CHAPTER 1

GENERAL INTRODUCTION

1.1 INTRODUCTION

This research addressed the phenomenon of child abuse among black children in the North West Province, Moretele District and the nature of social work services rendered by social workers concerning child abuse. The need for conducting this study came about after a serious consideration of the high rate of child abuse worldwide, and lack of social work guidelines for social workers rendering services concerning child abuse in the North West Province, Moretele District. This phenomenon of child abuse is escalating worldwide but especially in South Africa and particularly in the North West Province (SAPS Annual Reports, 1995 - 1999).

Child abuse is therefore regarded as a problem, which needs attention. Due to lack of research on the subject concerning the types, causes, symptoms of child abuse, the impact of child abuse on the abused child, the nature of services rendered by social workers concerning child abuse and the methods which are employed by social workers rendering services concerning child abuse. No efforts are being made to attend to this problem area, especially in the North West Province.

This chapter provides an orientation to this study and addresses the following aspects:

- Motivation for the choice of the subject;
- formulation of the problem;
- aims and objectives of the study;
- hypotheses of the study;
- research approach;
- type of research;
- research design;
- research procedure and strategy;

- pilot study which includes literature study, consultation with experts, overview of the feasibility of the study and the study of specific entities;
- the description of the boundary and population of the study; sampling;
- ethnical issues;
- problems encountered in the study;
- the definition of concepts; and
- the presentation of contents.

The above aspects are discussed below:

1.2 MOTIVATION FOR THE CHOICE OF THE SUBJECT

The researcher is working as a social worker since 1987 in the field of multi-problem families. During this term, the researcher became aware of the growing rate of child abuse among black children in the North West Province, lack of guidelines for social workers involved in child abuse cases and the need to conduct research in that area. This need is supported by the Annual Statistical Report on Social Welfare Services in the North West Province, Moretele District (1995 - 1998) which indicates the number of child abuse cases handled by social workers as follows:

Year	Number of cases
1995 →	621
1996 →	883
1997 →	997
1998 →	1050
1999 →	1231

No research has been undertaken in the North West Province regarding child abuse among black children and there are also very limited studies in the other provinces of the Republic of South Africa in this regard. A tremendous need for such a research therefore exist to explore this phenomenon. This study can therefore make a positive contribution to the North West Province, families of abused children, children as victims and the of social work profession.

1.3 PROBLEM FORMULATION

According to Dreyer (1995:373) formulation of the problem is the starting point of a research project. Padget (1998:28) adds to this by stating that if there is no problem there can be no research. The research problem is therefore the starting point of all research projects and influences all subsequent steps in the research process.

Mark (1996:83) argues that the orientation of the practitioner/researcher suggests that the problems for social work research should come from the day-to-day activities and intervention of social worker's caseload of service delivery.

Research problems therefore result from a critical review of professional social work activities and the ends to which they are directed. The research problem to which this study relates was identified from the social workers' caseload of service delivery in cases of child abuse among black children in the North West Province. The problems to which this study relate are as follows:

- The growing rate of child abuse among black children in the North West Province; and
- the lack of social work guidelines for social workers rendering services in child abuse cases.

1.4 AIM AND OBJECTIVES OF THE STUDY

The aim and objectives of the study is formulated as follows:

1.4.1 Aim of the study

Dreyer (1995:375) argues that the aims of the study may be referred to as the purpose of the study. The statement of the purpose of the study specifies its focus and scope. All social work research should therefore add information to the knowledge base of the profession. The statement of the purpose should answer two questions, namely:

- Why the study is being contemplated; and
- how the results will be utilised by social work.

The following aim of the study is set in relation to the above-formulated problems:

- To formulate guidelines for social workers rendering services concerning child abuse.

1.4.2 Objectives of the study

De Vos, Schurink & Strydom 1998:7 argues that objectives denote the steps one has to take one by one, realistically at grassroots level within a certain time-span in order to attain the aims.

Similarly De Vaus (1995:70) states that objectives refer to the actions of the study. The way a research problem is being defined determines what actions will be taken to alleviate it.

The objectives of this study are as follows:

- To gather information about the types, causes, symptoms and impact of child abuse among black children in the North West Province;
- to gather information about the nature of services rendered by social workers in child abuse cases;
- to gather information about the methods employed by social workers rendering services concerning child abuse;
- to gather information about the approaches employed by social workers rendering services concerning child abuse; and
- to formulate guidelines for social workers rendering services concerning child abuse based on the gathered information.

The above objectives were undertaken to achieve the aim of the study.

1.5 RESEARCH QUESTION

According to Morgan (1998:93) the objectives of a research may take the form of a general question to be answered or a specific hypothesis to be tested. Whether a general question or a specific hypothesis is to be used is determined by the existing knowledge base and previous research activity on the subject.

When more knowledge and research results are available, it is more likely that a specific hypothesis will be used. When there are little knowledge and research results, general questions are asked. In this research questions will be asked, as there are little knowledge and research results about this subject. The reasons for asking questions are as follows:

- To acquire the understanding and data needed to formulate specific hypotheses for use in subsequent more focussed studies;
- such general research questions will serve as guides to the kind of data that must be obtained to achieve the aims of the study; and
- such questions will help to organise the study plan and suggest how to arrange data analysis.

The questions, which were asked in this study, are as follows:

- What are the types of child abuse that occur in the North West Province?
- What are the causes of child abuse in the North West Province?
- Which are the symptoms of child abuse that are enough to identify an abused child?
- What is the impact of child abuse on the abused child?
- What is the nature of social work services rendered by social workers concerning child abuse?
- Which methods are being employed by social workers in their service rendering concerning child abuse?
- Which approaches are being employed by social workers in their service rendering concerning child abuse?

The above questions were asked to achieve the aim of the study.

1.6 RESEARCH APPROACH

According to De Vos, *et al*,. (1998:15) the directions of the research process and the research methodology are basically determined by the choice of the researcher between a quantitative or qualitative or combined quantitative-qualitative approach.

Leedy, as quoted by De Vos, *et al.*, (1998:15) identifies qualitative research methodology as dealing with data that are principally verbal and quantitative research methodologies as dealing with data that are principally numerical.

This study employed the quantitative approach to gather numerical data from the parents/caregivers and the social workers to achieve the aims and objectives.

1.7 TYPE OF RESEARCH

According to Rothman & Thomas (1994:3) research may be labelled basic or applied. Basic research seeks empirical observation that can be used to formulate or refine theory and its is therefore concerned with extending the knowledge base of the discipline while applied research sets out to solve immediate problems of the discipline (Arkava & Lane, 1983:12).

According to Arkava & Lane (1983:12) the majority of social work research is viewed as applied research as it strives to address immediate problems facing the caring professional in practice. The type of research, which is employed in this study, is applied research since it is sought to formulate guidelines for social workers involved with child abuse cases.

1.8 RESEARCH DESIGN

According to Creswell (1994:23) the research design is a set of decisions that has to serve as guidelines for planning the investigation of the problem. Similarly Smith (1996:35) argues that most contemporary social research is characterised by a study plan labelled the research design.

The research design is therefore a plan, which forms the logical strategies to carry out the aim or aims of the study. This design forms the basis for more specific preparations for data collection and includes details of measurement techniques for data collection such as questionnaires, interview schedules, observation and tests depending on the research. Bogdan & Taylor (1994:300) are of the opinion that the designs specifies the unit of analysis, the sampling procedures, variables on which

information is to be obtained, data collection and measurement procedures.

The aim of the research design is described by Marcus (1997:561) as "*... to provide a set of systematic procedures for producing data pertaining to the development, modification or expansion of knowledge* ".

The type of research design, which is be employed in this study, is the exploratory design, which is chosen on the basis of the findings by Dreyer (1995:16). Dreyer (1995:16) who argues that the most important condition for the exploratory design is that little or no research has yet been undertaken on the phenomenon. This condition is also applicable to child abuse among black children in the North West Province, as there is no research, which is being conducted.

According to Grinnell (1993:40) the aim of the exploratory design is only to explore and nothing more than exploration. This idea is similar to that of Lewis and Franck (1992:112) who state that the exploratory research design has predominantly exploratory objectives. Harrison (1996:23) adds to this by arguing that the purpose of the exploratory design is just to explore, that is to gather data or facts and to gain preliminary understanding of a phenomena or to stimulate the development of concepts, hypotheses and theories which can be explored more intensively later on. The most important aims of the exploratory research design are to refine concepts and to develop questions and hypotheses for further research.

The value of the exploratory research design is emphasised by Rothman & Thomas (1994:13) who argue that "*... it breaks the new ground and often illuminates a problem* ".

Marlow (1993:24) similarly refers to this design as "*... an excellent means of breaking new ground and generating existing insights into the nature of an issue when we know very little about the problem area* ".

Neuman (2000:19) gives the goals of the exploratory research design as follows:

- Become familiar with the basic facts, people and concerns involved;
- generate many ideas and develop tentative theories and conjectures;
- determine the feasibility of doing additional research;
- formulate questions and refine issues for more systematic inquiry;
- develop techniques and a sense of direction for future research; and

- develop a well-grounded mental picture of what is occurring.

The above mentioned goals provided a good understanding of what the exploratory research design can entail and how valuable it can be in this study, the exploratory research design will be employed to achieve some of the above mentioned goals.

1.9 RESEARCH PROCEDURE AND STRATEGY

The research procedure and strategy are discussed below:

1.9.1 Research procedure

The Oxford Learner's Dictionary (1992:991) defines "procedure" as a way or order of doing things. Different authors have identified various phases and steps which researchers should follow in an endeavour to answer research questions. Since this employs a quantitative approach, the phases identified for this approach by Rothery (1993) as quoted by Strydom (1998:39) were followed.

These phases are as follows:

- Selecting a problem area whereby child abuse and social work service rendering concerning child abuse were selected.
- Formulating questions in which questions regarding the nature of child abuse and of social work services concerning child abuse were asked.
- Formulating a research design whereby the exploratory research design was formulated.
- Collecting data whereby data was collected from the respondents by means of questionnaires administered in face-to-face interviews.
- Analysing data in which data was analysed by computer and presented in tables and figures.
- Writing the research report whereby a report in the form of a thesis was written.

1.9.2 Research strategy

According to Layder (1993:2) research strategy refers to the manner in which particular data collection methods are used in the study. Similarly Hox (1996:49) argues that research strategies are efficient means of data collection. In this study research strategy refers to data collection methods which according to De Vos & Fouché (1998:89) refer to the ways which data are actually obtained.

According to De Vos & Fouché (1998:89) data collection methods in the quantitative approach are as follows:

- Checklists which are types of questionnaires consisting of a series of statements. A respondent is requested to indicate the items, which are relevant to him, by ticking the correct items, e.g. "yes" or "no".
- Indexes, which are, viewed as measuring variables on an ordinary level.
- Scales which provide an internal or ratio level of a measure, and
- Questionnaires which are employed in this study as discussed below.

1.9.2.1 Questionnaires

The New Dictionary of Social Work (1995:51) defines a questionnaire as a "*... set of questions on a form which is completed by the respondent in respect of a project* ". The questions can be open, giving the respondent the opportunity of writing any answer in the open space or closed, offering the respondent the opportunity of selecting according to instructions one or more response choices from a number provided to him. The questionnaire can also contain statements on which the respondents are requested to react with the basic objective of obtaining facts and opinions about a phenomenon under study (Fouché, 1998:153).

According to Fouché (1998:153) questionnaires can be applied in various ways such as mailed, telephonic, personal, hand delivered or administered in a group.

Questionnaires are used to gather data in this study. Two different questionnaires are used for to gather data from the parents/caregivers and social workers. These questionnaires contain open and closed questions and statements. Both questionnaires were administered in face-to-face interviews whereby the researcher asked the questions in sequence and recorded the answers given. No further

information was gathered except that were required by the questionnaires. The reason for administering the questionnaires in face-to-face interviews and recording the answers with the parents/caregivers is that most of them are illiterate. The reason for administering the questionnaires in face-to-face interviews and recording the answers with the social workers is to obtain uniformity in obtaining data, as this was already done with the parents/caregivers. Data were gathered during October and November 2000.

1.9.3 Data analysis

Data analysis is defined by Reid & Smith (1991:199) as the categorising, ordering, manipulation and summarising of data to obtain answers to research questions either in tables or figures. According to De Vos & Fouché (1998:203) quantitative data in professional research can be analysed manually or by computer depending on the amount of data to be analysed and the number and types of analysis to be performed. A computer is used to analyse data of this study since there is a huge amount of data. This data is presented in tables and figures.

According to Hofmeyr (1995:1) tables are actually a summary of research data and an initial process of summarising all the data from the individual or any single item. Hagood & Price (1992:240) argue that tables and figures are the most generally useful and most indispensable forms of presenting data.

Frequency tables are used in this study. According to Atkinson (1994:240) a frequency table is one with several possible categories or measurement classes, together with the number of cases that occur in these different categories or measurement classes. The number of cases occurring in a certain category is known as the frequency for that category. In this study the frequencies refer to the number of times the response is indicated by the respondents and is converted to percentages and rounded off to whole numbers.

The following graphs are used:

- Bar graphs, and
- pie charts.

Bar graphs

Hofmeyr (1995:8) argues that a bar graph is a general way in which frequencies or percentages are represented. The points on the X-axis represent qualitative categories and the multi-angles representing the frequencies are not joined to one another. The bars are usually placed vertically with their basis on the horizontal axis of the graph. Bar graphs are used in this study.

Pie charts

Hofmeyr (1995:11) argues that when we represent the whole by a circle, and the segments by wedges, the result is termed a pie chart. A pie chart is therefore a segmental representation used when it is desirable that the various categories which data are gathered together add up to a single whole. The categories are pictured as segments by means of wedges or cuts in the circle. It can then be seen exactly what percentage of the whole is represented by the category. Pie charts are used in this study.

1.9.4 Interpretation of data

According to De Vos & Fouché (1998:203) interpretation of data refers to the explanation, the finding of meanings. Data is interpreted after it has been analysed. The interpretation will entail the drawing of conclusions concerning the answers given to the questions asked. Data is interpreted with the purpose of finding the broader implications of the findings of the study, which are guided by the general problem that is studied, existing theory of frameworks, the findings of existing previous research and the practical experience of the researcher.

1.10. PILOT STUDY

The New Dictionary of Social Work (1995:45) defines the pilot study as " ... *the process whereby the research design for a prospective study is tested* ". Alreck (1995:71) indicates that the pilot study is a miniaturised walk-through of the entire study design which can also be viewed as a dress rehearsal of the main investigation that is similar to the research planned but on a small scale. Such studies may make

or break a projected plan of a larger scope. In view of what is uncovered in a pilot study, a researcher may decide that little or nothing is to be gained through the implementation of a more extensive study.

The function of the pilot study is the exact formulation of the research problem and a tentative planning of the modus operandi and range of investigation. Huysamen (1993:205) views the purpose of a pilot study as an investigation of the feasibility of a planned project and to bring the possible deficiencies in the measurement procedure to the fore. Schurink (1992:17) mention the following specific functions of pilot studies:

- They help to discover and ameliorate mechanical problems associated with interviews, questionnaires and the like;
- they assist in developing better approaches to target populations;
- they help to develop meaningful methods of categorizing data to be collected; and
- they help to determine whether or not a more substantial investigation of the same phenomenon is warranted.

A pilot study is undertaken in this study with the above functions in mind. The pilot study consists of the following aspects:

- Literature study;
- consultation with experts;
- overview of the feasibility of the study; and
- study of specific units/pilot test of questionnaires.

The above aspects are discussed below:

1.10.1 Literature study

A variety of literature was consulted with the main aim of obtaining background information for conducting this study on child abuse. Such literature consisted of books, study guides, articles and both masters dissertations and doctoral theses, and focused on the following aspects:

- Social research;
- the family;
- the needs of children;
- child abuse; and
- social work methods used in service rendering in child abuse cases.

According to Grinnell (1993:55) the utilisation of literature is designed to accomplish the following objectives:

- To become familiar with problems encountered in previous investigations of the subject;
- to ascertain what is known about the subject and the degrees of certainty and doubts which surround the conventional wisdom and scholarly research available on a specific subject;
- to provide an introduction to the unique vocabulary and criminology in which the topic is typically discussed;
- to suggest the trends in the problems to which the policy is a response. It also identifies the significant actors and the special circumstances that have shaped the social problem and its various policy responses into its present form;
- to provide a perspective on the various models of investigations used and the utility, applicability or effectiveness in the clarifications of choice among policy options. Therefore it suggests the implications of models or approaches previously specified; and
- to give insight into the evaluation of the investigations and into the degree to which previous work has not been cumulative.

The above objectives, as mentioned by Grinnell (1993:55) have been achieved through the utilisation of literature study.

1.10.2 Consultation with experts

Strydom (1998:180) states that experts are persons who have been trained in a specialised area, who have undertaken research or who have been active for many years in that specific area, i.e. people who are knowledgeable about the subject. Experts have been consulted with the purpose of bringing unknown perspectives to

the fore and confirming or rejecting the researcher's own views. Such experts includes:

- Social workers of the Department of Health and Developmental Welfare, who are involved in service delivery in child abuse cases;
- University lecturers attached to the University of Venda and University of South Africa dealing with child abuse and research;
- the Child Protection Unit of the South African Police Services in the North West Province; and
- Health care workers attached to the Jubilee Community Hospital in the North West Province.

Consultation with the above experts focussed on the following aspects:

* **Choosing the topic of the research**

The following experts were consulted to assist with the choice of the topic for research;

- Mrs Monnakgotla - Senior Social Worker at the Department of Health and Welfare in the North West Province who is involved with child abuse cases and is also a supervisor to social workers involved with child abuse cases. She indicated the need to study child abuse as its rate is escalating as shown by their high caseloads.
- Inspector Tselapedi - Branch Commander of the Child Protection Unit in the North West Province. He also indicated the need to study child abuse due to the high number of criminal cases of child abuse handled.
- Ms Rapetswa, a qualified health care nurse attached to the Jubilee Community Hospital also indicated the need to study child abuse, based on the high rate of abused children who are treated by the hospital.

* **The research process**

- Mr. Mutavhatsindi – Senior Lecturer at the Department of Sociology, University of Venda, specialist in research was consulted for assistance regarding the process of the research.

* **The scope of the research**
  - Prof. Conradie - Professor in Criminology, Department of Criminology at the University of South Africa - specialist in child abuse and research, was consulted for assistance regarding the scope of the research.

These aspects helped the researcher to get ideas about the prospective project.

1.10.3 Overview of the feasibility of the study

This is the preliminary exploratory study involving the exploration of the research area with regard to its practicality. This is done because it is necessary to obtain a picture of the real practical situation where the prospective investigation will be executed.

During this exploration, the researcher should address the goals, objectives, resources, research population, procedures of data collection, the data gathering itself and possible errors which may occur (Strydom, 1998:182). This is important with a view to the practical planning of the research regarding transport, finance and time factors and can alert the researcher of possible unforeseen problems, which may emerge during the main investigation.

The researcher undertook the explorations of the research area and obtained practical knowledge of and insight into this area and came to the conclusion that no problems will be encountered during the main investigation, i.e. the study is feasible with regard to money and time.

1.10.4 Pilot test of questionnaires

Dreyer (1995:49) states that the study of specific entities implies that the researcher should expose a few cases to exactly the same procedures as planned for the main investigation in order to modify measuring instruments. Rubin (1993:272) adds to this by suggesting that the researcher should try the items out with actual subjects from the target population, then rewrite and edit again all items that cause confusion, annoyance and boredom.

The questionnaire is tested by administering it to ten parents/caregivers whose children were abused in the North West Province and four social workers who are involved in service delivery in child abuse cases. These parents/caregivers and social workers will be chosen from the Odi District of the North West Province due to the following reasons:

- To avoid studying the same respondents in both the pilot and final study; and
- respondents in the Moretele District are not enough for use in the pilot study and in the more intensive study.

Criticisms and recommendations were taken into consideration. This process helped to identify ambiguous questions and inadequate responses. Items which were not serving any essential purpose for the study and/or confirming were omitted from the final questionnaire.

1.11 DESCRIPTION OF THE BOUNDARY AND POPULATION OF THE STUDY

1.11.1 The boundary of the study

The study is undertaken within the boundaries of the North West Province, Moretele District as explained below:

The North West Province comprises largely of the former Western Transvaal and former Bophuthatswana areas. The population of this Province during 1995 to 1998 was 3043 thousand, which constituted 8.2% of the South African population. Black people constitute 90% of this population. The majority of people have Setswana as their mother tongue, while English, Afrikaans, Sesotho and Xhosa are also spoken by a significant number of people. Less than a third of the population is urbanised, with more than two thirds living in rural areas. The population is a young one, with about 40% being in the under 15 years age group (Setshedi, 1999:17).

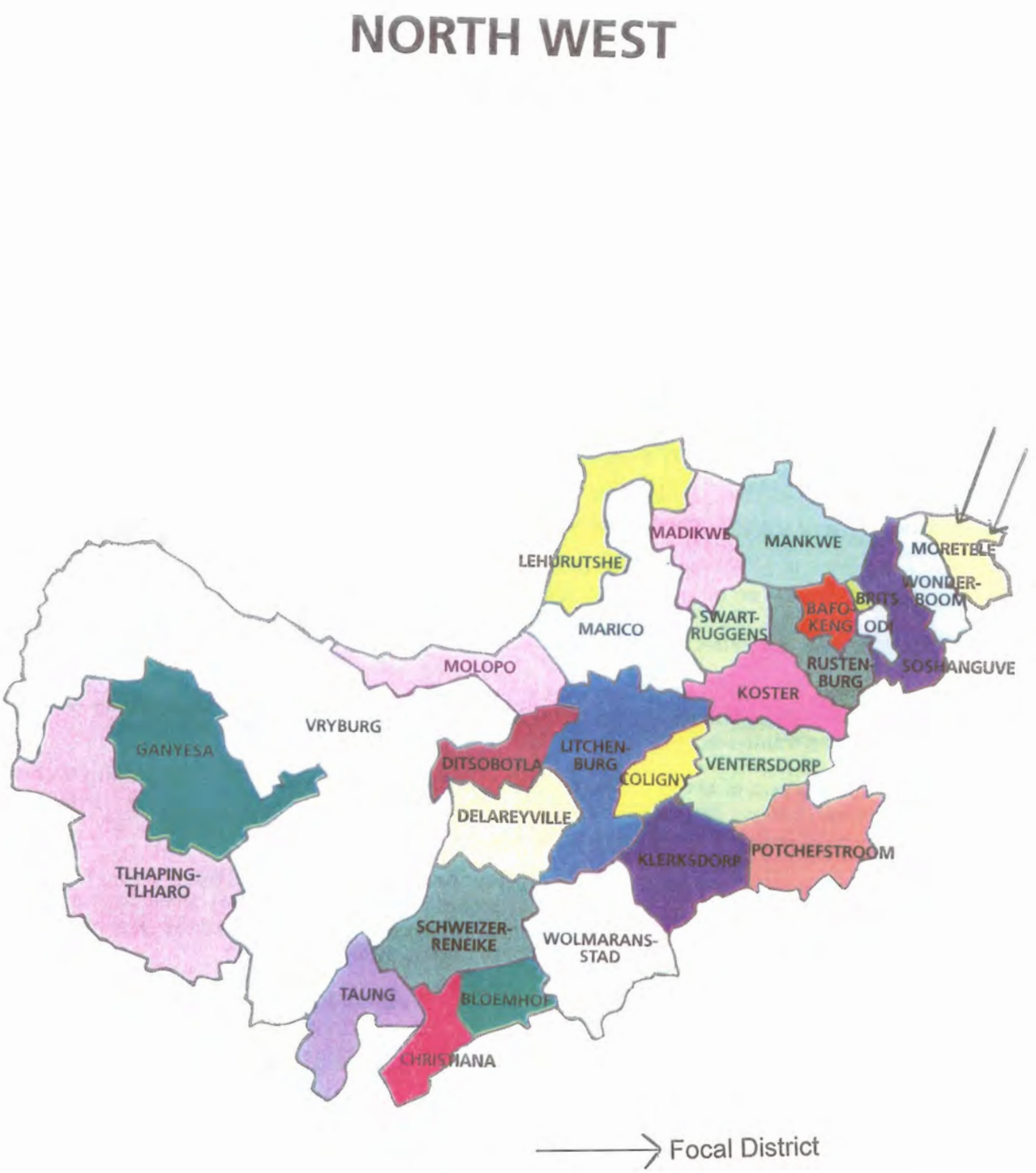
The Department of Health and Developmental Social Welfare established its new

health and welfare districts according to magisterial district boundaries. According to these boundaries, the Province is divided into five regions, which are subdivided into eighteen districts, which are as follows:

- Molopo region consisting of the following districts: Mafikeng, Lichtenburg, Zeerust and Delareyville.
- Vryburg region consisting of the following districts: Vryburg, Ganyesa, Taung, Kudumane and Schweizer-Reineke.
- Klerksdorp region consisting of the following districts: Klerksdorp, Potchefstroom, Ventersdorp and Wolmaransstad.
- Rustenburg region consisting of the following districts: Rustenburg and Mogwase.
- Odi region consisting of the following districts: Odi, Moretele and Brits.

The above regions and districts are depicted in figure 1 below:

Figure 1: The division of the North West Province into five regions and districts



This study focuses on Moretele District, which consists of the following areas: Cyferskuil, Ga-Maubane, Makapanstad, Stinkwater and Temba. These areas are not depicted in figure 1.

1.11.2 The population of the study

According to Jupp (1992:19) the population of the study refers to the largest unit of analysis, including all persons meeting the defined characteristics. Similarly, Strydom & De Vos (1998:190) argue that the population of the study is a term that sets boundaries on the study, i.e. individuals in the universe who possess specific characteristics being studied.

The population for this study is as follows:

- All the parents/caregivers whose children were abused in the North West Province during the period 1995 - 1999 and who receive or received social work services; and
- all the social workers employed by the Department of Health and Developmental Welfare who are rendering services concerning child abuse in the North West Province.

It is not possible to study the whole population of parents/caregivers and social workers as stated above, as a result a sample was drawn. According to Arkava & Lane as quoted by Strydom & De Vos (1998:191) refers to the element of the population considered for actual inclusion in the study which should be representative of the population. This means that the sample should have approximately the characteristics of the population relevant to the research in question so that it can be generalised from the sample to the larger population. A sample was drawn because it was not feasible to study the population in terms of time and resources.

1.11.3 Sampling

Purpose sampling was used. According to Singleton, as quoted by Strydom & De Vos (1998:199) purposive sampling is based entirely on the judgement of the researcher in that a sample is composed of elements, which contain the most characteristics representative or typical attributes of the population.

The researcher, in employing purposive sampling decided that the parents/caregivers whose children have been abused in the North West Province – Moretele District during the period 1995-1999 and who receive or received social work services and the social workers employed by the Department of Health and Developmental Welfare who are rendering social work services concerning child abuse in the North West Province – Moretele District. This is representative, i.e. they represent all the parents/caregivers whose children have been abused in the North West Province during the period 1995-1999 and who receive or received social work services and the social workers employed by the Department of Health and Developmental Welfare who are rendering services concerning child abuse in the North West Province – Moretele District. This is representative of the population in the North West Province, whereby the findings of the study will be generalised to this population of the North West Province due to similar structure and functioning of the Districts of the North West Province. Focus is therefore on the parents/caregivers and social workers. The judgement of the researcher is thus prominent in this type of sample.

1.12 ETHICAL ISSUES

Krimmel (1988:56) defines ethics as the rules that define the rights and responsibilities of researchers in their relationships with each other, and with other parties, including research subjects, clients or employers. Similarly, Strydom (1998:21) defines ethics as a set of moral principles which is suggested by an individual or group, is widely accepted and offers rules and behavioural expectations about the correct conduct towards respondents, employers, sponsors, other researchers, assistants and students.

Ethics therefore refers to rules of conduct that guide and control behaviour in research. The following ethical issues as given by Strydom (1998:24) were followed:

- Harm to experimental subjects whereby subjects are protected from any harm, e.g. emotional or physical harm. In this study no sensitive questions that can harm the respondents emotionally were asked.
- Informed consent whereby the respondents are informed about their participation and the nature of the research so that they understand the intention of the research and can decide whether to participate or not. In this

study the respondents were requested to sign a form which specify that they are participating on a voluntary basis.

- Confidentiality and anonymity whereby respondents are assured of the confidentiality of the information given and their anonymity. In this study the respondents were assured of confidentiality and anonymity by means of a covering letter.
- Co-operation with collaborators who are the sponsors for the completion of the study in terms of resources. In this study the researcher is co-operating with the Department of Statistics attached to the University of Pretoria with regard to data analysis by a computer.

1.13 PROBLEMS ENCOUNTERED WITH THE STUDY

The following problems were encountered with the study:

- The scarcity of literature and existing research on the subject of child abuse in the North West Province, especially with regard to the causes of child abuse. As a result, there was no existing guidance with similar background for the current research in the North West Province, and literature and research studies from other countries were relied upon, e.g. England and the United States of America.
- Delays regarding the granting of permission to conduct the study in the North West Province, Department of Health and Developmental Welfare. The researcher made an application in July 1998 and only received a response granting her the permission in July 1999. This means that the researcher had to wait for a year before starting with the study.

1.14 DEFINITION OF KEY CONCEPTS

The following concepts will be defined: child, black child, child abuse, caregivers, the types of child abuse, the causes of child abuse, the symptoms of child abuse, the impact of child abuse, social worker, prevention, social work perspective, social work methods.

1.14.1 Child

The South African Legislation, specifically the Child Care Act (Act 74 of 1993:191) defined a child as any individual under the age of 18 years. Similarly, Jacobs (1999:9) also argued that a child is any individual who is under the age of 18. The term "child" as used in this study is referring to any individual who is under the age of 18 years.

1.14.2 Black child

Section 1 of the Population Registration Act (Act 30 of 1950:7) defined a Black individual as a person who is Black. The term " a black child " as used in this study refer to an individual who is Black and under the age of 18 years.

1.14.3 Child abuse

Besharov (1998:2) define child abuse as the infliction or the allowing of the infliction of physical or emotional harm on a child by a person who is responsible for that child. Similarly the Child Abuse and Treatment Act as quoted by O'Brien (1992:3) defines child abuse as: any physical or mental injury, sexual abuse, neglectful treatment or maltreatment of a child under the age of eighteen by a person who is responsible for the child's welfare under circumstances which indicate that the child's health or welfare is harmed or threatened.

The concept of child abuse as applied in this study refers to any non-accidental injury to the child under the age of eighteen as a result of acts perpetrated by any person.

1.14.4 Caregiver

This concept is used to refer to a person who is having the care and management of the person during his minority. This definition correlates with the definition given by Besharov (1998:2) which regards the caregiver as any person who is responsible for taking care of a child. This person can be a parent or a guardian.

1.14.5 The types of child abuse

According to Blumenthal (1994:5) the types of child abuse refer to the nature of child abuse. This definition correlates with that of Buchanan (1996:8) which states that the types of child abuse refer to the forms of child abuse. The concept "type", as applied in this study refers to the categories of child abuse.

1.14.6 The causes of child abuse

According to O'Brien (1992:35) the concept "cause" refers to the antecedent of a phenomenon. This definition is similar to the definition of the concept "cause" as given by Blumenthal (1994:6), as referring to stresses or factors which predispose child abuse. In this study the causes of child abuse refer to the factors which led to child abuse.

1.14.7 The symptoms of child abuse

Besharov (1998:2) defines "symptoms" as the recognition of child abuse. Similarly Bousha (1994:106) refers to "symptoms" as the ways of detecting child abuse. In this study, the concept "symptom", is used to refer to the signs of the existence of child abuse.

1.14.8 The impact of child abuse

The Concise Oxford Dictionary (1996:537) defines the concept "impact" as the influence or effect of something. In this study, the impact of child abuse refers to the negative effects of child abuse on the abused child.

1.14.9 Social worker

This concept refers to a person registered and authorised in accordance with the Social Work Act (Act 110 of 1970) to practice social work, i.e. to provide social services (The New Dictionary of Social Work, 1995:60).

1.14.10 Prevention

The Concise Oxford Dictionary (1996:877) defines the concept of prevention as the taking of measures before something can occur. The concept "prevention" as used in this study, refers to the reduction of the incidence of child abuse from occurring or increasing.

1.14.11 Social work guidelines

The concise Oxford Dictionary (1996:477) defines a guideline as the directing principle. Social work guidelines are used to refer to the directing principles or standards for social workers involved with child abuse cases.

1.14.12 Social work methods

Social work methods is used to refer to professionally recognised procedures of social work supported by academic education, professional training and research to achieve the objectives of social work (New Dictionary of Social Work, 1995:61).

1.15 CONTENTS OF THE RESEARCH REPORT

The report is compiled as follows:

Chapter 1: General introduction
Chapter 2: Theoretical orientation on child abuse
Chapter 3: Theoretical orientation on the causes of child abuse
Chapter 4: Social work service rendering concerning child abuse.
Chapter 5: Empirical research
Chapter 6:Guidelines for social workers rendering services concerning child abuse.
Chapter 7: General summary, conclusions and recommendations

CHAPTER 2

THEORETICAL ORIENTATION ON CHILD ABUSE

2.1 INTRODUCTION

The phenomenon of child abuse occurs worldwide and draws widespread attention within the modern urban and rural societies on its prevalence. Child abuse is therefore a problem for all communities as children of all ages from all social and economic classes fall victim to this insidious crime. Children are being physically, sexually and emotionally abused and also neglected. This abuse is contradictory to the rights of children as set out by section 28 of the constitution of the Republic of South Africa, Act 108 of 1996 which are as follows;

Every child has the right:

- To a name and a nationality from birth;
- to family care or parental care, or to appropriate alternative care when removed from the family environment;
- to basic nutrition, shelter, basic health care services and social services;
- to be protected from maltreatment, neglect, abuse or degradation;
- to be protected from exploitative labour practices;
- not to be required or permitted to perform work or provide services that are inappropriate for a person of that child's age or place at risk the child's well-being, education, physical or mental health or spiritual, moral or social development;
- not to be detained except as a measure of last resort in which case the child may be detained for the shortest period of time;
- to have a legal practitioner assigned to the child by the state at the state expense in civil proceedings affecting him; and
- not to be used directly in armed conflict and to be protected in times of armed conflict.

Child abuse is therefore the violation of the right of children as discussed above. However, there is no agreement regarding the definition of child abuse and this has a negative impact on the actual incidence of child abuse, as each and every community has its own definition of child abuse.

This chapter will therefore focus on the definition, the history, the incidence and types of child abuse.

2.2 DEFINITION OF CHILD ABUSE

There is no clear-cut consensus on a definition of child abuse. Many definitions concerning child abuse exist. Some include the perpetrator of the deed, the degree of abuse, the consequences of the abuse in the definition while others examine the effect of the abuse on the child.

The examples of such definitions are as follows:

Gerbner & Ross (1993:16) postulate that anyone who abuses a child is guilty of a crime even if the deed is done in order to reprimand or punish the child. They define child abuse as the non-accidental physical injury resulting from acts or omissions on the part of the parents or guardians that violates the community's standards concerning the treatment of children and more specifically on its views on child rearing practices. They go further and say that the terms abusive and neglectful can be applied to all parents who use any form of physical discipline as well as to a few socially sanctioned practices.

This definition is vague because it is difficult to actually stipulate what the community's standards are regarding the treatment of children and more specifically on its views on child rearing practices.

Helfer & Kempe's (1998:7) definition takes the degree of abuse into consideration. They define child abuse as the non-accidental physical attack or physical injury, including minimal as well as fatal injury inflicted upon children. This definition does not mention the various forms of abuse, it focuses on physical abuse only.

Gelles & Strauss (1991:17) define child abuse as malnourishment, failure to care for and protect a child, failure to clothe a child, physical force, sexual assault and psychological abuse. This is a wide definition, which include all forms of child abuse but do not incorporate the perpetrator of the deed.

The definition of child abuse which has been accepted worldwide is the one given by the Child Abuse Prevention and Treatment Act of 1974, as quoted by Barry (1994) and

Mouzakitis (1995). According to these authors, the Child Abuse Prevention and Treatment Act of 1994 defined child abuse as the *"... physical or mental injury, sexual abuse or exploitation, negligent treatment or maltreatment of a child under the age of eighteen by any person under circumstances which indicate that the child's health or welfare is harmed or threatened "*. This definition is inclusive as it delineates the various forms of child abuse, namely: physical, sexual, emotional abuse and neglect.

2.3 THE HISTORY OF CHILD ABUSE

Jacobs (1998:16) argues that child abuse is characteristic of both ancient and modern societies. The Bible preaches that to "spare the rod" would be to "spoil the child". This has formed the basis of the belief that physical punishment was essential for discipline. The result was the centuries old prerogative of teacher and parents to whip and beat children and to take it for granted that they had every right to treat children as they saw fit. However, through time, there was a general move away from the abuse of children and by the end of the eighteenth century there were regulations curbing corporal punishment in schools (Radbill, 1998:5). Child abuse did not disappear as it is still continuing in today's society.

2.4 THE INCIDENCE OF CHILD ABUSE

The rate of child abuse is spreading rapidly, but its exact incidence rate is not known. However, with awareness of the problem increasing, more and more cases are reported every year. The 1994 report on World Humane Association for Child Abuse as quoted by Blumenthal (1994:79) indicates that there are about one million confirmed cases of child abuse worldwide every year, a 126 percent increase since it issued the first national analysis of reporting statistics in 1986.

Since these cases represent only those have been brought to the attention of the authorities, it is generally accepted that for every reported case, there are at least four that are not reported (Mouzakitis, 1995:7). This increase in incidence may not represent an actual rise in child abuse but rather improvements in reporting and in public awareness. Of the substantiated increases, 26 percent represents cases of abuse only, 43 percent neglect only and the rest both abuse and neglect (Mouzakitis, 1995:7).

The South African Police Services Annual Statistics (1995 - 1999) indicated that the

incidence of child abuse is increasing annually as follows: 1995 - 28482, 1996 - 35838, 1997 - 35867, 1998 - 36793 and 1999 - 38991. It is also noted that while boys and girls were equally as likely to be involved, boys were more numerous among young victims, and girls among adolescents (Faller, 1991:29).

The majority of reported cases are from lower socio-economic classes and minorities. While blacks constitute only 16 percent of the national population, they represent 27 percent of the reported cases. In the total of confirmed reported cases, 20 to 40 percent of the children have been injured seriously. Although children of all ages are victims, those younger than 5 years are the most frequent victims. The average age of abused children in South Africa is 7.1 whereby the majority of victims are represented in the category of children aged 5 and under 5 years (43%) children aged 6 to 11 years and 12 to 17 years respectively represent 33% and 24% of the reported cases (Conradie, 1997:2).

It is interesting and very important to compare the incidence of child abuse in the United States with that of South Africa and the North West Province in particular.

2.4.1 The incidence of child abuse in the United States

The first national survey that attempted to gauge the incidence of child abuse was reported by Gil in 1992. According to Gil (1992:77) approximately 6 000 children were abused in the United States in 1988. Other surveys of that time period reported abuse figures that ranged from 60 000 to 665 000 children (Light, 1993:111).

In an effort to gain reliable estimates, the National Centre on Child Abuse and Neglect funded the American Humane Association to conduct annual national surveys on child abuse. These investigations endeavoured to accurately portray documented reports of child abuse and neglect in the United States. The most recently available statistics show that 1 928 000 cases of child abuse and neglect were reported in 1995 (American Humane Association, personal communication, April 13, 1998).

The number of reports filed for 1994 versus 1995 (Morris, 1994:71 & Lubbe, 1995:30) demonstrate a 12% increase. The latest data from the American Humane Association suggests a rate of 30.6 children for every 1 000 children in the United States who are reported to be abused. The average age of these children was 7.2 years for all United States children. Pre-school children, from birth to 5 years represented 34% of the overall child population and accounted for 43% of abused children. Children aged between 12 and

17 years show the highest rate of sexual abuse and the lowest for neglect. In general neglect affected the youngest age groups, declining as children get older, conversely, sexual abuse increased with age. The highest risk of physical abuse is found among the youngest children.

The percentage and incidence rates for males and females differed only slightly when all forms of abuse and all age groups were considered. Adolescent females were more likely to experience the range of abuse as compared with their male counterparts. Teenage boys on the other hand are more likely to experience educational neglect and emotional abuse than teenage girls but are slightly less likely to experience physical neglect than girls (Gil, 1992:90).

2.4.2 The incidence of child abuse in South Africa

The Department of Paediatrics and Child Health (1998:6) has provided some statistics on the incidence of child abuse in South Africa which indicate that 250 cases per year per million of the population, or 6 - 10 cases per 1 000 live births have, are or will be abused. The Red Cross hospitals have found that 10% of all the injured children under 5 years treated in the casualty department have been abused. Furthermore statistics supplied by these hospitals note that one third of abused children are under 6 months, one third under 3 years and the rest older than 3 years.

A survey in 1997 by the Department of Social Welfare and Pensions as quoted in Kellerman (1998:27) provided that the age of attack is 73.34% of their sample of abuse cases and were younger than four years. The same survey showed that physical abuse was more prevalent in boys than in girls, 53.22% as opposed to 46.78%. Probable reasons which are indicated by Jacobs (1998:17) for the young age of the typical abuse victim are that the young child is extremely dependent on the parents, which increase frustration and that as the child gets older he is more able to control his situation by escaping from the attacker.

2.4.3 The incidence of child abuse in the North West Province

Conradie (1997:1) indicated that there is concern over the extent and severity of child abuse in the North West Province as the rate of reported cases is increasing rapidly.

According to research conducted by Conradie (1997:5) it was found that during 1995 there

were more than 3 000 incidents of child abuse reported to the Child Protection Units of the South African Police Services in the North West Province only. This is about 10 percent of all the reported incidents. If the rising trend of these reports keeps on track, it could be that this figure could exceed our wildest expectations. In 1993 there were 17 194 incidents of child abuse in the North West Province. This figure increased with 6 470 (37,6%) incidents in 1994. In 1995, the reported figures kept on rising until 28 482, which was an increase of 17,4 percent of the figures of 1994.

If we have an increase of only 10 percent in the 1996 incidents, then we could expect more than 3 100 reports which represents another extra 300 incidents. These incidents differ with the cases being handled by social workers as not all the reported cases at the Child Protection Units are referred to the social workers.

2.5 THE TYPES OF CHILD ABUSE

The types of child abuse, which are accepted worldwide, are physical abuse, sexual abuse, emotional abuse and neglect. This is confirmed by authors such as Ovens (1992:13), Barry (1994:2) and Mouzakitis (1995:8). According to these authors child abuse has been defined by the Child Abuse Prevention and Treatment Act of 1974 as the physical or mental injury, sexual abuse or exploitation, negligent treatment or maltreatment of a child under the age of eighteen by any person under circumstances which indicate that the child's health or welfare is harmed or threatened.

The above authors also agree on the characteristics of child abuse as discussed below:

- There is non-accidental injury or attack, which may be physical, mental or sexual on the child.
- This non-accidental injury is by any person or persons.
- The child's health or welfare is harmed or threatened.

The various types of child abuse will now be discussed in detail:

2.5.1 Physical abuse

Various authors such as Goldman & Hevey (1992), Blumenthal (1994) and Mouzakitis (1995) focused on physical abuse. They agreed upon that physical child abuse refers to any non-

accidental action that causes physical injury or harm to a child. Physical abuse therefore includes the following: injuries, burning, poisoning and suffocation:

- **Injuries**

Blumenthal (1994:41) stated that the commonest injury in child abuse is bruising. A bruise is defined as an injury to the skin and subcutaneous tissues causing rupture of the capillaries and small blood vessels with extra vasation of blood. Any bruising in a child below nine months should be viewed with suspicion. After that age the frequency of accidental bruising increases gradually to reach a plateau at about three years.

According to Blumenthal (1994:41) accidental bruising can be distinguished from abuse according to the following factors:

- Location of bruising;
- pattern of bruising;
- number of bruises; and
- dating of bruises.

The above factors are discussed below:

- **Location of bruising**

The commonest sites of accidental bruising are the forehead, under chin, spinal prominence, hips, distal arms and shins, while those of inflicted bruising are the ears, sides of the face, neck, trunk, proximal arms, thighs, buttocks and genitalia (Blumenthal, 1994:42).

Accidental injuries involve skin over bony prominence, e.g. it would be quite normal for an active toddler to have bruising of the forehead, bony areas of face and chin. About a quarter of children below the age of ten will have some bruising on the chins (Pascoe, Currie & Erasmus, 1997:245). Bruising on the arms, particularly the upper past, trunk and thighs is usually caused by finger marks as a result of the child having been gripped. Facial and distal limb bruising are caused by falls down stairs.

Chastisement with a hand or implement accounts for most bruising of the buttocks, lower back and lateral thighs. Bruising of the side of the face is a common site of an inflicted injury, the pressure from the fingers causing capillary disruption at the edges giving the

characteristic pattern. Bruising of the upper lip and labium frenulum may be caused by a bottle or dummy being forced into the mouth or by a blow. Bruising of the ears and the neck is rarely accidental. Ear bruising is due to the ears being boxed, pulled or pinched. Neck bruising is due to the neck being gripped in an attempt to throttle the child or to lift or restrain him. Children may be gripped by the neck as the head is banged against the wall. Circumferential area of bruising is rarely seen as a result of something being tied around the neck in an attempt to strangle the child.

Black eyes are frequently seen in inflicted injuries of the face. The object inflicting the injury e.g. a fist will usually be sufficiently large to avoid causing trauma to the eye but will damage the capillaries in the tissues surrounding the eye. The black eye will be swollen or tender.

- **The pattern of bruises**

According to Blumenthal (1994:43) the pattern of the marks helps to distinguish accidental from abusive injuries, e.g. striking with a looped card produces characteristic loops and hitting with belts, sticks and shoes produce characteristic imprints. Hand marks vary considerably depending on the way the skin is injured. The marks from such actions as grabbing, slapping, pinching, poking and squeezing will vary considerably. Buttock injury sometimes produces a characteristic pattern of vertical bruising in the gluteal cleft. A similar linear pattern occurs over the top rim of the pinna where the ear is traumatised.

- **Number of bruises**

A large number of bruises might raise suspicion of non-accidental injury. Non-accidental fractures of the skull, limbs and ribs can occur with no apparent bruising (Blumenthal, 1994:45). It is often difficult to decide when bruising is excessive given the range of activity of young children. There can be little doubt that some children are accident-prone and will have frequent bruises. The number of bruises should be viewed both in the context of activity level and in the explanation provided, e.g. extensive bruising on the face and distal limbs of a toddler would be plausible given a history of a fall down stairs, but not a fall in snow.

When confronted with a child with excessive bruises or who appears to bruise easily, the possibility of a bleeding disorder should be excluded, as most children with a bleeding will have a history of frequent bruising, nose or joint bleedings since the first months of life.

- **Dating of bruises**

Faller (1991:29) argued that abused children often have a number of bruises of varying age. The colour of a bruise is sometimes of importance from the medico-legal point of view in determining the age of an injury. It should always be emphasised that the use of colour to date bruises is very imprecise as bruises of identical age and cause on the same part of the body may not show the same colours nor undergo changes at an identical rate. The changes of bruises is indicated by Blumenthal (1994:47) as follows:

- From one to two days it is swollen;
- from two to five days it is red, blue or purple;
- after five days it evolves through a sequential pattern and might be green, yellow or brown; and
- from one to four weeks it resolves.

According to the research conducted by Mouzakitis (1995:37) there are different types of injuries inflicted on the children, such as head, face, thoracic, abdominal and bone injuries, which will now be discussed in more detail:

2.5.1.1 Head injuries

Head injuries accounts for more disability and death than any other type of non-accidental injury. This includes scalp bruising and tissue swelling. This might be due to lifting a child by the hair or pulling forcefully (Blumenthal, 1994:50).

Researchers such as Meservy (1997), Haller (1991), Duhaime, Geismar & Bourne (1992) and Blumenthal (1994) agreed upon that injuries of the head are of two types: impact or shaking, and that sometimes these two can occur simultaneously.

- **Impact injuries**

These injuries occur when the head is banged by or against a hard object. The impact causes craniocerebral distortion causing the skull to fracture along stress lines. The fracture may be linear or the skull may burst with tearing of the meninges and wide separation of the fragments (Duhaime et al., 1992:182).

Accidental skull fractures are common in early childhood as children are dropped or fall in the

home. When faced with a young child with a skull fracture it is the task of the medical doctor to judge whether the history is compatible with the degree of injury. Studies by Hobbs (1994), Meservy (1997) and Leventhal (1998) gave some guidance regarding differentiating between accidental and inflicted skull fractures.

Meservy (1997:172) and Leventhal (1998:90) have shown that most accidental and inflicted injuries cause single linear fractures involving one parietal bone. If both parietal bones or a parietal and another are fractured, the likelihood of an inflicted injury increases. Hobbs (1994:251) has indicated that fractures of the occipital bone are seldom accidental and should always arouse suspicion of abuse. This is in contrast to the findings of Leventhal (1998:91) in which 10% of accidental fractures were occipital.

Most accidental and inflicted fractures are narrow and referred to as "hairline" being 1 - 2 mm in width. According to Hobbs (1994:252) a width of more than 3 mm or a growing fracture strongly suggest abuse. When the skull bursts, the brain and meninges evaginate between the edges of the fracture preventing healing and causing the fracture to grow.

Complex fractures are more often inflicted than accidental. It is noted that in a study by Leventhal (1998:91) short distance falls between 60 to 120 cm caused complex fractures. Complex is defined as two or more distinct fractures of any type of a single fracture with multiple components.

Accidental fractures are well localised and would be consistent with the head having struck a projection of some sort. Such fractures would be inconsistent with a fall on a flat object (Blumenthal, 1994:52). When children fall accidentally, the severity of the injury is dependant on the distance and hardness of the floor surface. According to the findings of the studies conducted by Hobbs (1994:253) children falling short distances, seldom sustain a skull fracture. The risk of a fall of less than 90 cm being associated with a skull fracture is probably less than 2%. In a five year study of fractures in children under three by Leventhal (1998:93) it was found that eight children had linear parietal fractures after falls of less than 60 cm from a bed or sofa.

Skull fractures, which are detected in the first months of life, are often thought to have occurred at birth. Some depressed fractures occur in utero, while others which were absent at birth may develop over a few days and persist for two to three months.

- **Shaking injuries**

Blumenthal (1994:55) discussed shaking injuries as the shaken baby syndrome. According to Blumenthal (1994:55) the shaken baby syndrome is a well recognised and common form of child abuse with a high mortality and morbidity. Shaking a baby as a form of chastisement is widespread and is thought by some to be socially acceptable while others regard it as child abuse. The main features of the syndrome are subdural and retinal haemorrhages caused by shaking. The vast majority of children with shaking injuries are under twelve months.

Shaking injuries usually occur in a sudden fit of rage often in response to a child who is crying uncontrollably. The child is violently shaken and the rapid acceleration or deceleration produces differential motion between the skull and its contents. The motion of the brain to and from the subdural space causes traction and shearing of the veins.

The pressure in the venous system is low in which case symptoms may not be immediate but are apparent within twelve hours. Children usually present with loss of consciousness and/or seizures. There may be a preceding period of irritability. Suture separation and a bulging fontanel indicate raised intracranial pressure. In most occasions infants who are shaken in a rage are not laid back gently in the crib but are thrown down sustaining an impact injury as well. Such infants are particularly vulnerable to whiplash injury as the bridging cerebral veins are poorly supported as they pass through the subdural space, but do not have skull fractures. Grasping of the chest during the shaking process sometimes causes rib fractures. Vertebral abnormalities are often sustained in the lower thoracic or upper lumbar part of the spine and are caused by hyperextension as the head is tossed backwards and forward. There is narrowing of the anterior vertebral borders. Damage of the spinal cord accompanies only the most severe abnormalities (Blumenthal, 1994:55).

Most children with shaken baby syndrome have retinal haemorrhages. The detection of this retinal haemorrhage makes it difficult to time the injury. Most retinal haemorrhage resolve within a week or two. Massive blood accumulation would suggest a recent injury particularly in the case when an initial examination reveals retinal haemorrhage only and subsequent examinations shows migration of blood into the vitreous. Sparse haemorrhage at the initial examination is consistent with both early or late injury irrespective of the degree of trauma. A good prognosis is the preservation of the pupillary light reflex (Faller, 1991:192).

According to research findings by Caffey (1992), Alexander, Johnson & Melton (1994), Greenwald (1995) and Haller (1991), not all shaking injuries are abuse. A young child with apnoea, a seizure or following an accident may be unintentionally violently shaken in a panic

attempt to revive the child. If the child is not fully conscious, the muscular hypotonia makes him particularly vulnerable to retinal and brain haemorrhage. In such a situation, the history is of vital importance in ascertaining whether shaking was abuse.
Adults who abusively shake children may invoke shaking as part of a resuscitative procedure in their defence. They may claim that the child was shaken after he was found apnoeic or with a seizure. In these instances, skeletal survey is invaluable in highlighting evidence of abuse, which would serve to negate the defence, particularly in children who die when the charge is likely to be murder or manslaughter. A skeletal survey might reveal subtle x-ray changes such as metaphysical chip fractures, which are specific to abuse. Such changes would not be readily apparent on postmortem examinations thereby depriving the crown of valuable incriminating evidence and risking further exposure of any siblings to shaking.

2.5.1.2 Injuries of the face

Injuries of the face are being classified by Lambert (1992:639) as eye, mouth, nasal and ear injuries.

- **Eye injuries**

Injuries of the soft tissue above the eye are readily apparent as periorbital haematomas sometimes with swelling and tenderness. These are commonly known as black eyes and are frequently caused by a blow across the side of the face.

Inflicted injuries of the eye itself are not common but when they do occur morbidity is high, with loss of sight too. When these injuries do occur the advice of an ophthalmic consultant is invaluable. The most common injuries are intra-orbital haemorrhages mainly retinal, periorbital and conjunctival haemorrhages, retinal detachment, corneal injury, lens dislocation and any other eye injury which may be caused by child abuse (Schmitt, 1997:25).

Accidental injury of the eye or its surrounding tissue is usually unilateral as compared to bilaterally eye injury, which may be inflicted. Bilateral eye injury should strongly raise suspicion of non-accidental injury but it should also be noted that bilateral ecchymoses may occur after a bump on the head or in association with a basal skull fracture, often a day or two after the incident.

There is a spectrum of corneal injuries, which may be caused by contact producing a stain with fluorescing chemicals instilled in the eye or sharp objects producing deeper injuries.

When such injuries are found in association with eyelid bruising, inflicted injury should be suspected.

According to McNeese (1996:77) the eye may be injured in two ways, namely:

- Direct trauma, which is caused by the sudden compression of the front of the eye. The fluid filling the chambers is forced peripherally and backwards causing distortion of the globe, structural damage and haemorrhage; and
- shaking which causes acceleration or deceleration forces that are thought to damage the eye directly.

- **Mouth injuries**

Common injuries around the mouth are bruising and laceration of the lips, tearing of a lingual frenulum, breaking of teeth, injuring of gums and laceration of the tongue (Ludwig, 1992:7). Kleinman (1997:77) argues that the force of a blunt object or a hand trapping the lip between the object and the teeth, injures the lips. The sharp edge of the tooth may cause a laceration or contusion on the inside of the lip.

Some lip injuries are accompanied by a torn frenulum, while others are not. Lip injuries whether contusions or lacerations are not serious and look much worse than they actually are. The vast majority heal without treatment. A frenulum tear of the lip or tongue in a child who is not mobile usually in the first nine months is indicative of abuse. Such an injury occurs during feeding or by a blow. When the frenulum is torn during feeding it is as a consequence of parental anger or frustration in response to feeding difficulty. This occurs when a bottle or a spoon is forced into the mouth damaging the frenulum. In mobile children, particularly toddlers who are unstable on their feet, a torn frenulum can occur accidentally as e.g. a child may stumble and fall against an item of furniture such as a coffee table. Frenulum tears heal very quickly and seldom require treatment.

Dental injuries may require the assistance of a dentist. Avulsion of a deciduous tooth requires no action while avulsion of a permanent tooth is a dental emergency. The tooth should be reinserted as soon as possible and the best results are achieved within an hour. If delay is likely, the tooth should be preserved in milk until re-implantation.

- **Nasal injuries**

Kornberg (1992:93) stated that a blow to the nose, which may lead to bleeding or a deviated septum, might cause nasal injuries. A blood clot may be visible in the nose and when the septum is deviated the nose may be swollen and the septum visible in the nostril.

- **Ears**

Injuries of the ears are rare to occur by accident, because when children fall they do not injure their ears (Friendly, 1993:17). The ears being pulled, pinched or boxed commonly cause bruised ears. Repeated blows to the external ear cause bleeding and haematoma formation producing "cauliflower ears". A powerful blow directly to the ear can cause rupture of the ear drum or bleeding into the middle ear.

2.5.1.3 Thoracic injury

Rib fractures are commonly detected in abused children who are under two years (Cooper, 1992:53). According to the study conducted by Feldman (1994) and Brewer (1994) it was found that pressure applied to the chest during cardiac resuscitation does not cause fractures. In the absence of bone disease unexplained rib fractures in the young child are specific for abuse. The exception to this rule is when fractures detected in the first week of life are caused by chest compression during the birth process which are indeed rare.

The mechanisms responsible for most rib fractures are a violent anterior posterior compression of the chest as the infant is grasped and shaken. Rib fractures also occur as a result of blows to the chest, by stamping on the chest or by being thrown against a hard edge. Acute rib fractures may be radiologically invisible and only become apparent ten to fourteen days later when callus forms.

Fractures of the mid clavicle can occur by accident or as a result of abuse. Fractures of the lateral end, together with fractures of the scapula should be considered specific for abuse, particularly in the child under two years, as they are usually caused by violent traction of the arm, but may also result from sudden acceleration/deceleration in the shaken infant.

2.5.1.4 Abdominal injury

Research by Cooper (1998:1485) found that the incidence of abdominal injury in abused children is less than 2% and such children are over two years old. Abdominal trauma is the most common cause of death with the mortality being about 40 - 50%. The high mortality is

in part attributable to the frequent delay in diagnosis, which is caused by the absence of marks or bruises on the abdomen to indicate the cause of their distress. Most injuries occur from a forceful blow or kick to the abdomen.

2.5.1.5 Bone injuries

Research by Thomas (1991:474) indicated that bone fractures are the most common form of limb trauma. In addition, Woley (1995:73) indicated that fractures in children are often wilfully inflicted, particularly in the long bones which includes the humerus, tibia and femur. Some of the fractures of children in different ages are very suggestive of abuse while others are accidental.

Bone fractures on children are sometimes treated without examining the whole child. It is also done without taking a medical history of the child to determine whether history correlates with the nature of such fractures. Suspicions of abuse are sometimes raised after a third or forth time on the same type of abuse.

King (1998:587) mentioned aspects that should be noted, which indicate how bone fractures that are not inflicted by accident, could be recognised:

- Fractures of the middle bones in children before they are able to walk, which require a lever action which cannot take place on its own;
- split fractures surrounding joints, which can only occur when a joint is forced, such as when a child is grabbed and held onto a limb and twisted;
- injuries caused by pressure. In cases of child abuse these include the following:
  - multiple fracture of ribs which are usually detected by means of x-rays, but can be missed when x-rays of the chest is not taken; and
  - hand and foot fractures, which include fractures of fingers, toes and small bones of hands and feet which are occasionally found.

- **Burns**

Thermal injury is common in children between nine months and five years. According to the study conducted by Hight (1994:518) approximately 10% of injuries are inflicted burns, while the rest occur accidentally. It is frequently difficult to distinguish an accidental burn from an inflicted one as both inflicted and accidental burns can occur at similar sites, however, burns on the buttocks, perineum and back of hand are more commonly inflicted. Hight (1994:519)

indicated the factors that can help in making the distinction between inflicted and accidental burns as follows:

- The age of the child. Children who are able to get about and reach out are very likely to be accidentally burnt;
- the physical characteristics of the burn, which may help to identify the implement used; and
- the history, whereby a vague, inconsistent or implausible history particularly with failure or delay in seeking medical attention should raise strong suspicion about non-accidental burns.

The most common type of accidental burn is one that occurs when a toddler pulls hot liquid over himself. Children may be burned as a consequence of neglect, because they have been left unsupervised with matches or electrical appliances or a gas heater. A parent may intentionally burn a child by immersing the child in hot water or by placing the child in contact with hot objects such as stoves, heaters, matches or cigarettes.

Faller (1991:17) identified the following patterns of burn injuries in abuse cases:

- Cigarette burns that are about 5 mm in diameter on various parts of the body, e.g. face, hands, arms or abdomen;
- burns on the buttocks and perineum, especially in children who are in the process of being toilet-trained or who may have a problem with bed wetting or soiling clothes;
- contact burns that come from a part of the body being pressed to a hot source such as a stove or space heater, leaving a pattern of the heating element or protective grill; and
- burns from placing the child's hands down on electric coils of a stove to teach the child not to play with the stove or from burning the child with matches to teach him not to play with matches.

Faller (1991:17) distinguished the following three types of burns:

- First-degree burns that cause only redness such as sunburn;
- second-degree burns which lead to blistering and heal within one to three weeks depending on size; and
- third-degree burns that destroy the entire skin thickness and require healing from

the outside for small areas taking about one month or requiring skin grafting over large areas.

Burns result from exposure to flame, hot liquid, steam, electricity or chemicals. The depth of the burn, the amount of body surfaces involved and the ages of the individual burned determine the severity of a burn injury. The younger the child, the more serious even a small burn becomes.

- **Poisoning**

According to Blumenthal (1994:110) children are poisoned with a variety of drugs and common household substances. The most commonly used drugs are sedatives and tranquillisers that may cause seizures, coma and other unexplained neurological signs. Research by Dine, Fennel & Weinhold, (1992:33) showed that 20% of children had been abused and in 30% poisoning continued while the child was in hospital.

Blumenthal (1994:110) identified features that can alert a person that a child has been poisoned:

- Inexplicable signs, symptoms and biochemical values;
- neurological signs of acute onset such as ataxia, seizures and coma;
- episodic illness;
- relationship between timing of episodes and parental visits;
- child normal in hospital but recurrence after discharge; and
- unexplained illness, injury or death in a sibling.

If poisoning is suspected, the child should be rushed to the hospital. Diagnoses to prove poisoning are done by detecting the drug in the blood, urine or gastric contents.

- **Suffocation**

Meadow (1991:355) argues that there is a huge number of reports of children who have been suffocated by smothering. Scenes of smothering have been secretly captured on videotapes in hospitals and covert cameras are now used as a means of providing the diagnosis. Smothering may be done impulsively when the parent feels violent towards the child or it may be perpetrated in a repetitive, systematic way. It usually starts between the first and third months and continues for months or years until the child dies or it is detected. Children

- On lips, eyes or any part of an infant's face;
- of gum tissue caused by forced feeding;
- on external genitals;
- on the back of arms or legs; and
- missing or loose teeth.

Skeletal injuries:

- Corner fractures of long bones;
- spiral fractures, and
- stiff, swollen enlarged joints.

Head injuries which are shown by:

- The absence of hair;
- haemorrhage beneath scalp caused by pulling hair;
- subdural haematomas caused by shaking or hitting; and
- nasal, skull or jaw fracture.

2.5.2.2 Behavioural symptoms

- Fearful of physical contact;
- sporadic temper tantrums;
- craving for attention;
- wearing long sleeves or other concealing clothing even in hot weather;
- appearing frightened of parents or caregivers;
- demonstrates extremes in behaviour, e.g. overly aggressive or very withdrawn;
- often sleepy in class;
- arriving early for school or stays late;
- complaining that physical activities causes pain or discomfort;
- excessive school absence; and
- lack of curiosity.

2.5.3 Sexual abuse

According to Blumenthal (1994:3) sexual abuse refers to contacts or interactions between a child and an adult when the child is being used for sexual stimulation of the adult or another person. This definition of sexual abuse is similar to the one given by Faller (1991:144) whereby he argues that sexual abuse refers to physical contact between persons at different stages of development usually an adult and a child for the purpose of sexual gratification of the more mature person.

Sexual abuse may also be committed by a person under the age of eighteen when that person is either significantly older than the victim or when the perpetrator is in a position of power and control over the victim (Blumenthal, 1994:3).

Sexual abuse therefore encompasses a wide range of behaviours which one needs to be aware of, namely:

- Sexual contact of one or both participants' intimate parts, e.g. the penis, vagina, pelvic area, buttocks, anus and breasts.
- Fondling which may be fondling of the victim by the perpetrator, or the perpetrator may induce the victim to fondle him.
- Oral - genital contact (fellatio cunnilingus) whereby the perpetrator may stimulate the victim's genitals by sucking or licking or may persuade or force the victim to stimulate the perpetrator or both.
- Sexual intercourse.
- Anal intercourse.
- The use of the child's armpit for sexual gratification.
- Interfemoral, i.e. placing the penis between the child's legs.
- Sexual assault that occurs when the perpetrator is not related by blood to the victim. This includes situations of rape as well as ones where force is not used and actual intercourse does not occur. The perpetrator may be a complete stranger, someone the child recognises but does not know well, a friend of the family or someone actually living in the household but not related to the child, such as the mother's boyfriend.
- Incest which Mouzakitis (1995:13) classifies as the most common type of sexual abuse. It refers to any kind of sexual activity between the child and relatives, either related by blood or legally, including fathers, mothers, stepparents, grandparents or siblings. This means that the perpetrator may come from within

the nucleus family or be a member of the extended family (Faller, 1991:144-145).

The technical distinctions between incest and assault are useful guidelines for the beginning of the diagnostic process. However, the more essential diagnostic issue is the closeness or intimacy of the relationship between the perpetrator and the victim. This intimacy has implications for the psychological impact of the encounter, the way in which the relationship develops how long it persists and how frequently sexual contact occurs, whether force is used or not and the response of the victim and of the family to it. According to Faller (1991:145) the configurations of sexual abuse represent a continuum of relationships based upon the degree of intimacy between the victim and the perpetrator.

At one end is the assault, i.e. a single encounter with a stranger where there is no forewarning and force may be used. The child is likely to tell the parents right after it happens and they in turn will respond appropriately, taking the child to hospital, reporting the incident to the police and/or seeking mental health treatment for the child. At the other end of the continuum is the classical incestuous relationship which are sexual encounters involving natural fathers and daughters.

In contrast with assault, the relationship evolves gradually, beginning with appropriate affectionate interaction which becomes sexualised. The behaviour is likely to progress from the adult fondling the child, to mutual masturbation, perhaps then to oral-genital contact or interfemoral intercourse, and may never involve full genital intercourse. Force is usually not used although the father may bribe the child or use other inducements. Sometimes these relationships begin in early childhood and continue until adolescence.

Sexual contact may occur as often as once or twice a week. The child may be persuaded by the father not to tell. If she does tell her mother, the mother's response may not be appropriate, i.e. the mother may fail to support the child and may blame the child, sometimes will refuse to believe the child or may not seek treatment for the child or report the relationship to professionals. It is common that the relationship may terminate during adolescence when the child refuses to continue involvement because she wishes to establish relationships with peers and often as an older child rebels, a younger child or children are socialised by the father into sexual activity (Faller, 1991:146).

Between typical assault and classical incest there is a wide range of configurations of sexual abuse. In general, one finds that the relationships evolve more gradually and are of longer duration than in assault but less so than in incest. Force is less likely to be used than in

assault but is a factor more often than in incest. Families will be less appropriate in their response to discovery than in assault but more appropriate than in incest. An important characteristic of these relationships is that the incest taboo either does not exit or is lessened. The perpetrators are less deviant in their functioning than in either classical incest or rape. It also appears that the encounters tend to be less damaging to the victim than those at the two end of the continuum. The reason for this is that incest and assault are characterised by different factors associated with psychological damage. In cases of incest, damage results because the adult in normal circumstances will be a trusted person whose responsibility is to protect the child, not to exploit her. Force that is a second factor associated with trauma is likely to be used in assault.

There are also a number of commonly identified configurations falling between the incest and assault end of the continuum. One is a situation in which the perpetrator is a stepfather or a mother's boyfriend. It appears that such unrelated individuals are at higher risk for sexual abuse than are natural fathers. It is common to find that in situations where stepfathers or mother's boyfriends abuse children, the natural father was quite deviant and may also have been sexually abusive. Mothers in such families tend to be stronger than mothers in cases of classical incest. This is demonstrated by the fact that they have been able to put the first husband out of the home or divorce him. Such mothers frequently choose subsequent partners who are similar to their first or they may seek more appropriate partners and learn from earlier mistakes.

Faller (1991:147) argues that in cases where daughters were initially socialised into sexual relationships by their fathers, the sexual molestation by later partners of the mother is initiated quite quickly. One may find that the mother's new partner appears to be consort to both mother and daughter and there may be a great deal of jealousy and competition for his attention between the mother and the daughter.

Another common configuration is one where there is an ineffectual young man either in adolescence or early twenties, and a fairly young victim. The perpetrator may be related or not, a cousin or uncle, a babysitter or family friend.

Typically the abuser experiences heightened sexual drive, characteristic of this developmental stage for men. He may also feel too inadequate to attempt a relationship with someone of his own age. He therefore initiates sexual encounters with younger children, usually heterosexual but sometimes homosexual.

A fairly frequent type of sexual abuse is one involving an older abuser, a grandfather or aged uncle or occasionally someone unrelated to the victim. The older man usually engages in behaviour other than intercourse, such as fondling or oral - genital contact. He may well be physiologically impotent and his wife or partner may be deceased or may long have since ceased having sexual relations with the abuse victims can be of either sex. Families attempt to control this deviant behaviour in a number of ways such as instructing children never to be alone with the abuser or never to let him touch them. Adults in the family may also take the responsibility of seeing to it that the perpetrator is never alone with young children. In addition, the family will occasionally place the old man in a nursing home or sheltered living situation even though he does not need institutional placement.

Faller (1991:147) argues that child-child sexual behaviour deserves separate consideration as it applies both to incestuous relationships between children and encounters between children who are not related. Their behaviours should be classified as sexual experimentation and is developmentally normal among four year olds but not accepted with children from ten years who are attempting intercourse. Such experimentation should not be encouraged. The meaning of such intimacy should be communicated to the children involved because if sexual experimentation is harshly punished, the participants may have difficulty with sexual performance later.

There are some guidelines that can help the parents to determine when child-child sexual behaviour is problematic, e.g. when there is a large age gap or large developmental differentiation between the two participants such as a thirteen year old boy who attempts intercourse with a five year old girl or when force is used and the relationship is so consuming that the participants do not engage in developmentally normal relationships, particularly peer relationships.

According to Faller (1991:148) a small percentage of cases of sexual abuse fall into three fairly easily recognisable categories, namely:

- The polymorphous family. This is a family where many or even all of the family relationships are sexualised, i.e. there is likely to be father-daughter incest involving all daughters. There is usually mother-son incest, sometimes sexual relationships between siblings, there may be homosexual as well as heterosexual liaisons and the encounters may extend beyond the nuclear family to other relatives. Relationships may be transitory and shifting, there may be sexual encounters involving several people, with unstated rules about who may and may not be involved. The

polymorphous family is fairly rare, but needless to say, it makes a rather striking impact upon the professional community where it is discovered. These families may justify their incestuous behaviour with some sort of ideological under pruning. They are also extremely difficult to treat because there are so many relationships to be broken up and because there is pervasive, often overt support of the appropriateness of the sexual behaviour within the family.

- The second category is one where either the victim or the perpetrator is mentally retarded. In such cases the degree of retardation and other functioning need to be assessed by a psychologist and a plan be made accordingly.
- A third category is the family with a perpetrator who is psychotic and has some delusions, which support sexual involvement with the victim. Two factors must be assessed, namely; whether the psychosis is chronic or acute and whether the condition will respond to medication including whether the perpetrator will take the medication. If the psychosis is acute and responds to medication, it will usually be possible to keep the family together and provide treatment. If this is not the case, the psychotic must be hospitalised and treated.

2.5.3.1 Identification of sexually abused children

According to Winship (1998:14) sexual abuse is reported on a daily basis. In most cases it is not isolated incidents or only one experience. In the majority of cases somebody they know well and trust subjected these children to it for months and even years. Such children should be examined by medical doctors as patients and not for medical-judicial reasons.

Goldman *et al.*, (1993:22) and Schreier, Sager & Eiskine (1996:64) argue that there are both physical and behavioural indicators of sexual abuse as given below:

- **Physical symptoms**

  - Pregnancy at an early age;
  - bruises of external genitalia, vagina or anal regions;
  - bleeding from external genitalia, vagina or anal regions;
  - swollen or red cervix, vagina or perineum;
  - presence of semen;
  - torn, stained or bloody undergarments;
  - stretched hymen at a very young age;

- presence of sexually transmitted diseases;
- vaginal or penile discharge; and
- complaints of difficulty with urination.

- **Behavioural symptoms**

- Poor peer relationships;
- prostitution;
- withdrawal from social relationships;
- comments that he was sexually assaulted;
- exhibition of infantile behaviour;
- substance abuse;
- irregular school attendance;
- engaging in delinquent acts;
- arriving early or staying late at school;
- sleep disturbances;
- declining academic performance; and
- suicide attempts.

2.5.4 Emotional abuse

Blumenthal (1994:3) argues that it is difficult to define emotional abuse, as it is often subtle and difficult to diagnose. This difficulty is probably reflected in the fact that in 1997 only 1% of children in the North West Province was in the category of emotional abuse (Conradie, 1995:17).

Blumenthal (1994:3) is defining emotional abuse as a failure to provide an emotionally satisfying environment in which the child can thrive and develop. Similarly, Garbarino (1996:78) referred to the emotionally abused child as the psychologically battered child. Behaviour is considered psychologically abusive when it conveys a culture-specific message of rejection or impairs a socially relevant psychological process such as the development of a coherent positive self-concept. Children who are ignored, rejected or terrorised could be said to be emotionally abused. Nicol (1998:703) further adds that involving a child in occult practices may be construed as a form of emotional abuse.

Garbarino (1996:83) defined five forms of psychically destructive behaviour as:

- Rejecting which refers to behaviours that communicate or constitute abandonment, such as showing no affection or not acknowledging the child's accomplishments. There are no positive remarks, and if the child does something praiseworthy, the parents merely make this an excuse for further criticism. A typical remark is " *you see, he can do it if he tries. The trouble is he never does it* ".
- Isolating whereby the child is cut off from normal social experiences by the actions of the parent. He is prevented from forming friendships and is made to believe that he is alone in the world. This category includes overprotective parents who fail to send their children to school for a variety of reasons, such as medical unfitness.
- Ignoring in which the child is being deprived of stimulation for emotional and intellectual development.
- Terrorising which refers to terrorising the child with vague or extreme punishment, creating a climate of unpredictability and the use of scare tactics. This is " *emotional* " bullying.
- Corrupting whereby the child is " *mis-socialised* ", i.e. actively encouraged to engage in antisocial destructive behaviour and such deviant behaviour is reinforced.

Similarly, Blumenthal (1994:37) argues that a child is emotionally abused if:

- There is substantial and observable impairment of the child's mental or emotional functioning that is evidenced by a mental or behaviour disorder, including anxiety, depression, withdrawal, aggression or delayed development; and
- there are reasonable and probable grounds to believe that the emotional injury is the result of :

    - Rejection;
    - deprivation of affection or cognitive stimulation;
    - exposure to domestic violence or severe domestic disharmony;
    - inappropriate criticism, threats, humiliation, accusations of or expectations towards the child; or
    - the mental or emotional condition of the guardian of the child or chronic alcohol or drug abuse by anyone living in the same residence as the child.

Faller (1991:25) further adds that it is necessary to identify both specific behaviour of the parent and the resultant demonstrable harm of emotional disturbance in the child. Parental

behaviour must be chronic and take a variety of forms such as:

- Telling their children that they are evil, bad or worthless or that they are hated;
- threatening to send a child away or send the child to foster care;
- locking a child in a room, cellar or closet for long periods; and
- scapegoating one child while favouring others, e.g. requiring one child to eat on the floor out of a dog's dish while giving the others special good meals.

2.5.4.1 Identification of emotional abuse

Winship (1998:14-15) indicated that it is very difficult to identify emotional abuse but some symptoms have been isolated while others are not. According to Goldman *et al.* ,(1993:22) the child's behaviour is often the best indicator of emotional abuse. Goldman *et al,* (1993:22) gave the following behavioural indicators of emotional abuse:

- Absence of positive self-image;
- behavioural extremes: hyperactive and demanding or passive and withdrawn;
- depression;
- psychosomatic complaints;
- attempted suicide;
- impulsive, deviant, antisocial behaviour;
- behaviour inappropriate for the chronological age such as being too adult-like or too infantile;
- inappropriate habits such as nervous tics, rocking, sucking and head banging;
- enuresis;
- inhibited intellectual development;
- difficulty in establishing and maintaining peer relationships;
- overly fearful;
- sleep disorders;
- eating disorders;
- self-destructive; and
- rigidly compulsive.

Winship (1998:14) adds the following symptoms to the above:

- Failing to thrive;
- uncommunicative;

- lack of a smile;
- failure to cry a lot, e.g. even if a needle is inserted to obtain a blood sample;
- showing behavioural problems at school;
- low self-concept;
- continual seeking of attention;
- becoming school dropouts; and
- becoming unemployed adults.

Roberts (1993:34) explained the identification of emotionally abused children in terms of the following characteristics:

- **Rejection is an abusive form of parenting**

Through rejection the child learns that his parents do not like him. Therefore, to get the attention of his parents, the child becomes more pro-active and irritating to the parent and then they reject the child even more. In this fashion a vicious circle is enhanced. Rejected children are emotionally more unresponsive, unstable, more hostile and passive or aggressive.

Generally they are unhappy and depressive. They even consider suicide. It should also be noted that these children are not able to enjoy play activities relevant for their age. They are also not able to involve themselves in healthy relationships with friends and adults. They have the idea that they are bad and not acceptable due to bad parenting, lack of attention and low self-esteem. Some parents openly say they hate their children and did not want to have them while others hide it. Then, these children develop feelings of hopelessness, discouragement and pessimism. Research by Swanepoel (1992:24) has found that children's reaction to emotional abuse can cause smallness in terms of length and body weight as well as retarding of intellectual development. Eating non-eatable substances is also linked to serious emotional deprivation as well as behavioural problems.

Roberts (1993:34) explained that emotionally abused children manifest psychosomatic illnesses. This happens because they have no skills of how to handle the trauma and because they have not learned how to express their feelings in words. These children must therefore be taught to work through their emotions, otherwise these emotions of guilt, enmity, blame, denial and fear will build up and become an unpenetrable shield which gives the child a feeling of security, especially when he is placed away from home.

Children who were emotionally abused cry easily, do not want to acknowledge mistakes, do not trust anyone, become rebellious, are impulsive, aggressive and unfriendly towards their friends. They withdraw, loose interest, are blunt, hyperactive and self-destructive. In many cases serious problems occur at school and they start thinking that they are failures and losers and become exactly that (Roberts, 1993:34).

Similarly, Van Rensburg (1998:13) argues that these children are not able to trust their parents, other adults and friends. They shy away from physical contact with their parents and nursing staff and become suspicious. When hospitalised, the older children do not ask when they will be released to go home.

2.5.5 Neglect

Research and attempts to define child maltreatment have focused on child abuse and generalisations have been made from that point. Child neglect as a distinct, identifiable form of maltreatment is dealt with peripherally or by implication (Mouzakitis, 1995:11).

Various authors such as Ovens (1992), Blumenthal (1994) and Mouzakitis (1995) gave a similar definition of child neglect. They defined child neglect as a failure by a caregiver who is responsible for the child to provide that child with the necessities of life which are deemed essential for developing a child's physical, intellectual and emotional capacities. These necessities include the following:

- Nutrition;
- love;
- protection;
- supervision;
- shelter;
- clothing;
- medical treatment;
- hygiene, and
- education.

The above aspects are discussed below:

2.5.5.1 Nutrition

Blumenthal (1994:30) argues that children who are neglected frequently receive inadequate calories and fail to gain weight. The opposite may also occur whereby the child may be excessively fed creating an excess of weight gain. Faller (1991:26) adds to this aspect by indicating that children who receive inadequate nutrition are below average in height, weight and cognitive development. This is because a child's growth and development are highly sensitive to both physical and psychological stress.

Faller (1991:26) gave three separate diagnoses under the more general condition of failure to provide nutrition to the child, namely: Nutritional deprivation, failure to thrive and psychosocial dwarfism:

- **Nutritional deprivation**

This condition occurs when a parent/caregiver cannot or does not provide a child with adequate or proper food or drink. These children may appear emaciated due to inadequate calories and dehydrated or have a puffy face and feet and a large belly. Parents/caregivers who starve children in this manner are quite disturbed.

- **Failure to thrive**

This is a less extreme form of malnutrition and is a condition found in infants. These children's weights are below the fifth percentile, i.e. when compared with the general population of their age, 95% of babies weigh less than they should. Frequently their length is shorter than average. Medical evaluation is necessary to exclude defective digestion, heart disease or metabolic disturbances, which can also lead to failure to thrive.

Children with non-organic failure to thrive not caused by a physical problem may not grow because they are not fed enough or because they are not nurtured appropriately and experience parent figures as stressful.

A parent can fail to nourish a child adequately for a variety of reasons, such as:

- Not being aware of how much a child needs to eat;
- not feeding the child enough;
- diluting baby formulas more than directions specify in order to make it go

further due to lack of money

- when the parent's feeding technique does not mesh with the child's pattern, e.g. the parent may jiggle the bottle while it is in the baby's mouth or rock the baby excessively, preventing it from sucking;
- lack of care about the children, i.e. when there is lack of attachment, or when they feel hostile towards or competitive with them (children); and
- children are difficult to feed in which they may have a poor suck, not interested in food or may vomit or ruminate.

- **Psychosocial dwarfism**

This is a syndrome characterised by emotional deprivation, environmentally induced growth impairment, abnormally low growth hormone secretion and a variety of behavioural disorders. These symptoms cease when the child is removed from his family environment. Diagnostic clues of psychosocial dwarfism are retarded skeletal maturation, weight slightly below what one would expect for the height and a bizarre eating pattern such as indiscriminate eating, voracious appetite or stealing of food. Abdominal distension and unusual thirst are also common.

Mills, Scott & Stone, (1998:239) add that the following symptoms also occur in psychosocial dwarfism:

- Pain insensitivity;
- night wanderings;
- failure to sleep;
- lack of bladder control;
- disturbed interpersonal relationships; and
- language delay or immature speech patterns.

2.5.5.2 Love

Neglected children are seldom afforded the love and attention of a caring relationship. Typically when these children are admitted to hospitals, parents may not visit or make enquiries about the child, and many parents leave the hospital immediately before the admitting doctor has the opportunity to take a history. When these parents do visit, they often seem to be more interested in socialising and ward activities than caring for the child (Blumenthal, 1994:30). Lack of love frequently causes developmental delay whereby

children may have difficulty in socialising and speech may be impaired. Self-stimulatory behaviours such as head banging, rocking and rumination may be common. Older children often have educational problems and problems of school attendance. School attendance is not enforced and in some families, children are deliberately kept off school (Blumenthal, 1994:31).

2.5.5.3 Protection

Blumenthal (1994:31) argues that failure to protect is a common sign of neglect. Many of these children have frequent attendances at the Casualty Department having ingested household products and medication. Parents pay scant attention to household safety, e.g. they often leave hot irons and dangerous objects within reach of children. These children are predisposed to accidents by lack of attention to safety together with an absence of common protective devices such as fire guards and stair guards.

2.5.5.4 Supervision

According to Faller (1991:28) supervision of children is often taken for granted by many parents. Parental behaviour is regarded as inadequate supervision of the child when the following occurs:

- Supervision of young children is delegated to children a few years older;
- children are left alone in the home for long periods, and
- children are left alone in a pram outside the public house.

Faller (1991:28) stated that there are no hard and fast rules about when leaving children unsupervised is acceptable and when it is neglectful. Factors, which must be considered, are as follows:

- The length of time that the parent is away;
- the age of the child and its maturity;
- whether a child must supervise younger children;
- whether an arrangement has been made for a neighbour, friend or relative to be "on call"; and
- whether the parent can be contacted to return.

Faller (1991:29) gave the general guidelines, which can be used to evaluate the risk of the

situation, which are as follows:

- Children under three years should not be left unsupervised;
- children of three to seven years can only be left alone for brief periods;
- children of eight to ten years may be alright for two to five hours provided there is someone "on call" for them; and
- a child needs to be at least eleven years to be able to be left alone but there is likely to be subcultural variability in this area.

Poor and minority children may be socialised by necessity to take care of themselves and others earlier than the white middle class children.

Parents may also be neglectful if they leave children in the supervision of an adult who is likely to harm them or who is incapable of providing adequate care. Parents may be found neglectful if they leave a girl in the care of an adult who in the past has sexually molested the child and sexually abuses her again, or with an aged or ill adult who is unable to protect the child who is then injured.

2.5.5.5 Shelter

Blumenthal (1994:31) argues that it is difficult to define the minimal standards regarding shelter in terms of housing. This is because of the point that many children come from impoverished families. The basic requisite of housing inhabited by young children is that it should be safe and of sufficient cleanliness so as not to constitute a health hazard. Neglectful parents sometimes lock children out of the home as a form of chastisement.

2.5.5.6 Clothing

Neglected children often wear dirty and ill-fitting clothing. Socks and plastic pants may be supported by rubber bands, which are too tight and leave marks after removal. In winter, particularly hands and feet may have a deep pink or purple colour (Blumenthal, 1994:31).

2.5.5.7 Medical treatment

According to Mouzakitis (1995:11) medical neglect means that the child's health needs are not met or are not adequately met. Similarly, Faller (1991:29) argues that medical neglect is

failure to provide adequate care for a child's medical problems. Standards regarding medical neglect vary from community to community, but parents are generally defined as medically neglectful when failure to provide the care results in serious or life threatening consequences for the child. Some parents may not attend to their children's medical needs because of lack of finance while others may neglect to do so.

According to Blumenthal (1994:30) children who are medically neglected are often not immunised. Parents do not respond to their health needs, e.g. when these children are not well, no medical attention is sought, medical appointments are not kept and when accidents occurred, no action is taken, they pay little attention to the dietary and dental hygiene.

2.5.5.8 Hygiene

This means that the parents or caregiver leave the child unwashed, uncleaned and subject to environmental unhygienic conditions. Hygienically neglected children are commonly dirty owing to infrequent baths. Lice, scabies and skin infections such as inpetigo are often found. Many infants have severe napkin dermatitis from infrequent nappy changes (Blumenthal, 1994:30).

2.5.5.9 Education

According to Mouzakitis (1995:11) educational neglect means that the parents/ caregivers fail to ascertain the child's attendance in school. Faller (1991:29) adds to this by indicating that a parent's behaviour is regarded as educational negligence when that parent consistently fails to get the child up on time and dressed so that he can get to school. Or when the parent keeps a child at home to baby-sit or to provide the parent with company so that the child falls behind grade level.

The situation is defined as educational neglect only when the child's behaviour is under the parent's control. It therefore applies to younger children under the age of eleven. With older children, the situation might be more accurately defined as truancy. In such a case the child might refuse to get up or get dressed despite the parent's efforts or the child may leave the house presumably to go to school and go somewhere else (Faller, 1991:29).

The final prerequisite for the behaviour to be defined as educational neglect is that it be chronic and frequent, i.e. the child must miss several days per month on a regular basis.

This means that accurate documentation is crucial for behaviour to be regarded as educational neglect. Action should be taken before the child gets so far behind that the school experience is an unpleasant one.

2.5.5.10 Symptoms of neglect

Goldman *et al.*, (1993:21) gave both physical and behavioural symptoms of child neglect as follows:

- **Physical symptoms of neglect:**

  - Abandonment;
  - poor personal hygiene;
  - inadequate clothing;
  - absence of needed medical care; and
  - being hungry.

- **Behavioural symptoms of neglect:**

  - Falling asleep in school;
  - begging for or stealing food;
  - irregular school attendance;
  - use of drugs and/or alcohol;
  - engaging in delinquent acts;
  - failure to thrive among infants; and
  - poor academic performance.

2.6 SUMMARY

2.6.1 Child abuse is a serious problem, which existed in ancient societies and is still existing in modern societies.

2.6.2 There is no common definition of child abuse and this is due to the point that each society has its own definition.

2.6.3 The lack of a common definition has a negative impact on the incidence of child abuse.

2.6.4 There are four types of child abuse, namely: physical, sexual and emotional abuse and neglect.

2.6.5 Physical abuse include injuries of the head, face, thorax, abdomen and of the bones, burns, shaking, poisoning and suffocation.

2.6.6 Sexual abuse include sexual contact of the participants intimate parts, fondling, oral-genital contact, sexual intercourse, anal intercourse, sexual assault, incest and interfemoral.

2.6.7 Emotional abuse include rejection, isolation, terrorising, corruption, threats, inappropriate criticism and deprivation of affection.

2.6.8 Neglect refers to failure to provide a child with the necessities of life such as nutrition, love, protection, supervision, shelter, clothing, medical care and education.

2.6.9 Each of the four types of child abuse has its own physical and behavioural indicators.

2.6.10 Physical symptoms of physical abuse include:

- Bruises;
- lacerations;
- burns;
- skeletal injuries; and
- head injuries.

2.6.11 Behavioural symptoms of physical abuse include:

- Fearful of physical contact;
- temper tantrums;
- craving for attention;
- appearing frightened of parents or caregivers ;
- aggressiveness;

- sleepy in class;
- arriving early at school;
- excessive school absence; and
- lack of curiosity.

2.6.12 Physical symptoms of sexual abuse include:

- Pregnancy at an early age;
- bruises of external genitalia, vagina or anal regions;
- bleeding from external genitalia, vagina or anal regions;
- swollen or red cervix, vagina or perineum;
- presence of semen;
- torn, stained or bloody undergarments;
- stretched hymen at a very young age;
- presence of sexually transmitted diseases;
- vaginal or penile discharge; and
- complaints of difficulty with urination.

2.6.13 Behavioural symptoms of sexual abuse include:

- Poor peer relationships;
- prostitution;
- withdrawal from social relationships;
- comments that he/she was sexually assaulted;
- exhibition of infantile behaviour;
- substance abuse;
- irregular school attendance;
- engaging in delinquent acts;
- arriving early or staying late at school;
- sleep disturbances;
- declining academic performance; and
- suicide attempts.

2.6.14 Symptoms of emotional abuse include:

- Eating disorders;
- sleep disorders;
- uncommunicative;
- lack of smiling;
- low self-concept; and

- becoming unemployed adults

2.6.15 Physical symptoms of neglect include:

- Abandonment;
- poor personal hygiene;
- absence of medical care; and
- being hungry.

2.6.16 Behavioural symptoms of neglect include:

- Falling asleep at school;
- begging for food;
- irregular school attendance;
- use of drugs;
- engaging in delinquent acts; and
- failing to thrive as an infant.