who her daughter is. It seems for Thembi that neither the clinic nor her church, were able to support her worries and concerns about her daughter's rape. The Teddy Bear Clinic offers parents feedback, guidance and supportive counselling after the child's first

counselling session. Somehow Thembi was overlooked by the counsellor for supportive counselling.

Thembi's heartache and pain over the rape and her concerns over how her child will be affected comes through strongly in the interview. She keeps referring to whether the help she sought for her child is going to be enough for her daughter to start healing. There is a sense that she needs her own supportive counselling so that she can come to terms with what happened to her child. She has not shared in any part of the therapeutic process or had any feedback from the counsellor, other than the initial interview with the counsellor. Thembi seems to have been invisible to the therapeutic process. Because of this Thembi feels powerless and helpless. She seems to project her own fears and uncertainties on Thandi, saying that she is not sure whether the therapy is helping her child. She says that Thandi told her that she would tell her how she is after the sessions have ended, leaving her anxious and a bit frustrated as to whether her daughter has received any 'real' help and whether she is on the road to healing.

How the caregiver interacts and deals with the child after the rape is important. It is particularly relevant especially since it will be the caregiver, who will be helping the child recover from the rape. If the caregiver has not been taken care of and given the space to grieve for his/her child then the caregiver will be ineffective in helping the child deal with the trauma. When a parent learns of their child's sexual abuse or rape a series of grief stages follow ([www. childrenscenter.com](http://www.childrenscenter.com). Ways to support a caregiver when their child has been the victim of sexual abuse, n.d.). These stages of grief are observed in most parents who are dealing with the sexual abuse or rape of their child ([www. childrenscenter.com](http://www.childrenscenter.com). Ways to support a caregiver when their child has been the victim of sexual abuse, n.d.). Some of the symptoms the caregiver may experience are denial, anger, bargaining, depression or sadness and finally acceptance. It is evident from Thandi's extracts that she is in the stage of sadness and depression and is really struggling to make sense of her daughter's rape. This indicates a real need for the support of the caregiver, which should be identified by the counsellor dealing with the child. The counsellor should refer the caregiver to another organisation for help or help the parent with supportive counselling at the clinic itself.

There is no care for me on my side as the mother, mhmmm, that is the only unhelpful thing. [Thembi]

Uhhmm, [pause] maybe I am over expecting so hence I tell you that, eh, from the Teddy Bear Clinic, uhh, I don't think that they would do much for me, because of the case as it was handed to them by the police and the police are concerned with the victim so it means that I should get my own help somewhere.[Thembi]

Ah, eee, I don't know when will it be enough [big sigh] mhmm, I don't know when will it be enough. [Thembi]

Thembi is unsupported and left out of the therapeutic process. She is struggling with the effects that her daughter's rape has had on her. Thembi has a strong affiliation with her church and is a strong believer. However, even in this context she did not feel like she was heard or supported with her worries and concerns. Sharing in this mother's struggle to come to terms with her daughter's rape is heart-wrenching, indicating her sense of aloneness and isolation during this difficult time. Thembi says her child was the victim and it was okay for her to be overlooked as the mother, but looking back at it all, in terms of where she finds herself presently, she feels that supportive counselling for her would have been incredibly beneficial.

It is unclear whether supportive counselling was offered to the mother or whether the social worker just assumed that Thembi had access to counselling at the hospital where she works as a nurse, it is uncertain as the social worker was not interviewed. Pollock and Farmer (2005) state that the need for support and assistance is very important for the caregivers and this depends primarily on the skills and abilities of the service providers to identify and work closely with families to be in a position to provide optimal support and assistance to families. If parents are provided with services and support they are empowered to change their lives and help their children heal from abuse (Pollock & Farmer, 2005).

4.7.6 Giving back: peer support group

Both Sarah and Thandi express their gratitude for the help that they received at the Teddy Bear Clinic and describe how they would like to give back to the clinic by being involved in a peer support group or to talk to other children who have been through similar experiences.

Don't let your friends tell you what you must do. Don't do what your friends do, don't let them run your life [pause] and I think for a while my friends ran my life.... [Sarah]

That's a bit hard for me, I know that it's really hard to say 'no' and especially for me [pause] it's really hard to say 'no'. [Sarah]

I'd actually encourage the children who have had underage sex or who have had drugs, just to tell them to stop, just leave everything, don't let your friends tell you what to do, don't do what your friends do, don't let them run your life... [Sarah]

Sarah had a hard time saying 'no' and standing up for herself. There is a real sense of the pressure she felt just so she could fit in with her peers and to be liked. Adolescents go through profound changes during puberty. There is rapid physical growth as well as emotional changes related to sexual functioning. Puberty affects psychological development and social relationships (Berk, 2006). A number of problems such as eating disorders, depression, suicide and risky behaviour occur in adolescence. Adolescents spend most of their time with their peers. Stattin and Magnusson (1999), note that early maturing adolescents seek out older companions, sometimes with unfavourable consequences. Older peers encourage them into activities they are not yet ready to handle emotionally, including sexual activities, drug and alcohol use. The above illustrates the complexities involved with being a teenager. However, due to Sarah's mental disability, negotiation of the above challenges is that much more difficult as she struggles with judgement and making the right choices that are in her best interest.

Research also indicates that the majority of teenagers just want to fit in and be part of the in-group, while at the same time dealing with the sexual awakening of their bodies (Berk, 2006). Sarah talks about the difficulty of trying to fit in as well as being influenced by her peers to do things that she was not quite ready for. To add to this, Sarah does not have a trusting and supportive relationship with her stepmother, making it difficult for her to express her concerns about being a teenager. This is illustrated by Sarah when she says, 'we don't have a mother to hang onto, we can't talk about anything'. Having a physical body that may be on the same level as her peers, but a cognitive maturity level that is under-developed, makes trying to negotiate the right decisions for herself that much more difficult and problematic, making her vulnerable to exploitation by peers and others.

Sarah speaks enthusiastically about how she would like to contribute to the clinic. Being someone who had received help and support from the Teddy Bear Clinic, she felt that she would like to use her voice as part of a peer support group, where she could speak to other children who are going through a difficult process, to share her story and to tell other children to not let other children force you to do things you are not ready for. She would also want to express to other young people how important it is to speak out and get help at a place like the Teddy Bear Clinic. Sarah felt that she was given the help, support and, guidance she needed and wanted to give back to the organisation by being part of a peer support group.

Thandi says that she would like to use her voice and this experience to grow and develop as a person as well as share her story with others.

There are caring people out there who would want to help and listen to other people's problems. [Thandi]

I have grown from what happened to me, I have found closure and so like I said, today I am willing to talk about that. [Thandi]

Because you know there are a lot of people facing a number of things and just don't speak about it and closing it up is not really the best thing you can do, trust me. Personally, I think I could say I am fortunate that I spoke about it (pause), I told somebody and according to me, measures were taken and I am fine. I could say I am cleansed, it is always something that will remain in my mind, but I don't think about it as often and I don't let it affect me... [Thandi]

...what I would tell them to do is to speak about, well motivate them to talk you know you can't force somebody to talk. [Thandi]

Thandi describes how coming to the Teddy Bear Clinic helped her deal with the trauma of rape. She said that the benefits of speaking about what happened to her far outweigh keeping the pain locked inside of her. Seeking counselling allowed her to get the help she needed after the rape. Thandi had a positive therapeutic encounter where she was able to find some closure and healing after the rape. Thandi said that she would like to give back to the clinic by coming and speaking to other girls about her rape experience. Hoping that she would be able to encourage and inspire other young girls to share their experiences and thereby enabling them to also have closure. For Thandi the rape was the worst thing that could have

happened to her 'it is always something that will remain in my mind'. However, coming to a place like the Teddy Bear Clinic, showed her that she is a strong person who is able to cope with a life changing experience and who has grown personally from the trauma. 'I have grown from what happened to me.' Thandi shows courage in engaging in the therapeutic process. 'I could say [pause] I could have left here and not spoken about it but I told [counsellor] everything. I could say that I have grown from what happened to me.' She says that she would never have been able to deal with it on her own without the support and help she received at the Teddy Bear Clinic. 'I have found closure.' The rape happened. She cannot erase this memory. However, she has chosen to live more positively despite it. This experience showed her how important it is to seek help and speak about her experience of rape. The counsellor spent enough time with Thandi in sessions to allow for the emotional work to be done and it seems that she is on the road to healing.

4.7.7 Teddy bears and the therapeutic process

Teddy bears at the Teddy Bear Clinic are used as part of the therapeutic process on the child's journey to healing. Quotes from both the case studies are used to describe how the teddy bears influenced the therapeutic process for both the children and caregivers. The Teddy Bear Clinic has always used Teddy Bears as a symbol of the care and support they provide their child clients and is a cornerstone of the Teddy Bear Clinic. All children who pass through this process are given a teddy bear to take home which is a reminder of the caring attitude the clinic provides eliciting a positive attitude for the child towards the healing process.

From the first time that she [Sarah] came home with the teddy bear, she did say that it was nice [pause]. They made her feel confident that they are here for her to help her and not hit her over the head with it [pause], it wasn't the typical government thing that I thought it would be. [Joe]

Initially I was extremely uncomfortable I was not yet ready to speak about what happened. As time went on I felt comfortable, so I got carried away in looking at the teddy bears and looking at the different types of teddy bears, that were there [pause] then from then onwards, ja, I became comfortable, ja, cos honestly to me this place brings like comfort and the people here are friendly. [Thandi]

Joe (Sarah's father) describes his own experience at the Teddy Bear Clinic as not traumatic, although fearful as to how it would be handled by the professionals. He

seemed afraid of being branded a bad parent and whether or not the clinic will make the process difficult and uncomfortable for Sarah. However, Joe says that he was pleasantly surprised by how respectfully the clinic dealt with his daughter. Joe felt that Sarah was made to feel comfortable and the idea of giving a teddy bear is very symbolic of the care and safety they provide. He felt that this made him feel at peace knowing that she would be taken care of and his fears of her being dealt with in a punitive way were put aside. This feeling of care and safety is echoed in the quote in which she describes feeling welcome and safe at the Teddy Bear Clinic when she arrived for the intake session. Her experience of the teddy bears allowed her to feel a sense of comfort and safety. She found the people very friendly and said that the teddy bears put her at ease as she walked about the clinic as quoted in the above excerpt. As previously mentioned the teddy bears are symbolic at the Teddy Bear Clinic for creating a sense of warmth and containment for the children, setting the stage for clients to feel safe and cared about in this process. Thandi says when she first arrived at the clinic she was not ready to speak of the trauma, but somehow the teddy bears comforted her and made her feel safe enough to speak about the rape experience.

4.8 Conclusion

By means of the themes that have come up, the relevant themes for the Teddy Bear Clinic in terms of service evaluation will be discussed in the next chapter. However, the themes depicted throughout the study served to illustrate the clients' subjective experiences, adding to the richness of each participant's unique experience as well as empowering the children participating by giving them a voice to speak about their experiences at the Teddy Bear Clinic. Distinctive themes also added to the richness of their experiences. Though various emergent themes were consistent with some of the literature identified, it does not support existing findings as no qualitative research has been identified that describes the client's subjective experience of service evaluation at such agencies. In order to discuss the accumulative information gathered, the study will be concluded with an integrative discussion of data, recommendations and limitations to the study.

A summary of the themes and how they interrelate will be reviewed in the following chapter.

CHAPTER FIVE: DISUSSION AND RESULTS

5.1 Introduction

This chapter concludes the study. This study served to address the issue of therapeutic interventions in a clinic dealing with sexual abuse victims and their caregivers, namely 'how the clients experience these services and how they have made meaning of these on their journey to healing'. Attention will be given to the primary findings as well as the limitations and strengths of the study. Finally recommendations for future studies will be made.

The present research aimed to understand how clients at the Teddy Bear Clinic experienced the services. Specifically, an attempt was made to uncover participants' subjective experiences, the emotional and intuitive dimensions in the context of their experience as clients of this medico-legal clinic. This allowed insight into personal meaning(s) they ascribed to their therapeutic experience and how these influenced them either negatively or positively. Based on the analysis of the data, the findings reflected the clients' descriptions of their experiences as well as the means by which they talked about their experiences. Novel themes that arose serve to enrich the understanding of the clients' experiences within the clinic and the participant's experiences as they relate to the therapeutic services.

5.2 Integrative discussion of findings

It was observed that knowledge reflected in existing literature proved to be incomplete, with limited relevance to the South African context. Such observations served as motivation for the current study, aiming to explore the unique experiences of the clients who were recipients of the clinic's services, subsequently contributing to the field of research and providing a foundation for future studies. No studies have been identified which explore this phenomenon, making it difficult to compare findings. With reference to some of the literature on the evaluation of services, Walton, (2001); and Wells (1994) claimed that excessive and complex legal proceedings harm rather than help child victims. Jenson, Jacobson, Unrau and Robinson (1996) also note that legal proceedings can be regarded as additional abuse. Spies (2006), states that the uncaring attitude displayed by confidantes, including professionals, contributes to feelings of shame and guilt. Wells (1994)

stated that inter-agency coordination is a way of reducing trauma experienced by children during the investigative process. Steele (1992) also notes that a coordinated effort among diverse professionals is an effective way to investigate child sexual abuse and related issues. Mash and Wolfe (2005) researched the usefulness of multi-disciplinary teams in working with sexual abuse victims and treatment programmes. However, no qualitative studies have been identified that focus on the clients' experiences within these agencies and so this study brings some explorative understanding of the things the clients found relevant in their experience of the therapeutic process.

The following primary findings are identified as significant in terms of how the client experienced the services at the Teddy Bear Clinic. Giving a voice to the child and caregiver was the crux of this research study, allowing clients a voice to express their opinions and ideas on the services received, which was an important element of this study. Allowing the client to talk about the meanings and subjective experiences that were experienced by them as clients at the Teddy Bear Clinic allows a platform for their voices to be considered as part of the on-going service evaluation at such an agency, thereby improving the client-professional relationship.

Exploring the experiences of victims and their caregivers who were recipients of the therapeutic interventions at a medico-legal clinic and how these were perceived by them is what this study has attempted to explore. The following themes emerged and are identified as significant in terms of how the clients experienced the services at the Teddy Bear Clinic.

5.3 Main findings of the study

5.3.1 Background influences affecting the therapeutic experience

One of the main findings of this study indicated that even though all the participants came to the Teddy Bear Clinic based on the presenting problem, the participants in this study entered the Teddy Bear Clinic with background influences that affected the therapeutic relationship either negatively or positively and these can be seen in the interrelationships that are interwoven with the presenting problem. For instance Sarah and Joe's preoccupation with the law and the fear of punishment seems to echo in both father and daughter in their initial sessions with the counsellor. Due to

Sarah's intellectual disability she is easily influenced and coerced into taking on other people's ideas as her own as seen in her quote of 'I can't say no', her father says 'she is not one I can easily let go of, she has got no social boundaries and that is why we are here, she is easily influenced and pushed around'. The therapeutic relationship was influenced therefore by both Sarah and Joe's echoing pattern of fear of punishment. Sarah was influenced by her father's preoccupation with what the law will do to them, creating anxiety and worry about being punished which Sarah felt and so when she entered the therapeutic relationship she felt stressed and pressured to talk until she realized that the counsellor was there to help her and not punish her.

Thandi also seems to echo Sarah's initial reluctance to enter and trust the therapeutic relationship due to her background influence of having had a previous negative experience with the school counsellor. This, together with her personality which she describes as someone who struggles to open up and discuss her difficulties, 'I don't like to talk about my problems' which made her reluctant to enter into the therapeutic relationship initially, until she felt she could trust her counsellor. 'It was uncomfortable cos honestly I am not the kind of person that talks about my problems, only people I know I can really trust, so when I got here, I gave away bits and bits of my life away before you know it I was telling her [counsellor] everything'. Indicating the importance of each client's past narratives which influences therapeutic relationship in one way or another.

The background influence of relationship with Sarah's stepmother, influences the therapeutic process which in turn influences the counsellor's role as seen in the way Sarah connected with her counsellor seeing her as a nurturing figure. Even though Sarah had presented to the clinic for underage sex, the counsellor spent much of the therapy on a maternal connection before the counsellor could address the underage sex issue. Sarah and Thandi used their therapeutic relationship to deal with their personal difficulties, both in different ways, however relying heavily on the counsellor-client relationship before meaningful healing work could begin. For Sarah it was about developing a nurturing connected relationship with the counsellor that resembled a maternal figure for her as she did not have this connection due to the loss of her mother and the disconnected relationship she has with her stepmother. In the therapeutic relationship with the counsellor she was able to emulate a mother

figure which she needed to support, hold and connect with, so that she could begin to allow the counsellor to help her deal with what had happened to her. The counsellor developed a 'good enough' relationship with Sarah, she illustrates this by saying 'I have got other people to go and talk to, like my grandmother and my counsellor, she also understands me.' For Thandi the therapeutic relationship of trust, respect and understanding was developed early in the therapeutic encounter and this allowed her the frame and containment she needed to trust that she would be helped to cope and deal with the rape. Thandi describes the trust and connection with her counsellor saying 'she [counsellor] honestly is like my best friend and I am quite sad that I am not going to see her again'. Perhaps, this suggested the importance of the therapeutic relationship over and above interventions and models to help the traumatised child.

In the background theme of outside support structures, the care-giver's beliefs and values are also very important for the counsellors to consider in the developing therapeutic relationship. Children tend to take on their caregivers' ideas, values and beliefs and these are then projected into therapy (Lines, 2007). As such, counsellors have to be sensitive to these values and beliefs for therapy to be meaningful and trusting. Corey (2005), states that professionals should strive to be culturally competent to ensure respectful and compassionate understanding of children and caregivers. Therefore cultural values and beliefs should be kept in mind when working therapeutically with clients. Joe commented on the views and beliefs of Sarah's counsellor, saying that they were different to what he has been imparting to Sarah and that, counsellors should consider this when working with their children as it can be counter-productive. 'Some views of things that were said to Sarah, I was not happy with.' Perhaps this is what caused Joe to not accept the supportive counselling that was offered to him as he was put off by the views of the counsellor and felt that the church support would be more beneficial to him in terms of his views and beliefs. Thembi looked for solace through the support of her church to help her deal emotionally with her daughter's rape. However, the sermon that she attended at this specific time seemed to add to her sense of helplessness and worry about how her daughter would heal from the rape. The message she had received from the sermon at her church about sex caused her to misinterpret it in terms of her child's rape and she has been agonizing over this message. Thembi was not offered

supportive counselling which if given could have alleviated her sense of helplessness and worry about the rape and the impact this has on her child. So for this caregiver neither the church nor the clinic, were able to alleviate her worry and anxiety. The care-givers' sense of distrust or belief in their child's counselling process is projected onto the child who either allows and or embraces the counselling and so the child feels safe to engage fully with the process or to engage with the process on a superficial level. 'It's important to respect the parents' background, especially religion, some views of things that were said to Sarah, I was not happy with.' This indicates that the caregiver's values and beliefs are firmly entrenched in their children and as such, should be carefully considered by counsellors in the therapeutic process. Background influences have a huge impact on any therapeutic encounter that the client and therapist enter into and this is no different for any therapeutic relationship that clients enter into at the Teddy Bear Clinic. Counsellors should make their clients aware that each case, each client, presents with different problems, different family dynamics and different individual characteristics which they bring to the therapeutic encounter. This makes a 'one size fits all' approach impossible in therapy (Corey, 2005). Of particular significance is the fact that sexual abuse cases are complex and many variables come into play as can be seen in the many sexual abuse definitions as well as the legal definitions for each case. Therefore while a structure may help to inform the process each client's set of unique circumstances may be more pressing for the client than the agenda set by the therapist. The clients should be told to expect the shifts, changes and modifications that are part of therapeutic process. Such changes apply not only to the frequency and duration of visits, but also to the character of the client, counsellor relationship and the approaches or techniques the counsellor uses in treatment (Corey, 2005).

5.4 The voices of children and caregivers on the therapeutic experience

In this theme; giving the clients a platform to express how they found these therapeutic services enabled the client participants to feel that they are taken seriously and that what they have to say is important. The following are the main findings of the service related experiences which the client participants felt the clinic could improve on or add as part of their services.

5.4.1 Feedback and clarification

In this theme of feedback and clarification of the therapeutic process, the caregivers felt that the clinic could have done more to help them understand the therapeutic process as well as keep them updated with their child's progress. This is rather significant for the Teddy Bear Clinic in terms of client services. Both caregivers felt that not enough was done by the counsellors to 'keep them informed'. For Joe it was about the clinic not giving him clarification and feedback about the case and on whether the alleged child involved with Sarah had entered into the diversion programme. Joe felt that the clinic could have done more to force the boy and his family to come forward.

'I am damn upset with them because they have not come forth [parents of the other child], the clinic should hold them more responsible cos that is their position and they have to deal with it and they haven't, the clinic needs to put more pressure on these people. It's only fair that we are kept in the loop.' It is really important for him and his family to have closure, for this to happen it means that the other child has to go through the same process that Sarah went through. For Thembi it was about not being informed with feedback by the counsellor, on how her child was progressing in therapy. It seems that it is important for the caregivers to feel that they have some control over an uncontrollable process. By giving feedback and clarification to the caregivers of the therapeutic process allows them a way to feel that they are in some way involved in their children's healing journey. Both the caregivers felt uncertain about the process they felt they were not informed of the unfolding process between the child and counsellor or between the legal authorities and management of the case in terms of outcome. The caregivers felt that it would have been very helpful and respectful to receive periodic feedback and be 'kept in the loop'.

Joe says that 'I would like to know, because sooner or later I am gonna, someone is gonna snap somewhere.' This caregiver's anxiety around the legal issues surrounding Sarah's case left him feeling powerless and helpless and at the mercy of the professionals at the clinic. However, no feedback was given to alleviate his stress. For Thembi it was about how she could help her child between therapy and after termination 'I think it was going to be better if she would, like, give me feedback.' However, no feedback was given and she had to wait until termination to

hear from Thandi whether she felt the therapy helped her or not, thereby adding to Thembi's sense of worry and stress about whether her child was receiving the help she needed to heal from the rape. Both the caregivers felt isolated and invisible which created more anxiety and worry to add to their already stressed situation. Joe noted, 'She did not point out from the start that there would be twelve sessions, we ran into fourteen or fifteen, so there is a little bit of vagueness.' Research has suggested that outcome assessments conducted on a continuous basis can lead to increased effectiveness (Reese, Norsworthy & Rowlands, 2009). When caregivers bring their children for therapy it is important for them to feel a part of the process, it is essential that they are provided with periodic feedback as to how therapy is progressing and be involved in assisting the child on their journey to healing. Such monitoring leads to increased opportunities to repair alliance ruptures, to improve the relationships between therapist and clients, and to avoid feeling left out of the process, as well as avoid premature termination (Reese, Norsworthy & Rowlands, 2009). Continuous feedback provided by therapist and clients can help determine when therapy is not effective, identify client deterioration, and provide opportunities to make the necessary changes to the treatment approach as well as allay caregiver concerns (Reese, Norsworthy & Rowlands, 2009).

Giving an introductory pamphlet to the client is also an important factor to consider in terms of service evaluation as the caregivers felt that so much stress and anxiety is present on the first visit to the clinic that much of the information given at intake is forgotten by the time they get home. 'Like an introductory pack and also where you going.' Joe felt that they would have benefitted from an introductory brochure to guide them on what to expect and the process involved.

It is felt that it is a necessary part of the intervention process to keep the caregivers in the loop with periodic feedback so that they are included and acknowledged in this process. It is the caregivers that the children go home with and as such it is the caregivers who are left to deal with the child. If they are given information and coping skills they are then empowered to help and understand what is going on with their children as they continue to heal thereby building a better and stronger relationship between the child and caregiver.

5.4.2 Caregiver support groups

Another main finding was that the children and caregivers expressed a need for support groups. A support group for the caregivers as well as a peer support group for the children. Such support groups are valid and a worthy recommendation for the clinic to consider implementing. Thembi found the isolation and lack of care for her as the mother of a child that had been raped very lonely and distressing. She felt that if there was a support group for caregivers whose children have been victims of rape or abuse to be supported through a network of other parents going through similar situations would have been very helpful to her. 'There was no help for me, it would be helpful to be part of a support group to share one's experiences, parents of victims where they can sit and talk about their experiences, their problems, to encourage some positivity in them'. It is clear from the expressed quotation that it would be a valuable service for the clinic to consider implementing support groups as these can be very therapeutic as well as preventing the caregiver from feeling isolated and alone. By being part of such a support group the caregivers are connected to a resource of support and help during the difficult months ahead, while they are trying to support and help their children on their journey to healing. The most helpful therapeutic elements are the opportunity to vent pent up feelings and emotions, the validation of their experiences, the affirmation of coping abilities, the encouragement for continuing care, mutual support and sharing of information (Toseland, Rossiter, Peak & Hill, 1990).

Mash and Wolf (2005), state that the way the parents deal with the child's disclosure impacts the therapeutic encounter and thus influences the healing process either negatively or positively. And as such supportive counselling for caregivers is a very important factor in the child's healing process. It is quite clear that the caregivers are not given enough attention in terms of supportive counselling. There was no support for Thembi who was carrying so much grief and anguish over her daughter's rape, 'This person has raped my daughter, what is, it going to do to my daughter, it really worries.' The Teddy Bear Clinic states that it offers supportive counselling to the caregivers. However, in Thembi's case she was overlooked and was not offered the support she so desperately needed. It should be made standard procedure to offer supportive counselling to the caregivers periodically throughout their child's therapeutic process.

5.4.3 Giving back – peer support group

The children participants' voices came through very strongly in terms of a peer support group or the theme 'giving back'. They felt that they would like to give back to the clinic by becoming involved in a peer support group for children who have been through an abuse or rape trauma. They felt they could provide a forum for sharing their experiences and helping other children speak up against rape and abuse. They felt that it would help other children heal from the trauma. Sarah said her experience made her realize that it is important to talk about it and tell other children how she was supported at the Teddy Bear Clinic and encourage other children not to be afraid of standing up for themselves and to not allow friends to bully and make you do things you not ready to do. 'I'd encourage the children who have had underage sex or who have had drugs, just to tell them to stop, just leave everything, don't let your friends do, don't let them run your life.' For Thandi it is important to speak out about one's experience thereby encouraging others who have had similar experiences to seek help. 'What I would tell them to do is to speak about, well motivate them to talk you know, I have found closure, I am willing to talk about that to others.' It seems that peer support groups would be something valuable that the clinic could add to their therapeutic interventions. This could be a positive and therapeutic course that may be considered by the clinic, it allows the children a 'voice' to express themselves in a space that is safe and free of judgment and bias. By being part of such support groups other children who have been through similar experiences can come together and share in their pain and difficulties, thereby working together as a collective unit to help each other.

5.4.4 Teddy bears and the therapeutic process

In the theme 'teddy bears' the clients felt that the teddy bears play a very big part in the developing therapeutic relationship and the child's initial reaction to the Teddy Bear Clinic. The teddy bears that are given to each child at the beginning of every intake, nurtures a sense of care and safety. It is a cornerstone of the clinic's service and should be continued, thereby promoting the symbolic handing out of teddy bears for both young and older children clients. This gesture is in itself the beginning of a therapeutic relationship with the clinic. Both children and caregiver participants of this study expressed the important impact that the teddy bears had on them, Thandi

stated that when she first arrived at the clinic she was not yet ready to trust and speak to someone about the rape experience, but somehow the teddy bears comforted her and made her feel safe enough to begin to speak about the trauma that had happened. 'Initially I was extremely uncomfortable, I got carried away with all the different types of teddy bears, from then onwards, ja, I became comfortable.' Joe said that from the moment that Sarah came home with the teddy bear he knew that she would be taken care of and would be helped through this process. 'From the first time that Sarah came home with the teddy bear, they made her feel confident that they are here to help her.' The teddy bears seem to have a very therapeutic impact on the children and this is something that the clinic must continue to implement as part of their service.

5.5 How the aim of the study was realised

The aim of the study is to provide an integrated picture of the client's experiences in a clinic dealing with sexual abuse; their journey to healing. This aim is attained through using an interpretive research paradigm that focuses on the understanding of the phenomenon under study from the participants' point of view and explores the subjective reasons and meanings behind behaviour (Terre Blanche & Durrheim, 1999).

5.6 The strengths of the study

The strengths of the study are that it uses an interpretive epistemology (embracing phenomenology) which lends much depth and 'thick description' to the study (Denzin, 1989). This is the first time that clients' from the Teddy Bear Clinic have been studied using this theoretical framework. As a result new information and insights are attained. Existing theory is at times supported. However, not much theory exists for service evaluation from the perspective of the client and as such needs to be explored further. Supervision and consultation were used to check the interpretation thereby improving the quality of the study.

5.7 Limitations of the study

Epistemological integrity is defined as a 'defensible line of reasoning from the assumptions made about the nature of knowledge through to the methodological rules by which decisions about the research process are explained' (Thorne, 1997).

In an attempt to uphold this criterion, decision-making at various levels of the research reflected the central aims of the research: the clients' experiences and how they made 'meaning' of these. As such, epistemological standpoints premised on an interpretive approach (embracing phenomenology), were revealed in the research questions and carried through in strategies of data interpretation (Thorne, 1997). Thematic analysis of data based on narrative content and narrative form represented a contextualist method of interpretation, bridging the gap between an essentialist/realist approach that acknowledges subjective meaning of experiences (Braun & Clark, 2006). Little research examining the subjective experience of the clients' experiences of services within a medico-legal clinic have been carried out within an interpretive paradigm. As a result comparisons to other studies cannot be made within certain sections of this study. More research using an interpretive paradigm would be useful. Similar studies should be carried out within other clinics dealing with sexually abused clients and their caregivers so as to provide a broader understanding of these subjective experiences, thus providing an understanding of the client so that therapeutic interventions may be better geared at focusing on the needs of the client.

Due to the methodology used in this present study, which uses a small sample, it does not enable one to generalize findings and as such a larger sample could be looked at from the detail gained through a qualitative study such as this, so that through the use of a larger sample the findings can be generalized (Durrheim & Painter, 2006).

5.8 Representative credibility

The Teddy Bear Clinic as a clinic for sexually abused children in Johannesburg was contacted in order to recruit participants. By targeting this specific organization, the researcher was facilitated in gaining access to what appeared to be an, 'invisible population'. This convenience approach to sampling, however, precluded other clients from other clinics that deal with sexually abused children and their caregivers. As such, the diversity of experiences may not have been fully captured. The criterion of 'representative credibility' (Thorne, 1997) may be more apt within a qualitative paradigm. Simply put, this pertains to the consistency between theoretical claims made by the research and its method of sampling. Reliance on a convenience

sampling approach, as Ritchie, Lewis and Elam (2003) point out, potentially introduces other forms of bias. The organization may encourage participation from certain individuals perceived as more articulate or having more 'colourful stories' to tell, or alternatively from those from whom positive accounts about the organization can be derived. A larger quantitative study could be more useful to gain a larger perspective of the clients' experiences in a clinic such as this. However this was not the aim of the present research. More pertinent to the research was the identification of themes that view service evaluation in an organization such as the Teddy Bear Clinic with a view to enriching understanding of the clients' experiences of the therapeutic services.

5.9 Correctness of evidence

In qualitative research, a research reading is said to reflect 'correctness' if it 'represents accurately those features of the phenomenon that it is intended to describe, explain or theorise' (Ritchie & Lewis, 2003). This relates to the correctness of interpretation and its correct labelling (Ritchie & Lewis, 2003). One way to assess correctness of evidence is to verify the interpretations with participants for correspondence in meaning (Kelly, 1999). In terms of the present research, such a dialogue has not been formally engaged in at the time of write-up. However, the results will be made available to the participants and the wider scholarly audience at a future date. Apart from assessing final interpretations, the validity of conclusions may also rest with how fully the said phenomenon is captured (Kelly, 1999).

5.10 Recommendations for the Teddy Bear Clinic

- Establishing caregiver support groups.
- Establishing peer support groups.
- Engendering an open and transparent process by providing periodic feedback to the caregivers
- Clarifying and giving clear and concise information about the clinic as well as the professionals working within the organization, so that the caregivers have an understanding of the process involved and what role each role player provides within the clinic as part of the therapeutic services.
- To continue to use teddy bears as a symbol of care and safety for the child

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LIST OF APPENDICES

APPENDIX A: Letter of Informed Consent

Section A: Research Information for Adult Participants (English)

- Title of study:** A Journey to Healing: Exploring the clients' experiences of services in a clinic dealing with child sexual abuse.
- Purpose of the study:** This study will explore the experiences of the participants with regards to the services offered by the Teddy Bear Clinic. The participants will share their experiences and concerns around the services they received at the clinic, for example what was unhelpful and what was helpful for them.
- Role of the participant:** The researcher will ask the participants some questions about their experiences. This will be done through an interview which will last approximately 1 to 2 hours.
- Information:** The experiences shared during the interviews will be used as a basis for a master's thesis in psychology and possibly a published paper.
- Benefits:** The benefits to the participants will be that by sharing their experiences, they will have a place to express their negative or positive experiences about the services at the clinic. This can be used to give the professionals in the clinic a better understanding of how the clients experienced the services at the Teddy Bear Clinic, thereby contributing to developing the services further

and contributing to a better experience for other clients that visit the clinic.

Researcher:

The information will be treated anonymously and the participants will not be identified in any way (The real names of participants will not be used). The participants and legal guardians of the children will give their informed consent for themselves and their children to participate in this study. The participants will be informed of the recordings of the interviews by means of an audio tape recorder.

Participation in this study is on a completely voluntary basis and the participants can withdraw from the study at any time. If they do withdraw all records will be destroyed. If any of the participants feel that they would like to discuss anything further they will be referred to a professional within the Teddy Bear clinic. Should the participant feel they would like to see someone outside of the organization, a suitable referral will be provided. My cell phone number will be given to the participants so that they may contact me regarding the study for the duration of the research process. The data will be stored on the researcher's personal computer and a code will be used to protect the data from unauthorized access. Thereafter the information will be stored at the University of Pretoria for a period of 15 years, in accordance with the regulations of the University.

Thank you,

Ms Katia Nicolaides
Researcher

Ms Vicky Timm
Supervisor

Section B:

Consent Form for Adult Participants (English)

Please sign the consent form below

I, _____, hereby freely give permission to take part in the study as explained in Section A, give permission for the researcher to use an audio tape recorder.

Participant:

Signed: _____ Date: _____

Name in print: _____

Legal Guardians, please sign the consent form below

We, _____, hereby freely give permission for our child to take part in the study as explained in Section A, give permission for the researcher to use an audio tape recorder.

Legal Guardians:

Signed: _____ Date: _____

Name in print: _____

Signed: _____ Date: _____

Name in Print: _____

SECTION C:

Assent form for the child participant

Please indicate by means of Yes/No

Child Participant

The researcher has explained what the study is about and I understand what is required of me.

I am willing to participate in this study: _____

I am unwilling to participate in this study: _____

Participant:

Name in print: _____

Researcher:

I have explained the study to the participants, and provided them with a copy of the participant information sheet.

Sign _____ Date: _____

Name in print _____

APPENDIX B

Interview Guide:

1. Can you tell me about how you came to know about the Teddy Bear Clinic?
2. How did it happen that you came to the clinic?
3. What was your experience at the clinic?
4. What did you find helpful?
5. What did you find unhelpful?
6. How do you believe the clinic should deal with clients?
7. What specifically in your opinion do you feel could be done differently?
8. How would you set up the services in a clinic dealing with abuse?
9. Is there anything you would like to say about your experience to the people at the clinic?
10. How did you feel about this interview?

APPENDIX: C

Letter of permission from the Teddy Bear Clinic

Appendix C: Letter from the organisation

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Or 933 3346
Head Office (011) 484
4554/4539
Fax (011) 484 4551

24th November 2009

Dear Sir/Madame

Permission for Katia Nicolaides to conduct research at the Teddy Bear Clinic

This letter serves to confirm that Katia Nicolaides has been granted permission to conduct research at The Teddy Bear Clinic for Abused Children, pending the approval of her research proposal by the University of Pretoria's Human Ethics Committee. Katia proposes to access client files for her sampling procedure, for which we do obtain signed consent in our intake forms. This consent includes the use of information for research purposes, so long as the client cannot be identified by the data used.

Furthermore, we encourage Katia to use our organisations name in her writing up of this research, and offer her our support in terms of the provision of therapists who will make themselves available to the participants in the study, should they need it.

If you would like any further information, please contact me via the following means:

Tel: 011 484 4554

Cel: 083 280 9613

Email: sherie@ttbc.org.za

Yours sincerely,

Sheri Errington

Research and Stats Manager

The Teddy Bear Clinic for Abused Children