



**GUIDELINES FOR SOCIAL WORKERS
RENDERING SERVICES CONCERNING CHILD
ABUSE**

by

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Dedication

**This work is dedicated to my parents Sarah and the
late John Nkuna and my child Tumelo.**

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Summary

GUIDELINES FOR SOCIAL WORKERS RENDERING SERVICES

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Department: Social Work

Degree: Doctor Philosophiae in Social Work (D.Phil.)

Child abuse is a problem, which occurs worldwide. This study focused on child abuse in the North West Province-Moretele District. There is lack of knowledge of the types, causes, symptoms, impact of child abuse and guidelines for social workers rendering services concerning child abuse. A exploratory research design was implemented using purposive sampling of 150 parents/caregivers whose children were abused during 1995-1999 and 14 social workers rendering services concerning child abuse.

The aim of this study was to formulate guidelines for social workers rendering services concerning child abuse. The following questions were asked to achieve the above aim:

- What are the types of child abuse that occur in the North West Province?
- What are the causes of child abuse?
- What are the symptoms of child abuse?
- What are the impacts of child abuse?
- What is the nature of social work services rendered in the North West Province?
- Which method and approaches are employed by social workers in their service rendering concerning child abuse?

The result of the study showed that the types of child abuse, which were experienced were physical, sexual, emotional abuse and neglect. Each type of child abuse has its own physical and behavioural symptoms. Child abuse is caused by various factors, which included both main and contributory causes. Child abuse has psychological, behavioural, cognitive and personality effects on the abused child.

Social work service rendering focused on identification, investigation, intervention and prevention.

From the research findings it became clear that social work methods employed by the social workers rendering services were social work with the individual, social work with the family and research were always employed. Social work with the group, social work with the community and an integration of these methods were never employed by the social workers, which pointed out a lack of proper service rendering.

The social work approaches employed by the social workers rendering services were problem solving and ego psychology. The social workers never employed behaviour modification and crisis intervention and cognitive restructuring were employed some of the time.

Guidelines for social workers rendering services concerning child abuse were formulated, focusing on the nature of child abuse and the nature of social work services concerning child abuse.

The following hypotheses were formulated for future research:

If parents are able to identify the symptoms of child abuse then the rate of child abuse will drop.

If parents are involved in social work service rendering concerning child abuse then child abuse can be prevented.

If guidelines for service rendering concerning child abuse are formulated for social workers and are being used properly, then their service rendering can improve.

Opsomming

RIGLYNE VIR MAATSKAPLIKE WERK DIENSLEWERING TEN OPSIGTE VAN KINDERMISHANDELING

deur

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Kindermishandeling is 'n probleem wat wêreldwyd voorkom. Hierdie studie het gefokus op die voorkoms van kindermishandeling in die Noord Wes Provinsie – Moretele Distrik. Die navorser het gevind dat daar 'n gebrek is aan kennis oor die tipes kindermishandeling, simptome, die impak van kindermishandeling en die riglyne vir maatskaplike werk dienslewering ten opsigte van kindermishandeling. Daar is van 'n verkennende navorsingsontwerp gebruik gemaak en 'n doelbewuste steekproef is geneem wat bestaan het uit 150 ouers/versorgers wie se kinders mishandel is gedurende 1995-1999, 14 Maatskaplike werkers is betrek wat dienste lewer ten opsigte van kindermishandeling.

Die doel van die studie was om riglyne saam te stel vir maatskaplike werk dienslewering ten opsigte van kindermishandeling. Die volgende vrae is gevra om hierdie doel te bereik:

- Wat is die tipes kindermishandeling wat voorkom in die Noord Wes Provinsie?
- Wat is die oorsake van kindermishandeling?
- Wat is die simptome van kindermishandeling?
- Wat is die impak van kindermishandeling?

- Wat is die aard van maatskaplike werk dienslewering in die Noord Wes Provinsie?
- Watter maatskaplike werk metodes en benaderings is aangewend deur die maatskaplike werkers in hulle dienslewering ten opsigte van kindermishandeling?

Uit die empiriese studie het dit geblyk dat fisiese mishandeling, seksuele mishandeling, emosionele mishandeling en verwaarlosing voorgekom het. By elke tipe mishandeling is fisiese- en gedragssimptome geïdentifiseer. Daar is ook gevind dat kindermishandeling veroorsaak word deur verskeie faktore nl: hoof - en bydraende faktore. Die kindermishandeling het 'n effek op die psigiese, fisiese gedrag, kognitiewe ontwikkeling en persoonlikheid van die mishandelde kind.

Die maatskaplike dienslewering het identifisering, ondersoeking, intervensie en voorkoming behels. Vanuit die navorsingsbevindinge het dit duidelik geblyk dat die maatskaplike werk metodes wat aangewend is deur die maatskaplike werkers maatskaplike werk met die individu en familie en navorsing was. Die navorser het egter bevind dat maatskaplike groepwerk en gemeenskapswerk en die integrering van hierdie metodes egter nooit deur die maatskaplike werkers aangewend is nie.

Die maatskaplike werk benaderings aangewend deur die maatskaplike werkers in hulle dienslewering was probleemoplossing en ego psigologie. Die maatskaplike werkers het egter nooit gedragsmodifikasie toegepas nie. Krisis intervensie en kognitiewe herstruksturing is soms toegepas.

Die navorser het riglyne vir maatskaplike dienslewering ten opsigte van kindermishandeling geformuleer deur te fokus op die aard van kindermishandeling en die aard van maatskaplike werk dienslewering.

Die volgende hipoteses is na aanleiding van hierdie studie saamgestel ten einde toekomstige navorsing te rig:

- Indien die ouers in staat is om die simptome van kindermishandeling te identifiseer, sal die voorkoms van kindermishandeling verminder kan word.
- Indien die ouers aktief betrokke raak by maatskaplike werk dienslewering ten opsigte van kindermishandeling, kan kindermishandeling voorkom word.
- Indien daar riglyne vir maatskaplike werk dienslewering ten opsigte van kindermishandeling geformuleer word en behoorlik toegepas word, kan die maatskaplike werk dienslewering verbeter.

Key terms

Child

Black child

Child abuse

Caregiver

Types of child abuse

Causes of child abuse

Symptoms of child abuse

Impact of child abuse

Social worker

Social work guidelines

Sleutelterme

Kind

Swart kind

Kindermishandeling

Versorger

Tipes kindermishandeling

Oorsake van kindermishandeling

Simptome van kindermishandeling

Impak van kindermishandeling

Maatskaplike werker

Maatskaplik werk riglyne



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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. Padgett (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 to 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 interval 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

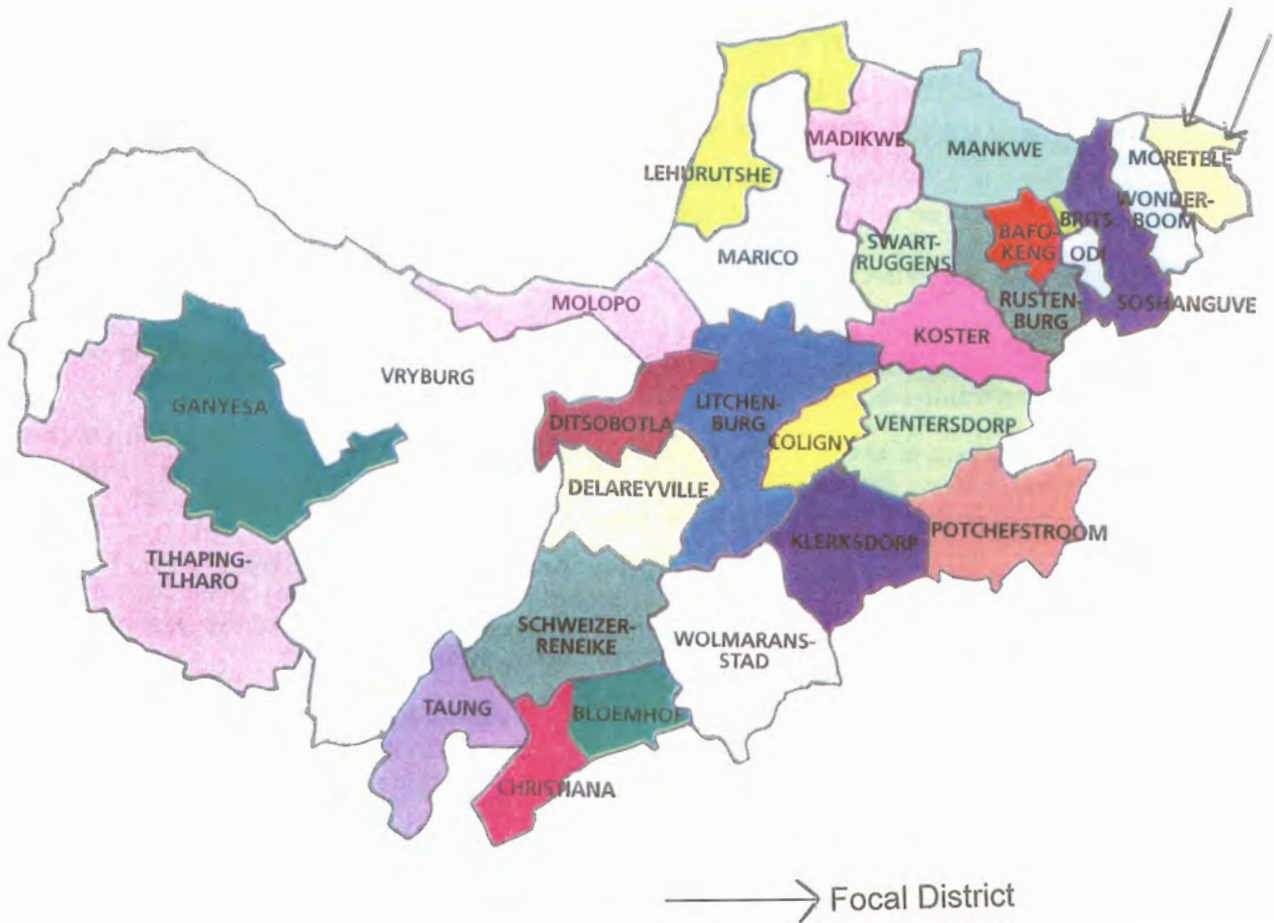
health and welfare districts according to magisterial district boundaries. According to these boundaries, the Province is divided into five regions, which are subdivided into eighteen districts, which are as follows:

- 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

NORTH WEST



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 fourth 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 inter-femoral 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 exist 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 ends 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, lose 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 impetigo 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.

CHAPTER 3

THEORETICAL ORIENTATION ON THE CAUSES OF CHILD ABUSE

3.1 INTRODUCTION

The causes of child abuse are complex as reflected by many models that have been proposed to explain child abuse and the various causal factors of the different types of child abuse, together with the impact of these types of child abuse on the optimal growth and development of the abused child. Theories on the causes of child abuse fall into essentially different categories such as: the psychodynamic; learning, environmental, biosocial and the psychosocial system models. The various types of child abuse have different causal factors related to parents, the environment and the abused child. These various types of child abuse have different impacts on the growth and development of the abused child.

This chapter will focus on the above models of explaining child abuse, the causes of the various types of child abuse and the impact of child abuse on the abused child. A discussion follows below:

3.2 MODELS EXPLAINING THE CAUSES OF CHILD ABUSE

Below follows the discussion of the following models: the psychodynamic, learning, environmental, biosocial and the psychosocial system models.

3.2.1 The psychodynamic model

According to Justice & Justice (1993:25) this model attributes the sources of child abuse to the parental inadequate psychological functioning and understanding of their parental roles. Justice & Justice (1993:25) saw the lack of a "mothering imprint" as the basic dynamic of the potential to abuse. In other words, a person has been reared in a way that precluded the experience of being mothered and nurtured. Therefore as adults, such persons cannot mother and nurture their own children.

Combined with this inability to nurture is an interplay of other dynamics such as:

- Lack of trust in others;
- tendency towards isolation;
- non-supportive marital relationship;
- excessive expectations towards the child;
- a special child in which the abusing parent view the child as retarded, hyperactive or in some other different way; and
- a crisis which might be in the form of a major stress or something as minor as a broken washing machine.

An important implication of the psychodynamic model is that an act of abuse will not occur unless the psychological potential is present.

The psychodynamic model also focuses on the character of the parents who abuse their children (Schroeder, 1996:6). The reason for abusing children is due to the parents' psychological makeup, i.e. this is just the way they are. These parents are described as immature, self-centred, lonely, impulse-ridden, chronically aggressive, highly frustrated, suspicious and untrusting.

Merryl (1992:77) divided abusive mothers and fathers according to their psychological characters into five groups, namely:

- The first group consists of parents who are described as chronically hostile and aggressive. They show traits that often result in conflict with the world in general.
- The second group is made up of parents who are rigid, compulsive, lack warmth and a reasonable approach to things.
- The third group consists of parents who demonstrated a high degree of passivity and dependence. They are also depressed, irresponsible and immature.
- The fourth group consists of young fathers who are unemployed and stayed at home to take care of the children. They are characterised by frustration, which often vent itself in child abuse.
- The fifth group consists of parents who are mentally ill. Contrary to this, a study by Kempe (1991:339) showed that no more than 5% of abusive parents were psychotic, and a study by Tracy (1991:31) concluded that the attacking adult can rarely be fitted into a psychotic or parapsychotic grouping. This study held that approximately 2% of

abusing parents were psychotic and this is supported by research conducted by Blumberg (1993:13) which stated that psychosis is rarely a factor in child abuse.

Schroeder (1996:8) added the following features of the psychodynamic model:

- Role reversal.
- Scapegoating.
- Disengagement.

A discussion of the above features follows below:

3.2.1.1 Role reversal

Role reversal refers to parental expectations that the child will act like an adult and give the parent love and care rather than vice versa (Schroeder, 1996:8). The reason for this behaviour can be traced to the parents' own childhood, when their parents did not provide them with sufficient mothering and care resulting in their need for dependency being unfulfilled. Schroeder (1996:9) explains the role of this early psychological deprivation as a cycle, which is as follows:

The cycle begins with a child being born to parents who, for a variety of reasons, do not meet its needs but hold unrealistic expectations that the child is there to meet the needs of the parent. The child grows up being ineffective in getting its own needs met, disturbing people and feeling that he is not good. These experiences affect the choice of a mate and the consequent relationship. When a child is born of the union, the parent thinks "at last! there is someone who will love and take care of me", and the cycle of abuse repeats itself.

Role expectations of the child, alliance, coalitions, enmeshments and disengagement among family members are part of a family system's view of child abuse. The repeated finding by Helfer (1997:43) that illegitimate and unwanted children are high risks in terms of being abused. This is related to the concept of coalitions, e.g. a coalition may involve a parent who sides with one child against the abused child or both parents may side against the abused child.

3.2.1.2 Scapegoating

Justice & Justice (1993:29) indicated that scapegoating is another behaviour, which is often cited as resulting in child abuse. Scapegoating may refer to the following situations:

- When a parent takes out his frustration on a child;
- a power struggle in which a child gets caught up because of his parents' wish;
or
- an alliance that one spouse resents and makes the child pay for through physical injury (Justice & Justice, 1993:29).

3.2.1.3 Disengagement

Disengagement may occur on the part of either the mother or father who may decline to play a significant role in the family (Justice & Justice, 1993:29). Disengagement can also be central to child abuse when a father assumes little or no responsibility for managing the child. The wife often boils with resentment towards both her husband and child. Since the child is the one who demands the mother's attention and an easy target for her resentment, he is the one who gets hurt.

3.2.2 Learning model

Justice & Justice (1993:33) argued that learning theories of child abuse emphasise the failure of abusive persons to acquire the skills and knowledge to adequately parent their children. These individuals are seen as lacking social skills to gain little satisfaction from their roles as parents. They are also frequently ignorant of child development, expect behaviour to be too advanced for young children and use physical discipline to discipline their children.

These abusers lack knowledge of the following:

- Stages of child development;
- the needs of children at different stages;
- how healthy parents respond; and
- management of children (Justice & Justice, 1993:33).

Learning theories also include attachment theory according to which the early infant-caregiver attachment relationship provides the prototype of later relationships. Through the early experiences with the caregiver, the child evolves expectations of the availability of others in time of need and a complementary model of the self as worthy of care (Schroeder,

1997:12).

The child who has formed a secured attachment is likely to possess a representational model of attachment figures as being available, responsive and helpful. A securely attached child is more likely to enter into a loving and trusting relationship with confidence in oneself and others than the one who did not develop such attachment. In contrast, infants whose needs have not been appropriately met develop expectations that care is not available and others cannot be trusted. As adults, they are more likely to have difficulty in entering into supportive relationships with others and providing adequate care for their offspring.

Blumberg (1991:24) argued that abusing parents have learned to abuse, as they were themselves abused, neglected and deprived of love and mothering when they were children. Because of their early rejection, they did not develop the ability to love. Therefore, as adults, they are narcissistic, immature, have poor ego control, demand nurturing themselves, have a poor self-image, low self-esteem, cannot accept any criticism, react with impulsive violence and experience inner conflict.

3.2.3 The environmental model

Browne (1998:111) argued that environmental approaches to child abuse take account of external factors that can promote child abuse such as: economic stress, unemployment, social isolation, overcrowding, poor housing, poor education and/or occupational stress. The implication of the model is that if it were not these adverse environmental factors there would not be any child abuse.

According to research by Mouzakitis (1995:78) economic stress on poor people is seen as weakening their self-control and leading to child abuse. Poverty and child abuse have a causal relationship. There is a high incidence of child abuse among the poor as confirmed by research undertaken by Mouzakitis (1995:79). The vast majority of fatalities occur among the very poor.

Fontana (1991:97) noted that as stress increases, so does child abuse. As economic pressures mounted, child abuse increases. This increase to the stresses and strains that is experienced by our society, is attributed to the frustrations, poor quality of life, increase in the addiction of drugs and alcoholism.

Bennie (1996:99) viewed child abuse as a lower-class phenomenon. This is supported by the view of Blumberg (1997:29) who argued that interfamilial child abuse is more common among the working class and that physical abuse is part of the style of discipline that poor people use.

While there is no doubt that environmental stresses do play a role in many instances of child abuse, these theories leave thousands of cases of child abuse occurring in the homes with no economic or environmental stresses. In contrast Spinatta (1991:197) pointed out that the elimination of environmental stress factors and battering may reduce the amount of child abuse.

3.2.4 The biosocial model

Justice & Justice (1993:25) argued that the biosocial model considers abuse from the standpoint of factors that influence the amount of investment that a parent is willing to make in a child. These include the benefits as well as the costs that a child is seen as presenting to the parent. This model is also called the parental investment theory, which is defined as any investment by a parent in an offspring that increases the recipient's fitness at the cost of parental capacity to invest elsewhere.

The theory emphasises the limited amount of parental resources, such as time, energy and attention that can be apportioned to offsprings over the course of the life span of both parents and offspring. At each step of parenthood, parents are reassessing the current and future prospects of each child. Faced with limited resources and unfavourable circumstances, parents may decide to limit or cut off their investment.

Justice & Justice (1993:37) suggested that certain groups of children are more likely to be undervalued and consequently be seen as a poorer investment of parental resources than others. Such broad groups are as follows:

- inferior health status;
- handicapped children;
- sex of children;
- developmental stage;
- unusual births; and
- behavioural characteristics.

A discussion of the above mentioned aspects follows below:

3.2.4.1 Inferior health status

Children whose health is inferior are more likely to receive poorer care. In societies with high infant and child mortality, the stronger child is more likely to receive preferential treatment (Justice & Justice, 1993:37).

This observation is supported by research conducted by Mouzakitis (1995:79) which showed that premature children are difficult to care for and are at higher risk for abuse. Malnourished children have also been found to be vulnerable. It is theorised that apathetic, anorexic, and unresponsive behaviours of malnourished children may fail to evoke a nurturing response that would improve their health as well as their behaviour. This would certainly be true with abusive parents who are looking to be nurtured and affirmed by their offspring. To nurture a non-responsive, ill child would probably demand of these parents more altruistic giving than most could put forth.

3.2.4.2 Handicapped children

Whether or not a handicapped child is targeted for abuse seems to depend on the cultural appraisal of the child (Justice & Justice, 1993:37). In some societies, handicaps are seen as indicating supernatural gifts and the child is accorded special status and care, while in others the child is seen as a burden, an ill omen or non-human. Understandably, with this sort of low value placed on the child, he is not likely to be cared for adequately.

3.2.4.3 Sex of children

The value placed on a male or female child in a particular culture influences the treatment of the child (Justice & Justice, 1993:38). Female children are at greater risk of abuse in societies with strong son preference, such as India or China. Woman's economic participation and rights of land inheritance have been linked to regional differences in female infanticide and to differential access to food and medical resources.

Girls are less likely to be fed than their brothers are or to receive the same standard of medical care, but those who survive are more likely to be treated warmly by their mothers in

later childhood than are the sons. It is possible to assume that these mothers are more willing to invest in their daughters when they can see a greater potential return for the investment, e.g. helping the mothers to do housework or finding a son-in-law to help care for the family.

3.2.4.4 Developmental stage

Children appear to be at greater risk of being abused as toddlers and adolescents. Toilet training accidents, broken curfews and oppositional behaviours of both these stages lead all parents to question, if only momentarily, whether or not the parenting struggle is worth the effort. For parents who have unrealistic expectations and diminished emotional or social support, the answer may be a violent “no”.

3.2.4.5 Unusual births

Children may be assessed to be a poor investment from the moment of their births or even before birth in some societies. Among the Machiquenga, a difficult birth indicates an excessively angry child, which is then more likely to be killed, abandoned or given to another family. If an infant is born face down or with a smile into the Bariba tribe of West Africa, it is labelled “witch baby”, and killed or sold off. In some societies, multiple births are considered a good omen, and in others the offspring may be regarded as animal litters rather than human beings. If these infants are not killed at birth, they may be abused later. Too many children can push a parent to withhold limited resources from one or more of the offspring.

3.2.4.6 Behavioural characteristics

Parental assessment of the behaviour of the child is influenced not only by the parents’ own experience of having been parented but also by cultural appraisal of different behavioural characteristics (Justice & Justice, 1993:39). This make it clear that it is useful to look at the broad context of available investment resources in order to understand all the factors that play a role in child abuse.

3.2.5 The psychosocial system model

According to this model, child abuse cannot be explained by a single factor but by certain stress factors and adverse background influences which may serve to predispose the

individual to child abuse which will occur in the presence of precipitating factors such as a misbehaving child (Frude, 1998:121).

This model takes into account the shifting dynamic forces at work in the abusive family, in the environment and in the culture in which the family lives. The abuse of a child is the end result of a system of interaction between the spouses, the parent and the child, the child and the environment, the parent and the environment, and the parent and society that affects another.

Since the family is the main system in which all interactions take place, it is impossible to speak of child abuse without mentioning the abusing family, the forces that operate in that total unit, and the influences that impinge on it. According to Helfer (1993:7) the family must be considered as a unit and child abuse be considered as a family affair. The precursors of child abuse will be found in the individual parent, the child, the crisis, which they face and in the system and subsystems of which they are a part. Child abuse can therefore be understood by first understanding the abusing family system.

According to Bowen (1997:17) the relationship between family members constitute a system in the sense that a reaction in one family member is followed by a predictable reaction in another, and that reaction is followed by a predictable chain reaction pattern. Therefore, when a parent competes with a small son or daughter for nurturance, all the other family members become part of the competition.

Jenkins & Lystad (1992:87) pointed out that child abuse often occurs generation after generation in the same family as if a cycle of violence is inherited. What is inherited is not a genetic propensity for abuse but a particular kind of emotional and relationship system that requires the family to absorb large amounts of tension. One expression of this tension is violence, whereby one target of this violence is the child.

The abusing family is characterised by the kind of emotional and relationship system that is one of great intensity, force, and fusion, i.e. it is dysfunctional. The spouses are tightly bound to one another, one parent is fused with the child or the husband or wife is still intensely tied to his/her family of orientation. This kind of fusion is healthy and necessary only when it exists between a mother and her baby. It is imperative that an infant fuse with its mother or some mother surrogate for service. Bowen (1991:400) calls these people undifferentiated in the sense of being fused into others who make up the nucleus or extended family. They do not have a separate self and problems may occur during stress.

Such problems may be expressed in three areas, namely:

- Marital conflict;
- dysfunction in a spouse; or
- transmission of the problem to one or more children.

An explanation of the above mentioned aspects follows below:

Marital conflict takes the form of fights between the spouses as if to see which one will obtain more of a common self-dysfunction. Dysfunction in one of the spouses usually means that one has given in to the other. This dysfunction may be physical, emotional or social. Physical dysfunction includes acting out behaviour such as violence, which may be transmitted to the child in the form of child abuse. The family system must absorb so much undifferentiation that there may not only be violence by the father or mother, but a problem in all three areas, i.e. conflict between spouses, dysfunction of one spouse and something wrong with the child.

The root of the problem is competition within the family system. The spouses fight over who will give in to whom, who will wait on whom, who will do more for whom. The winner is taken care of and the loser turns to more extreme behaviour to obtain care. The acting out is directed at the child who is perceived by parents as being most in need of attention or care and is therefore the most threatening competitor to the parent seeking the same thing. The parent's violent behaviour towards the child represents an extreme effort to get somebody to step in and give that parent the attention and care that he/she seeks (Bowen, 1991:403).

In a single parent family, there is nearly always a fusion between the single parent and a relative in the family of orientation. If that relative does not provide the single parent with the desired attention and care, that single parent turns to the child who cannot possibly meet these demands and abuses him.

Blair (1996:8) argued that single parents are over represented among abusive and neglectful parents. Nkuna (1996:71) who argued that single parents must perform the functions of two parents supports this. If such parents are in the area of child rearing, then the parent can be defined as neglectful. Alternatively, the strain of trying to perform two roles may lead to child abuse. Problems are likely to exist in terms of meeting children's needs for both nurturance and control.

The single parent may also be at a disadvantage in disciplining children. It is easier to exert control over the children if two people are doing it rather than one. In addition, collaboration on what the limits should be and what kind of punishment should be used can be very helpful. Without this, the single parent may not have the energy to control the children, may overreact to children's behaviour and punish them excessively or may alternate between these two responses (Walters, 1990:69).

Steele & Pollok (1994:128) argued that the attacked child in the family can also act as a precipitating factor towards abuse, e.g. sex, time of birth, health status and behaviour. The child may innocently and unwillingly contribute to the attack that is unleashed upon him. Bowen (1991:420) suggested that children who were abused by their parents might possess characteristics, which either attract abuse or make them more vulnerable to abuse.

Research by Lynch (1997:113) gave the following characteristics of children in high risk of abuse:

- Premaritally conceived;
- babies conceived by accident;
- a child of a sex other than that expected by the parents;
- a child who exhibits behaviour patterns unlike those that the parents expected;
- babies born with congenital defects who require much medical care; and
- perfectly normal infants who are always ill or cry to indicate hunger.

3.3 THE CAUSES OF THE TYPES OF CHILD ABUSE

Mouzakitis (1995:36) examined the causes of the various types of child abuse by giving the possible contributory factors related to parents, the environment, the abused child, the impact of the unborn child as a result of maternal use and abuse of alcohol and drugs. A discussion of the causes of the various types of child abuse will be discussed below:

3.3.1 The causes of physical abuse

Mouzakitis (1995:37) argues that the causes of physical abuse are receiving increasing amounts of attention. Focus is on the following causes: fatal alcohol syndrome, addiction during pregnancy, inflicted burns, intentional poisoning of children and child factors as

discussed below:

- **Fatal alcohol syndrome**

Fatal alcohol syndrome is defined by Mouzakitis (1995:38) as a pattern of multiple congenital abnormalities that occurs in varying degrees in children of mothers who chronically ingest alcohol during pregnancy. It is characterised by prenatal growth retardation which results in low birth weight, subsequent postnatal growth retardation, central nervous system dysfunction, mental retardation, malformed eyes, cardiac defects, cleft palate, ocular abnormalities and limb deformities.

Research by Wright (1995:71) indicated that children born to alcoholic women have a 30 to 50% risk of foetal alcohol syndrome. Studies by Palmer (1996:93) indicated that 10% of women who drink alcohol in the first trimester of their pregnancy produce infants with recognisable abnormalities.

Wright (1995:79) argued that although the effects of foetal alcohol syndrome are permanent, abstinence or a reduction in alcohol intake even as late as the third trimester of pregnancy lowers the risk of damage to the foetus. In most cases endangerment of the foetus is inadvertent and information about the effects of alcohol is sufficient to curtail maternal drinking during pregnancy.

- **Addiction during pregnancy**

Mouzakitis (1995:39) argued that drug addiction during pregnancy also poses a major threat to the developing foetus. This is in agreement with Wilson (1996:103) who stated that the problem of chemical dependency is increasing and estimated that about 10% of children in South Africa are at risk. Infants born to addicted mothers experience potentially life threatening withdrawal syndrome and are at high risk for prematurity, low birth weight and lack of prenatal care. The problem of addiction during pregnancy raises the issue of foetal abuse and is compounded by the point that drug use is illegal. This combined with the poverty that is characteristic of the addict's life style poses a formidable barrier to prenatal care.

- **Inflicted burns**

Research by Feldman (1990:103) indicated that burns are a common form of physical abuse

in children. This finding is similar to the findings of Cook (1991:13) which indicated that over 40% of the cases of child abuse at the Jubilee Hospital in the North West Province were the result of inflicted burns. Similarly, more than 50% of all burn victims under 10 years of age were found to be abused in South Africa, and abuse was suspected in another 4% of the cases (Stone, 1994:90).

Most victims of burns are under four years of age. Infants and toddlers are at the highest risk, with abuse peaking in the 13 - 24 months' range (Hight, 1994:69). Families of children with inflicted burns are characteristically from the lower economic classes, although probable reporting bias must be kept in mind. Researchers such as Balalar (1991), Moore (1993) and Hight (1994) have documented a high incidence of broken homes, absence of a primary caregiver, severe environmental stress, inappropriate expectations of children and poor parent-child relationships in families of burn victims.

The high number of inflicted burns occurring during the toddler period and the family characteristics noted above suggest that such injuries may result when an unsupported and highly stressed parent is faced with a child who is developmentally unable to meet the parent's unrealistic demands (Mouzakitis, 1995:43).

- **Intentional poisoning**

Shnaps (1991:120) argued that intentional poisoning as a form of child abuse has received little attention in the literature. This is probably due to lack of recognition, but recent studies by Dine (1998:34) suggest that abuse by poisoning is common.

Child abuse by poisoning is likely to occur during the pre-school years and is usually carefully planned and manipulative. In many cases, the poisoning has been going on for several months and is continued by the abuser, usually the child's mother or caretaker after the child is hospitalised for treatment of symptoms. The mother is frequently described as co-operative with the hospital staff, pleasant and concerned about the child's symptoms.

A high incidence of serious mental disorders has been noted in these parents and Shnaps (1991:121) suggested that chemical abuse may represent an escape from the parent's own problems and a means of eliciting attention and support that the parent is unable to obtain elsewhere.

- **Child factors**

Mouzakitis (1995:46) argued that the role played by the child in physical abuse is controversial because of the difficulties in separating the effects of abuse from pre-existing characteristics of the child that may have contributed to the abusive situation. Siefert (1993:111) have identified the following characteristics of the child as possible causal factors in physical child abuse:

- Prematurity;
- low birth weight;
- physical illness;
- difficult infant temperament; and
- developmental deficits resulting from faulty parenting in early childhood.

Siefert (1993:112) has documented an increased risk of abuse in children who have been born pre-term or small for gestation age or who have suffered serious illness requiring hospitalisation in the neonatal period. Investigations of causal factors in the abuse of these children has focused on biological factors as discussed below.

- **Biological factors**

Studies of biological factors as potential contributors to abuse have observed that premature and low birth weight infants may be more difficult to care for than full-term infants. This is due to the point that premature infants exhibit delays in motor and mental development. Studies by Sugar (1997:80) indicated that although certain characteristics of pre-term and low birth weight infants may contribute to abuse. Other factors intervene to enhance or suppress the effects of biological impairment in determining the outcomes, e.g. factors such as environmental factors and prolonged parent-infant separation due to the newborn's hospitalisation in a neonatal intensive care unit with restricted visiting hours and family characteristics, such as poor housing, unemployment and single-parenthood.

Children with handicaps, mental retardation and congenital anomalies are at greater risk of abuse (Friedrich, 1996:589). Research by D'Orban (1997:569) indicated that in most of the cases of child homicide studied, the child's crying, screaming, vomiting or feeding problems precipitated fatal battering.

Similarly, Helfer (1992:223) indicated that infant temperament play a role in physical child abuse. The infant who is difficult to care for or who does not meet the parent's expectations

may inhibit the process of parent-infant attachment. A cycle of disturbed parent-child interactions may ensure, producing developmental deficiencies in the child that increase the likelihood of abuse. It should be noted, however, that the majority of parents cope well with the task of caring for premature, handicapped or difficult children and that the characteristics of the child do not alone explain abuse.

3.3.2 The causes of emotional abuse

Mouzakitis (1995:75) argued that there is little systematic research regarding the causes of emotional abuse. Researchers such as Cohn (1998), Garbarino (1998) and James (1999) agreed that perpetrators have at least two traits in common which predispose them to abuse the child emotionally, namely:

- A pervasive sense of worthlessness; and
- underlying feelings of rage.

These two emotions are blended together in such a way that which came first cannot be determined. These two emotions are discussed below:

- The sense of worthlessness

The sense of worthlessness results in an insatiable need to establish control. Emotionally abusive parents have an overwhelming urge to control even the least important facet of their children's lives.

- The underlying feelings of rage

The underlying rage of the emotional abuser is part of the intent to hurt. It is also possible that the true objective of the rage and the effort to hurt is the abuser him/herself. In bringing shame or ridicule on the child, the abuser may be symbolically punishing him/herself.

Research by Martin (1996:101) showed that the parent's inability to cope with the growing child is a cause of emotional abuse, e.g. their reaction to the different stages of child development, and the unexpected acute difficulties that parents may face as the child progresses from one stage to another.

Parents may be annoyed, or even angry about the fumbling assertiveness of their children,

e.g. sexual exploration, teenage defiance and the beginning of heterosexual interests.

Emotional child abuse is therefore a reaction to normal child development. Parents reacting to these sensitive periods have no conscious wish to punish or hurt the child.

Emotional abuse is also part of a reaction to difficult life events, e.g. grief following the birth of a defective child may lead to the parents' psychological withdrawal from the infant. This will compound the original problem by adding difficulties in the important early bonding (Mouzakitis, 1995:76).

- **The child as a cause of emotional abuse**

The child can also be the cause of emotional abuse. The child's characteristics such as powerlessness and dependence on the parent are making the child a prime target to emotional abuse (Shengold, 1998:421). Kinard (1998:97) adds to this by arguing that the child is further forced by his normal intense need for a good parent which damps down the impulse to question or complain and fosters the delusion that the parent is indeed loving and protective.

3.3.3 The causes of sexual abuse

Mouzakitis (1995:82) discussed the causes of sexual abuse with reference to the different types of perpetrators. According to Mouzakitis (1995:83) total strangers, adults known by the children prior to the abuse, peers, parents and siblings, can perpetrate sexual abuse. Similarly, Hayman (1991:483) examined the causes of sexual abuse by classifying abuse as offences perpetrated by others outside the immediate family (non-familial sexual abuse) and offences perpetrated by members within the family (familial sexual abuse or incest). The discussion of the causes of sexual abuse will focus on non-familial and familial sexual abuse as indicated by Hayman (1991:483):

3.3.3.1 The causes of non-familial sexual abuse

Non-familial sexual abuse frequently includes abuse by adults known to the child from a variety of sources such as neighbours, family friends, school friends, parents' friends as well as abuse within sex rings (Pettet, 1997:26). Several theories are offered by Langa (1991:333) to describe the motivation of non-familial perpetrators to engage in sexual

activities with children, namely:

- The adults' position of dominance;
- bribes of material goods;
- threats of physical violence; or
- misrepresentation of moral standards.

Children often co-operate out of need for love, affection, attention or a sense of loyalty to the adult perpetrators. Dulton (1995:25) suggested that children may engage in sexual activities with adults to defy parental figures or to express anger about chaotic home lives. De Vine (1992:78) indicated lack of adequate supervision by parents and the failure to set proper controls for children's behaviour as contributing factors to sexual abuse. To this end, De Francis (1999:129) indicated that about 41% of the families in his study of the causes of sexual abuse showed behaviour indicative of psychosocial disturbances.

Costel (1995:86) suggested that sexual abuse offences against children and adolescents occur both in circumstances where the offenders' behaviours are expressions of abnormal sexual preferences and in situations where normal preferred sexual outlets are thwarted. In situations where normal preferred sexual outlets are thwarted, incest often results.

Adolescents can also perpetrate non-familial sexual abuse (Mouzakitis, 1995:83). Two profiles emerge from the offences committed by adolescents against other children, as indicated below:

In the first type of adolescents, offenders may show signs of immature psychosexual development and do not progress beyond childhood sexual play and exploration. Their sexual activity with other children is an extension of earlier permissible developmental sexual curiosity and play.

The other type of adolescent offenders is classified in a more serious light. In these cases, their sexual behaviour may be an early manifestation of paedophilia or aggressive sexual behaviour. Typical responses of these offenders are force, control and aggression, which by adult sexual assault standards are typically classified as rape (Mouzakitis, 1995:84).

3.3.3.2 The causes of familial sexual abuse

Pettet (1997:26) argued that familial sexual abuse refers to abuse within the nucleus and

extended family and may involve relatives such as uncles, grandparents, siblings, parents, adoptive parents or foster parents. Incest is the most emotionally charged and socially intolerable form of sexual abuse. It is the one type of sexual abuse that is the most threatening, difficult to understand, accept and detect because it tends to remain a family secret by its nature. Incest can take various forms such as:

- Sibling incest or sexual activity among young children.
- Incest between older children which is indicative of dysfunction in healthy social and emotional development.
- Incest between children and adults particularly parental figures (Mouzakitis, 1995:84).

The discussion of the causes of incest will be limited to members of the nucleus family, i.e. the father, mother, daughter and son as indicated below:

- **Father-daughter incest**

According to May (1998:99) father-daughter incest is the most frequently reported type of incestuous relationship, as well as the most researched, discussed and treated form of sexual abuse. There are many factors that contribute to the development of father-daughter incest sufficient to cause the incest.

It is generally recognised that in father-daughter incest, a triad of participation occurs among the father, mother and daughter. Each has a role to play in the development and perpetration of the incest without which the incest would not occur. The examination of the triad describes how and why father-daughter incest occurs (Mouzakitis, 1995:84):

* **The father**

Incestuous fathers are characterised as average to below average in intelligence, very timid and cautiously passive in social relationships outside their families (Mouzakitis, 1995:85). Spencer (1998:585) reported that a high number of incestuous fathers are from lower socio-economic levels. This finding supports the earlier research of Weinberg (1995:99) whereby it was indicated that 65% of the families investigated were in the low socio-economic bracket, and the work of Kaufman (1994:266) which noticed that the incestuous fathers came from poverty backgrounds typically characterised by inadequate housing and little education.

Brown (1989:441) reported that incestuous fathers lack a strong masculine identity, often the result of a domineering and over controlling mother and a corresponding weak or absent father who demonstrated little warmth during the early periods of development. This lack of identity, coupled with a concomitant low self-esteem may be greatly magnified during a period of mid-life adjustment, often referred to as middlecence (Summit, 1998:241).

During middlecence, all semblance of sameness is gone and men may seek a re-endorsement of youth and masculine vitality via love affairs with younger women. Due to their intrafamilial orientation, incestuous fathers seek to have their sexual needs met within their marriage. When attempts to rekindle their love affair with their wives fail, the oldest daughters are often used as objects for sexual gratification. Attempts to re-establish their self-worth and self-identity are made through their incestuous relationships with their daughters. The affair almost always ends during the adolescent years when the daughters begin to struggle for independence and seek to establish close relationships with their peers (Molner & Cameron, 1995:373).

Summit & Kryso (1993:245) suggested that incestuous fathers exhibit a lack of impulse control due to stress and poor superego development. They become unable to stop or control their actions and incest continues.

Burgess & Holmstrom (1991:559) suggested that incest occurs on a level called "pressured" sex whereby physical force or the threat of physical force is seldom the vehicle by which incest occurs. Father-daughter pressured sex usually involves the process of conditioning by the father towards the daughter. There is frequent body contact and caressing by the father, evolving into genital contact and play, which exists for a period of time before culminating in actual coitus. These actions may be stimulated by the habitual absence of the wife due to the following reasons:

- Work;
- social recreations;
- loss of the wife by divorce;
- separation;
- death;
- inordinate amounts of time spent with the daughter due to long term unemployment of the father; and
- sexual rejection of the husband by the wife.

Cases of pressured sex incest may be marked by the belief that it is the father's duty to teach the daughter the facts of life. As an educational practice, fathers righteously believe that sexual activity with their daughters is the best technique to teach sex education.

Sarles (1995:640) described incestuous fathers as chronically brutal, demanding and alcoholic. They have psychopathic personalities characterised by indiscriminate promiscuity and are in turn unable to form any tender attachment with their wives and children, viewing them as sexual objects. They tend to be domineering, rigid, restrictive and exhibiting over-protective parenting practices towards their daughters with whom they chose to initiate sexual contact.

* **The mother**

Mouzakitis (1995:86) characterise the mother who operates within a father-daughter incestuous family as passive, infantile, dependent, possessing a poor self-image, emotionally immature and depressed. She feels worthless as a mother and as a woman, is unhappy in her marriage and grows increasingly disenchanted with her husband. She rejects the sexual role of a wife and the maternal role as a mother.

A mother-daughter role reversal occurs in which the mother assumes with the daughter the relationship she wishes she had with her own rejecting mother. The mother shows general denial of sexuality, which makes it easy for her to deny the sexuality changed intimacy she has encouraged, perhaps unknowingly between her husband and daughter.

Sarles (1995:640) indicated that the mother in a father-daughter incest family promotes the relationship by abandoning and frustrating her husband sexually or by actually altering the living arrangements to foster the incest. Once the incestuous relationship is in place, the mother will usually tolerate the incestuous activity with little protest or she will use denial to deny any thoughts of the incest. She may be motivated to deny the reality of incest because she had a hand in unconsciously setting up the incest situation and wishes it to continue in order to relieve her of her sexual role in the marriage. The denial may commonly be the result of avoiding divorce, loss of financial support, humiliation in the community and legal proceedings against her husband (Merselman, 1998:99).

* **The daughter**

Mouzakitis (1995:87) argued that the daughter who falls victim to her father's sexual advances can be of any age. Researchers like Luther (1990:161) and Price (1991:55) suggested that the average onset of the incestuous activities occur when the girls are between the ages of eight and fifteen.

Bovolek (1994:77) suggested that the girl is usually approached between the ages of six to nine years and the relationship reaches the critical stage of awareness outside the family during adolescence. The girl is often the oldest of several children, usually of average intelligence, although abnormal intelligence of the daughter may be present in some cases.

The emergence of the daughter as the central female figure of the household plays a key role in the development and perpetration of the incestuous activity (Roth, 1988:19). The daughter is set up by her mother to assume the role of lover and surrogate wife to the husband, coupled with subtle or overt rejection by the mother of the daughter's beauty, youth and energy, the daughter becomes available prey for her father's sexual advances. The daughter may unknowingly contribute to her own demise through her normal developmental physical growth and increasing curiosity towards sex. The father then uses this opportunity to satisfy his own deteriorating identity and image through approving, admiring and being responsive to his daughter's sexual attraction.

- **Mother-son incest**

According to Merselman (1998:91) incest between mother and son is regarded as being the least common and most intensely taboo form of heterosexual incest. May (1998:12) argued that although there may be instances in which the son has sex with his mother without serious emotional disturbances, emotional disturbance must be considered a likely factor in all cases of mother-son incest.

Weinberg (1995:77) pointed the role of repressed incestuous feelings of the son towards the mother. The son in his oedipal fantasy wishes to destroy his father and marry his mother.

Mouzakitis (1995:88) classified mother-son incest into two types, namely: mother-initiated and son-initiated incest. In mother-initiated incest the mother may deeply love her son and rationalise incest as the highest expression of that love. Mother-initiated incest may also occur under the following circumstances:

- The guise of sex education;
- the guise of personal hygiene;
- the mother who is shut off from the world and turn to her son for human contact;
- little age discrepancy between mother and son;
- the lack of other sexual objects available to the son;
- a general history of incest in the family;
- serious emotional disturbance; and
- alcoholism.

In son-initiated incest the son is almost always classified as seriously emotionally disturbed, brain damaged or psychotic.

- **Father-son incest**

Mouzakitis (1995:89) argued that father-son incest is rarely recognised but it is the most common form of homosexual incest reported. Rare accounts of father-son incest may be due to the double stigma it causes, namely: incest and homosexuality. Characteristic traits of the father which generally suggest that he is the one who almost always initiates the sexual behaviour are as follows:

- He may be alcoholic or using alcohol to justify the behaviour;
- he may have had strong homosexual desires since childhood;
- he may have experienced incest or witnessed incest during early childhood;
and
- he has unresolved adolescent sexual conflicts (Mouzakitis, 1995:89).

The incestuous son does not resist the father, despite damaged feelings. Father-son incest is usually short-lived, ending when the son begins to develop strong negative feelings towards his father and their relationship.

- **Mother-daughter incest**

Mother-daughter incest occurs but is rare (Merselman, 1998:102). Female homosexual relationships within the nucleus family are the most understudied area of incest. The occurrences of mother-daughter incest focuses on the speculation that the mother is

expressing deep-seated repressed homosexual feelings to her daughter, or that she (the mother) avoids any further contact with her husband and chooses to initiate sexual activity with her daughter as a prelude to father-daughter incest.

- **Sibling incest**

Sibling incest is defined by Mouzakitis (1995:90) as either heterosexual or homosexual activities among brothers and sisters that exceed allowable and normal developmental sexual play and experimentation. It is the most frequently occurring type of incest. In cases of the reported sibling incest, older children almost always initiate the act with younger children. The younger sibling often perceives the relationship and sexual activity as exploitative and unpleasant. In heterosexual incest between brother and sister, the younger sister often perceives the older brother as a father figure.

Most of the sexual behaviour, which takes place among young children, seems to be motivated primarily from natural curiosity. This behaviour often occurs in the context of a game that is designed to provide children with a mutually permissible mechanism by which their sexual curiosity can be expressed. Both children participate freely and the intent is usually limited to playful examination and manipulation of body parts (Mouzakitis, 1995:91).

Finkelhor (1999:12) reported that many cases of sibling incest were exploitive and the participation of one sibling was usually by force.

Mouzakitis (1995:93) classified sibling incest into three categories, namely:

- Brother-sister incest
- Brother-brother incest
- Sister-sister incest

A discussion of the above categories follows below:

* **Brother-sister incest**

Several types of families have been described in cases where brother-sister incest has occurred. It is suggested that unique characteristics of the family structure serve as catalysts for the escalation of normal sexual play between siblings into incest.

Merselman (1998:107) argued that brother-sister incest occurred in families where children lack adult supervision, particularly with regard to their sex play. In this family type, the father is either physically or symbolically absent, i.e. he lacks the ability to control his adolescent son due to his own weak personality structure, alcoholism or old age. When this occurs, the oldest son is often deviated to the role of father and the ensuing sexual activities, which occur with his sister, are clinically comparable to actual father-daughter incest.

Weinberg (1995:111) described families in which brother-sister incest occurs as exhibiting little regard or concern for the children's sex play. In these families, parents speak openly about sex with their children and do little to prevent children from seeing them engage in sexual intercourse. The sexual knowledge and overt stimulation is manifested in children attempting to replicate the adult sexual activity.

* **Brother-brother incest**

Finkelhor (1999:15) argued that brother-brother incest is rarely reported and little is known about the behaviour. Speculations exist that brother-brother incest results from either prior sexual stimulation by the father or homosexual interests between the brothers (Cory, 1993:232).

* **Sister-sister incest**

Reported cases of incest between sisters are extremely rare. Cory (1993:235) offers two theories as rationale for the absence of information on sister-sister incest, namely:

- Affection and physical contact between sisters is more acceptable and therefore carries less stigma and psychological trauma resulting in fewer actual cases reported.
- Incestuous activities between sisters is a rare occurrence and therefore relatively unreported in the literature.

- **Child pornography**

Child pornography is defined as films, photographs, magazines, books and motion pictures which depict children under a certain age involved in sexually explicit acts, both heterosexual and homosexual (Mouzakitis, 1995:95).

Child pornography is often considered a more perverse form of sexual abuse. According to Gerber (1997:177) there were at least 64 different magazines in South Africa which depicted sexual acts among children. In 1997 the use of children under the age of sixteen in the production of pornographic materials mailed or transported in interstate commerce was prohibited.

Many of the children who run away from home become involved in child pornography, e.g. victims of physical or sexual abuse at home who escape from the intolerable conditions of home life. From this population, adults who seek to exploit children in pornography are able to attract willing participants through the promise of food, money, shelter and/or drugs. Other children exploited in pornography are recruited from the offender's own family or from other families (Lloyd, 1998:112).

There are adults who are willing to sell their children for financial gain. The vast majority of adults who engage children in pornography may be parents who are drug addicts, pornographic performers themselves, prostitutes or more frequently, parents having incestuous relationships with their children whom they wish to memorialise in photographs or movies.

Summit (1998:241) suggested that adults who engage in child pornography needed to explore whatever is considered the most forbidden sexual activity. They wanted to record their achievements and put their fantasies into action, which seems to heighten the excitement.

- **Child prostitution**

Child prostitution refers to sexual abuse for profit. Child prostitution differs from other forms of sexual abuse due to the element of repayment usually in the form of drugs, gifts, clothing, money, food or other items.

Children engage in prostitution for a variety of reasons. A substantial number of child prostitutes are runaways. Many children leave homes to escape physical and/or sexual abuse, some because they are bored and unchallenged, still others because their families have become too distant and pre-occupied. Runaways turn to prostitution for survival, which ultimately can lead them to lives characterised by drug and alcohol abuse (Fisher, 1992:211).

Bovolek (1994:111) suggested that the buyers of children for sex are almost exclusively men from all classes and races, many are married, although they often feel inadequate and are unable to relate to peer sexual partners meaningfully. They also seek the love and affection from the child prostitute, which is lacking from their own developmental period with their parents.

3.3.4 The causes of child neglect

Mouzakitis (1995:55) mentioned the following factors as causes of neglect:

- Societal values;
- poverty;
- the social context;
- early life experiences;
- parental knowledge;
- parental isolation; and
- characteristics of parents.

A discussion of the above causal factors is given below:

3.3.4.1 Societal values

Gil (1991:231) argued that negative, hostile and dehumanising societal values, beliefs and attitudes that shape both individual and organisational behaviours could result in child neglect. Societal values are found in three levels, namely:

- In the child's own home;
- in institutional and community services; and
- in the societal readiness and sanction to use force in general including adult-child relations in particular.

3.3.4.2 Poverty

Numerous authors affirm that poverty is a key cause of neglect, as indicated below:

Gil (1991:299) stated that poverty is a major source of insecurity, frustration and stress, and that poor parents have fewer options than affluent ones for dealing with these and for making

alternative child care arrangements. Poor households have less space and this may lead to neglect.

Pelton (1991:103) took the position that poverty is one of the major causes of neglect. He maintained that neglectful families are overwhelmingly poor and have multiple problems. Polansky (1992:712) argued that poverty does expose parents to additional stress that may impair their capacity to care for children.

3.3.4.3 Social context

The social context of neglect refers to the interactions between parents and their environment (Mouzakitis, 1995:58). According to research conducted by Wolock (1992:17) neglecting parents saw their neighbourhood as more unfriendly, crime-ridden and rundown. There was lack of support for parents and their chaotic lives led to substantial stress and disrupted relationships.

Giovannoni & Billingsley (1990:99) concluded that severely deficient income and material resources caused great parental stress and these stresses may have deterring effects upon their capacities to care adequately for their children.

3.3.4.4 Early life experiences

The childhood of neglecting parents, particularly the mother, have been filled with distress and unhappiness. Substitute caretakers have raised these parents. Raised partly out of the natural home, living on welfare, having no or few clothes, being hungry, physically beaten, severely beaten, sexually abused and neglected, feeling unwanted, not sure of being wanted and the presence of a heavy drinker in the home (Mouzakitis, 1995:59).

3.3.4.5 Parental knowledge

Cantwell (1994:67) pointed out that neglect is caused by parental lack of knowledge, judgement and motivation. Parents may:

- Be unaware that a young infant has to be fed every three to four hours;
- have no knowledge of how to prepare a meal;
- not know the nutritional content of foods;

- not know the developmental stages;
- be uninformed about the ways of encouraging learning;
- fail to recognise a child's need to be seen by a physician;
- fail to understand that every child must receive emotional nurture;
- lack parenting skills;
- have little chance to rehearse the role of caregiver; and
- have trouble to learn the role of the parents.

3.3.4.6 Parental isolation

The parent's feeling of isolation from the larger community is the cause of child neglect. These parents may isolate themselves from the community's support and therefore become unable to use community resources. Stresses within the family may reduce one's ability to go out of the house and seek help from the existing community resources (Wolock, 1992:25). Neglecting parents also have fewer contacts with both relatives and friends whom they can call upon when in need.

3.3.4.7 Characteristics of parents

Mouzakitis (1995:63) gave the following characteristics of parents as causes of neglect:

- Limited intelligence (IQ below 70);
- has failed to achieve more than an eighth grade education;
- has never held public employment;
- has a vague or limited idea of what the children need emotionally and physically;
- has grown up in a family in which parents were retarded or showed deviant or criminal behaviour;
- is less able to love;
- is less capable of working productively;
- is less open about feelings;
- is more prone to living impulsively;
- is susceptible to psychological symptoms;
- cannot cope well with life in general;
- lacks competence in many areas of living; and
- is verbally inaccessible to others.

3.4 THE IMPACT OF CHILD ABUSE ON THE ABUSED CHILD

The impact of child abuse on the abused child evokes public outrage and substantial professional concern. Responses to the impact of child abuse show that it is totally not good for children, as it is detrimental to their optimal growth and development. According to research by Engeland (1991), Stroufe (1992) and Spitz (1994) child abuse affects children differently and such children experience different developmental problems depending on the type of abuse they suffered. A discussion of the impact of the different types of child abuse on the abused child is given below:

3.4.1 The impact of physical abuse

Green (1991:11) argued that the impact of physical abuse on the developing child has been extensively studied. It appears to be multidimensional and may present with psychological components, behavioural patterns, personality characteristics, cognitive aspects and neurological consequences as discussed below:

3.4.1.1 Psychological components

Kernberg (1994:79) considered the actual or threatened acute physical or psychological assault as equivalent to a traumatic neurosis, often accompanied by ego disorganisation, regression, narcissistic injury, a painful affective state, primary defence mechanisms, compulsion to repeat the trauma, severe panic and a feeling of helplessness. Green (1991:15) suggested that in most cases of child abuse the post-traumatic stress disorder is satisfied, namely:

- A recognisable stressor, i.e. the short- and long-term results of abuse;
- re-experiencing of the trauma is observed, i.e. recurrent dreams and intrusive recollections of the abusive experience;
- reduced involvement with the external world is noted, i.e. constriction of affect and detachment; and
- traumatic symptoms, consequences of the abuse are clinically evident, e.g. disturbance of sleep and avoidance of situations or activities which may lead to exaggeration of symptoms of repetition of the trauma.

Other authors also emphasise the traumatic nature of child abuse. Kris (1994:91) suggested that the abused child with an overwhelming trauma or a shock trauma might perceive the actual physical assault with the inherent threat of destruction and abandonment. Khan (1993:108) argued that the underlying harsh, punitive parenting and the eventual neurological damage from physical abuse would be the components of a strain or cumulative trauma.

According to Green (1991:21) the following primitive defence mechanisms can be observed among abused children: avoidance, distancing behaviour, raising of sensory thresholds, denial, projection and splitting. These defences are reinforced by the denial of the abusive episodes by the parents, threats of additional punishment, the child's effort to protect himself and the fear of retaliation or annihilation if the child would acknowledge the reality of the situation. The use of denial, projection and splitting allows the child to maintain a good parent fantasy in that the parental malevolence is projected and displaced onto others or onto the child himself. The child experiences splitting of self-representation into good and bad parts which seem similar to the adult borderline personality organisation (Kernberg, 1994:87).

Abused children frequently avoid eye contact, may exhibit frozen watchfulness, i.e. sitting passively and immobile but alert and hyper vigilant so as to watch for any danger, or avoid their parents. These behaviours may be the precursors of denial, projection and splitting observed in some of these children in later childhood (George, 1998:112).

Abused children may show a tendency for repetition of the trauma in dreams, fantasies, play - and object relationships. They may act either as helpless and overwhelmed passive victims or actively repeat the original traumatic experience by assuming an active, aggressive role in fantasy or play with peers. Other evidences of this repetition may be seen through self-destructive activity, behaviour that may provoke attack or accident proneness (Green, 1991:30).

According to Sandgrund (1994:91), impaired self-concepts, depressive affect or self-destructive behaviour may be frequently encountered among abused children. These situations may be secondary to the child's scapegoating which induces self-blame and the feeling that he deserves the punishment. Scapegoated children may manifest projection or externalisation. It is also common to observe isolation, denial, gradual constriction and numbing of affect. Johnson & Morse (1998:133) found that abused children were

unresponsive, negativistic, stubborn and depressed. Goldstone (1995:91) noticed that they were apathetic, unappealing, fearful, with a poor appetite and a blunting for human contact.

Martin (1992:65) reported that abused children show low frustration tolerance, are impulsive, suspicious, mistrusts adults, tend to control, manipulate and exploit objects. These children have a need for immediate gratification, exaggerated aggression, preference to use motor activity for expression, tend to provoke others, violent fantasies, pseudo independence, precocious achievements in some areas, fear, feelings of worthlessness, helplessness, depression, bad self-image, a sense of guilt, anger and low self-esteem.

Aggressive fantasies and activities represent defences against these painful states. The anger towards the abusing adult is displaced on others such as teachers, peers and siblings or against themselves as suicidal behaviour. Further punishment and rejection by adults follow these behaviours and a vicious cycle ensues with repetition of the original trauma. Abused children also appear to have marked difficulty with impulse control and the control of anger (Elmer, 1991:97). Sandgrund (1994:113) suggested that abused children exhibited problems with impulse control, body image, reality testing, thought processes, defence, object relations and overall ego competency.

According to Martin (1992:79) chronic abuse may lead to the development of primary identification with the aggressor, impaired impulse control and a proneness towards violence. The fears of helplessness and annihilation induced by the traumatic experience are replaced by a sense of power and omnipotence when the abused child identifies with the aggressor. The same mechanism may also represent a displacement of the child's rage towards the abusive parent, as well as means for counteracting painful affects and relieving tension. Furthermore, the imitation of parental impulsive and aggressive attitudes may eventually lead to aggressive behaviour as the main way for object relationships (Alfaro, 1993:5). Similarly, Duncan (1988:301) suggested the existence of a relationship between child abuse and subsequent violent behaviour.

Parke & Collmer (1995:219) believed that children who have grown up in an abusive and violent environment have an increased tendency to become abusive parents and spouses. Similarly, Sarles (1996:17) argued that if the child views violence in a home as a method of problem solving, that child may then incorporate this value. Also, the mechanism of identification with the aggressor, i.e. the parent who is a model for the child's super ego formation, seems to play a significant role in this context (Steele, 1990:80).

When abused adolescents become parents, they are likely to continue the vicious cycle of child abuse towards their own children by identifying with their own abusive parents and projecting towards their own children by identifying with their own deficiencies, incompetence and unmet needs (Oliver, 1991:109).

3.4.1.2 Behavioural patterns of abused children

Research by Yates (1991:90) observed three distinct patterns of behaviour shown by physically abused children, namely:

- Destructive behaviour
- Frightened behaviour
- Private behaviour

A discussion of these patterns of behaviour follows below:

- Destructive behaviour

Physically abused children destroyed property, disobeyed rules and assaulted other children. Their ego functions were limited, they reacted to their parents with recriminations, screamed or showed violent affection, restlessness, hyperactivity, had overt identification with the aggressor, elicited abusive fantasies in their caretakers, failed at school, exhibited poor peer relationships and showed paranoid, borderline or overly depressive features.

- Frightened behaviour

Physically abused children appeared passive, withdrawn, anxious, avoided contact, seemed compliant, remained in bed, were fussy, obstinate, compulsive stealers, picky eaters, showed deficiencies in ego functions, growth, speech, cognition, and had underlying identification with the aggressor.

- Private behaviour

Physically abused children in this group were pleasing, attractive and appeared bright. On

the other hand, they were manipulative and had poor peer relationships. In some areas they exhibited precocious ego functions while in others they exhibited serious defects. Some cognitive skills were very advanced, they did well at school, adapted well in foster homes, and showed good impulse control and attention span. They showed an ability to tolerate frustration, sublimate in autonomous functions, demonstrated lack of separation anxiety, mild behaviour problems, had no transitional objects and seemed to be able to predict behaviours of adults towards them.

Their reactions to parents were guided by their parent's needs as opposed to their own. Their precocity and charm masked their internal emptiness. Their obeying rules and pleasing adults were adaptive mechanism toward an environment perceived as threatening and their ego appeared "fluid". They either did not value relationships or the latter had no effectual significance for them (Compare Yates, 1991:90).

3.4.1.3 Cognitive aspects of abused children

Rodeheffer (1996:81) argued that other results of child abuse may be a compromised ability for learning. According to Gregg (1993:137) there is an increased incidence of mental retardation among abused children.

Quite frequently, it is difficult to ascertain whether mental deficit preceded the abuse, whether the abuse was responsible for mental deterioration or whether the impaired mental ability was secondary to the abuse. In the latter, physical abuse may lead to cerebral damage resulting in mental deficiency.

Conversely, various psychosocial impediments may contribute to the possibility of mental retardation, namely: unpredictable non-nurturing environment, reduced opportunities for learning, impaired stimulation, inadequate support, pre-occupation with fears, anxiety, fantasy world, mental energies focused on survival, danger of age-appropriate performance and non-performance (Beezley, 1994:117).

Gregg (1993:141) stated that physically abused children demonstrated above-average or even superior intelligence, explaining this phenomenon as the children's need to acquire information, to be perceived as capable and to sublimate their aggressive and libidinal drives into learning.

3.4.1.4 Neurological sequelae of abused children

According to Green (1991:80) a variety of neurological signs have been noticed among physically abused children, these included: spasticity, paresis, impaired cranial nerve function, paraplegia, focal signs, deficiency in proprioceptive, tactile, blindness, hyperactivity, delay in motor skills and increased muscle tone.

The physically abused children's inhibitions of speech and mobility may be a consequence of learned avoidance to protect themselves from further abuse or may be an adaptation to the abusive environment (Green, 1991:93). The observed speech and language disorders consist of delayed speech development and problems in articulation and expression. Problems of motor development consists of motor clumsiness, transitory, reversible disorders in body tone, co-ordination reflexes and inhibitions of age-appropriate motor acts e.g. crawling, walking, reaching and getting into things (Green, 1991:95). Hanson (1994:110) suggested that language retardation was found in younger abused children in which they demonstrated more striking delays and deficits in speech and language while older children had learned substantive and communicative language.

3.4.2 The impact of emotional abuse

According to Mouzakitis (1995:71) the pain of emotional abuse is more damaging than assault against the body. Emotional abuse expose children to a number of fears, e.g. fears of abandonment, injury and loss of love. It also arouses more anxiety and emphasises the child's helplessness. Many parents do not allow the young victim to register his/her distress. He may not question, complain or even verbalise his state of mind. This repeated suppression of feelings is apt to lead to inability to recognise one's own reactions, therefore the normal range of emotions is compressed and distorted.

The emotionally abused child's fragile self-esteem are wilted and he blames himself for the attacks and experience self-hatred. The aggression that rightfully should be aimed at the perpetrator is instead directed inward at himself. One result may be prolonged depression, another may be self-punitive behaviour e.g. an excessive number of accidents, or more direct self-mutilation (Shengold, 1995:70).

Main (1991:130) argued that emotionally abused children may show the following behaviours:

Fail to thrive, uncommunicative, cry a lot, withdrawn, low self-concept, drop out from school, passive, unhappy, depressed, consider suicide, feel hopeless, fail to acknowledge mistakes, pessimism, mistrust, rebellious, aggressiveness, impulsiveness, unfriendly towards friends, suspicious, self-destructiveness and hyperactiveness.

3.4.3 The impact of sexual abuse

The impact of sexual abuse has been the focus of many studies such as the research by Bass & Davis (1998:33), Sanderson (1990:57) and Spies (1996:1). Sexual abuse permeates everything: sense of self, intimate relationships, sexuality, parenting, work life and even a person's sanity. Bass & Davis (1998:37) specifically constructed the following description of the impact of sexual abuse on the abused child: "When children are sexually abused, their natural capacity is stolen. They are introduced to sex on an adult's timetable, according to the adult's needs. They never had a chance to explore naturally, to experience their own desires from the inside. Sexual arousal became linked to feelings of shame, disgust, pain and humiliation".

Mzarek (1994:17) argued that there is a serious concern regarding whether sexual abuse is causally related to the later disturbances in development or whether these children were already presenting with various problems. Several researchers such as Rasmussen (1990:70), Bender & Blau (1994), Rascovsky (1995) and Merselman (1996) agreed that sexual abuse has both short- and long-term effects as discussed below:

3.4.3.1 Short-term impact of sexual abuse

According to Rasmussen (1990:11) there is evidence that sexual abuse is harmful to the abused child. It is psychologically harmful to children. Bender & Blau (1994:19), Rascovsky (1995:39) and Merselman (1996:15) argued that sexual abuse has a variety of ill effects. Various psychological and behavioural manifestations were described, namely:

regressive symptoms e.g. nail biting, enuresis, and encopresis, sleep problems including nightmares, fears and phobias, anxiety states and acute anxiety neurosis, loss of self-esteem, pessimistic or callous attitude, guilt or shame, suicidal ideation, impulsive, self-damaging behaviour, tendency to withdraw from activities of normal childhood, character disorder, obesity and depression.

In an area of interpersonal relationships, abused children were frightened by contact with

adults, showed increased seeking of affection from adults, developed hostile dependent relations, demonstrated bewilderment in regard to social relations, were shocked by parental reaction to the discovery of the assault, ran away from home and had homicidal ideation (Dixon, 1988:103; Maisch, 1992:17 and Burton, 1995:3).

Isaacs (1993:31) argued that sexually abused children showed disturbance in their psychosexual development, e.g. increased masturbatory activity, rush into heterosexual activities, prostitution, homosexuality, pregnancy, promiscuity, molestation of younger children, impaired feminine identification, desperation secondary to the inability to control sexual urges, purposelessness and non-enjoyable sexual acting out.

Browning & Boatman (1997:49) reported school problems of sexually abused children, namely: truancy, learning disorders, and mental retardation

3.4.3.2 Long-term impact of sexual abuse

Authors such as Katan (1993), Werner (1993), Rhinehart (1995) and Medlicott (1996) agreed on the long-term impact of sexual abuse. They reported the following psychological disturbances: non integrated identity, neurosis, chronic depression, low self-esteem, psychosis, suicidal ideation, homicide, character disorder and obesity.

Goodwin (1999:32) reported the following impact on interpersonal relationships: social isolation, difficulty in establishing close human relationships and fear of or conflict with parents or in-laws.

There are also various references to the long-term effects of sexual abuse on psychosexual adjustments: problematic sexual relationships, various sexual dysfunctions, prostitution, sexual molestation of children, aversion to sexual activity, illegitimate pregnancy, homosexuality, involvement with other incestuous relationships and impulses to sexually assault children (Armstrong, 1988:29).

The specific familial sexual abuse have their own impacts as discussed below:

3.4.3.3 The impact of familial sexual abuse

Flugel (1993:43) discussed the impact of the types of familial sexual abuse on the children as follows:

- **Father-daughter incest**

In these cases, the impact on the victims ranged from no apparent ill effects to promiscuity, psychopathic traits, frigidity, frank psychiatric symptoms, depression, learning difficulties, running away, poor sense of identity, behaviour problems, delinquency and prostitution.

- **Mother-son incest**

Mother-son incest may lead to problems in identification and tendency to repeat the traumatic experience.

- **Father-son incest**

Father-son incest may result in further homosexual experiences among the victims, male prostitution or sexually abusing their own sons.

- **Mother-daughter incest**

Lidz & Lidz (1997:121) described three cases in all of which the daughter became schizophrenic.

- **Sibling incest**

Karpinski (1992:207) observed promiscuity and guilt feelings among siblings.

3.4.3.4 The impact of neglect

Parental neglect in the form of deprivation (physical or emotional), inadequate care (psychological, physical, medical, educational, social), separation or malnutrition has been the focus of many studies such as by Brenneman (1990), Bakwin (1992), Ribble (1992) and Goldfarb (1995).

These authors agreed on the wide range of implications of neglect on the physical, psychological and social development of children. Breneman (1990:7) and Ribble (1992:15) wrote about the child's needs for maternal stimulation, the loneliness of children deprived from their mothers and the correlation of effects of hospitalisation to inadequate mothering. Bakwin (1992:21) suggested that deprivation of mothering in institutions might be related to behaviour problems, neurologic disturbances, mental retardation or even death.

Goldfarb (1995:19) emphasised the crucial importance of deprivation on the mental health of the child. The lack of loving care, warmth, intimacy, and a continuous relationship with the mother has ill effects on the child's development. Partial deprivation leads to anxiety, feelings of revenge, guilt, depression, disturbance of psychic organisation, neurosis and instability of character. Complete deprivation has even a more deteriorating impact on personality development, leading to an inability to form relationships.

Psychological malnutrition as exemplified by high-strung authoritarian parenting and inadequate approval of children shows a significant correlation with behaviour problems such as later school failure, truancy, stealing and destructiveness (Talbot, 1993:7).

3.5 SUMMARY

3.5.1 The causes of child abuse are complex as reflected in the models that have been proposed to explain them.

3.5.2 Five models have been used to explain the causes of child abuse, namely:

- The psychodynamic model
 - Learning model
 - Environmental model
 - Biosocial model
 - Psychosocial model
-
- The psychodynamic model attribute the causes of child abuse to the parent's inadequate psychological functioning and understanding of their parental role. The following factors are emphasised:

- Lack of trust in others;
 - tendency towards isolation;
 - non-supportive marital relationship;
 - excessive expectations towards the child;
 - chronically hostile and aggressive parents;
 - rigid and compulsive parents;
 - passive and dependent parents;
 - unemployed fathers;
 - mentally ill parents;
 - role reversal;
 - scapegoating; and
 - disengagement.
-
- Learning theories with the premise that parents abuse their children because of having had abuse role models in their own childhood or because they have inadequate skills for appropriate parenting. The following characteristics of parents were suggested as causal factors:
 - Lack of knowledge of the stages of child development, the needs of children, how healthy parents respond and child management.
 - Attachment theory emphasising early relationships between the infant and the caregiver.
 - Learning experience by parents who were themselves abused and neglected.
-
- The environmental model suggesting that a lack of material resources or social support is the main contributor to child abuse. The following factors were mentioned:
 - Economic stress;
 - unemployment;
 - social isolation;
 - overcrowding;
 - poor housing;
 - poor education; and
 - occupational stress.
-
- The biosocial model that considered abuse from the standpoint of factors that influence the amount of investment a parent is willing to make in a child. These

included the benefits as well as the costs that a child is seen as presenting to the parent. This model focused on the following broad groups of children seen as poorer investment of parental resources:

- Inferior health status;
 - handicapped children;
 - sex of children;
 - developmental stage; and
 - behavioural characteristics.
- The psychosocial system model which consider child abuse to be caused by multiple factors such as:
- The abusing family system, characterised by dysfunctions by parents and children;
 - marital conflict;
 - transmission of the family problems from parents to children;
 - competition among family members;
 - the child as a causal factor in abuse due to the following child characteristics:
 - premaritally conceived
 - unplanned babies
 - babies born with congenital defects
 - babies with behaviour that is not expected by parents
 - infants who cry abnormally

3.5.3 The various types of child abuse also have specific causes as indicated below:

- The causes of physical abuse were analysed in terms of the following:
 - Fatal alcohol syndrome;
 - addiction during pregnancy;
 - inflicted burns;
 - intentional poisoning; and
 - child factors.

- The causes of emotional abuse were given, such as:

- A pervasive sense of worthlessness, which includes an overwhelming urge by parents to control the important facet of their children's lives.
 - An underlying feeling of rage which is part of the abuser's intent to hurt.
 - Reaction to difficult life events such as grief or sexual exploration by children.
 - Child's characteristics such as powerlessness and dependence on the parents.
- The causes of sexual abuse were discussed with reference to non-familial and familial sexual abuse:
- Non-familial child sexual abuse include abuse by adults known to a child from a variety of sources such as neighbours, family, friends, parent's friends and/or school friends.
 - Perpetrators to familial sexual abuse such as the father, daughter, mother, son and/or siblings.
 - Other casual factors of child sexual abuse are child pornography and child prostitution.
- The causes of neglect are as follows:
- Societal values;
 - Poverty;
 - the social context;
 - early life experience;
 - parental knowledge;
 - parental isolation; and
 - characteristics of parents.

3.5.4 The various types of child abuse has different impacts on the abused child as discussed below:

- The psychological impairment, behavioural problems, disturbed emotional-cognitive development and physical disabilities present the impact of physical abuse.
- Emotional abuse expose children to a number of fears such as fears of abandonment, injury or loss of love.

- Emotionally abused children may generally be withdrawn, hyperactive, depressed, feel hopeless, cry a lot, drop out from school, rebellious, passive, unhappy, pessimistic or fail to thrive.
- Sexual abuse permeates everything, e.g. sense of self, intimate relationships, sexuality, parenting, work life and a person's sanity. It steals the children's natural capacity by introducing them to sex on an adult's time table without having a chance of exploring naturally.
- Sexual abuse has both short and long-term effects
 - Short-term effects are observed on the psychological and behavioural components, interpersonal relationships, psychosexual development and on school performance.
 - Long-term effects are observed as the psychological disturbances, difficulty in establishing relationships and psychosexual adjustments.
 - The impact of the types of familial sexual abuse were discussed, with the impact on the victims ranging from no apparent ill-effects to apparent ill-effects such as psychopathic, delinquency, prostitution, homosexuality, poor sense of identity and being schizophrenic.

CHAPTER 4

SOCIAL WORK SERVICE RENDERING CONCERNING CHILD ABUSE

4.1 INTRODUCTION

Child abuse can be life threatening and is regarded as society's most critical area of concern. This is due to its high rate and its devastating effects. It therefore creates an urgency that is unparalleled in our society. A wide range of families is in need of social work services regarding this problem area. This chapter will therefore focus on the following aspects:

Social work functions concerning child abuse. This includes service rendering concerning child abuse.

4.2 SOCIAL WORK FUNCTIONS IN CHILD ABUSE

Richard (1991:156) argued that social work has developed specific functions for managing the widespread problem of child abuse. Such functions are as follows:

- Identification;
- investigation;
- intervention; and
- prevention.

A discussion of the above functions and service rendering concerning child abuse follows below:

4.2.1 Identification

Child abuse must be identified before intervention of any kind can be rendered. The report of abuse must therefore reach the appropriate person. The reporting phase is dependent on the following:

- Public awareness of what constitutes child abuse;
- public awareness of reporting procedures;
- the willingness and ability of the person or agency that has identified the incident of child abuse to initiate a report; and
- the availability of a qualified person to receive a report, i.e. a person who can obtain necessary information and initiate an appropriate response (Richard, 1991:156).

When the report is finally made, the social worker then faces the first action to be taken in a reported case of suspected child abuse, to give the case a priority based on two criteria: the allegations in the report and the seriousness of the incidents. Richard (1991:157) argued that the priority of reports could be classified into three, priority one, two and three as discussed below:

- Priority one includes death, brain damage, subdural haematoma, wounds, poisoning, bone fractures, abandonment, sexual molestation, sexual penetration, incest, failure to thrive and burns.
- Priority two includes cuts, bruises, human bites, dislocations, tying, substance abuse and medical neglect.
- Priority three includes mental injury, malnutrition, inadequate shelter, inadequate clothing, educational neglect and inadequate supervision.

The social worker involved must weigh the seriousness of the incident and risk of harm to the child. Priority two and three allegations may actually be moved to priority one, based on the seriousness or potential risk of the child.

When any priority one or two allegations of harm is listed on the report, the report is priority one or two respectively. When the incident is serious or a child has been taken into temporary protective custody, the report is a priority one report regardless of the allegations. Allegations are considered to be priority three only when the social worker has determined that there is no risk of injury to the children, there is no need for temporary protective custody and there are no priority one or two allegation in the report.

The identification function of social work concerning child abuse includes interviewing, as discussed below:

4.2.1.1 Interviewing

To acquire the necessary information for a report, the social worker interviews many people involved in the child's situation, namely: the child, parents or caretakers, all adults in the home, witnesses, the initial reporter and professionals such as teachers, nurses or physicians.

The two interviews, which are most demanding of the social worker's sensitivity, insight and withheld judgement are with the parents and the child. Broadhurst (1989:17) gave the following suggestions to assist in conducting such delicate interviewing:

What the social worker must do when talking with the parents, they must:

- Select interviews appropriate to the situation;
- conduct the interview in private;
- tell the parents why the interview is taking place;
- be direct, honest and professional;
- tell the parents that the interview is confidential;
- reassure the parents of the support of the program;
- tell the parents if a report has been made or will be made; and
- advise them of the worker's legal responsibilities to report.

What the social worker must not do when talking with the parents, they must not:

- Try to prove abuse or neglect by accusations or demands;
- display horror, anger, or disapproval of parents, child or situation;
- focus on family matters unrelated to the specific situation; and
- place blame on the parents or child.

When talking with the child, who can understand the interview, the social worker must do the following:

- Make sure the interviewer is someone the child trusts;
- conduct the interview in private;
- sit next to the child, not across the table or desk;
- tell the child that the interview is confidential;
- conduct the interview in the language that the child understands;

- ask the child to clarify words or terms that are not understood; and
- tell the child of any future action that will be required.

When talking with the child, the social worker must not do the following:

- Allow the child to feel in trouble or at fault;
- criticise the child's choice of words or language;
- suggest answers to the child;
- probe or press for answers which the child is not willing to give;
- display horror, shock or disapproval of parents, child or the situation;
- force the child to remove clothing;
- conduct the interview in a group of interviewers; and
- leave the child alone with a stranger.

4.2.2 Investigation

Investigation of a suspected child abuse case is carried out through assessment of the child, parents and the family circumstances (Richard, 1991:160). Assessment contributes towards effective planning or intervention to resolve the case. Social workers need to have a knowledge of family dynamics, human development and environmental factors for making decisions regarding intervention and of each type of abuse, i.e. physical, sexual, emotional and neglect in terms of having its own different character and dynamic patterns. Below follows the issues to be explored regarding the parent and the child from a general perspective:

4.2.2.1 Parent assessment

In assessing the abusive parent, the social worker must try to determine what degree of risk to the child lies in allowing the child to remain with the parents. Certain special considerations must be taken into account to make a decision, e.g. in the case of physically abusive parents, the major emphasis is on the parents' reaction to the injuries incurred. The following are important: the family's attitude towards corporal punishment and the role this may have played in the injury, the ease with which the parents lose control of their behaviour and the amount of stress required to trigger this and the role of the non-abusive spouse in abuse.

In cases of neglect, the social worker first needs to know what caused the parents to neglect their children. She must try to discover which needs of the parents caused them to turn away from the child. Secondly, it is also important to know which needs of the parent interferes with nurturing the child, and lastly a distinction between environmental stress and psychological stress must be made.

In cases of emotional abuse, professionals agree that there must be an action or series of actions or omissions by the parents that can be shown to have caused emotional harm or injury. Qualified mental health professionals can only determine the cause and extent of injury.

An assessment of sexually abusive parents must evolve from considerations of very complex issues of both parents such as relationship with the abused child, e.g. is he a stepchild or not, interaction between the parent and the child and/or type of housing in which they are accommodated.

4.2.2.2 Child assessment

According to Finkelstein (1992:70) questions which are most commonly asked in assessing an abused child focus on the child's role in the parent/child interaction that resulted in abusive or neglected actions and on the extent of harm to the child. This data is basic for planning treatment. Individual variations in data obtained generally reflect the age of the child. With the age factor in mind, the social worker surveys the psychosocial functioning of the children relative to their own development, to their family and to the particular abusive incident. There are several core issues when assessing children as well as special issues relevant to particular age groups as discussed below:

Some of the special issues of infancy are the degree of attachment between parent or parent surrogate and the child and developmental delays. Physically abused infants as well as neglected infants often demonstrate failure to thrive and developmental delays.

In evaluating the pre-school child, it is important to note whether the child is a problem child, i.e. a child whose developmental delay manifests in provocative behaviour, such as rigidity negativism and hyperactivity. These children often become targets of abuse or neglect. Normal developmental tasks of this period such as separation and toilet training can over stress the inadequate parent, resulting in abuse. Precocious separation or hyper maturity is sometimes secondary to abuse and neglect and may mask a significant lack of depth in

interpersonal relations.

Latency or school age children who presented developmental delays or personality traits such as difficult toilet training and negativity in their pre-school period may now manifest refusal to attend school. At this stage problems such as school failure, poor peer relations and cranky behaviour at home play a role in abuse. Childhood depression is another prevalent result of abuse and neglect. The social worker is dealing with children who may defend the parent out of fear of loyalty and this may be guarded against.

Adolescents are more likely to report abuse or neglect than younger children either to the school authority, police or social workers. These adolescents want help but not at the expense of alienating parents or destroying the family. They are more subject to guilt feelings about the effects of the report on their parents. Changing their minds or their stories regarding abuse manifests this ambivalence. The adolescent may be out of control and actually be of an age to victimise the parents but whatever the provocation for parental abuse, the abusing parent is also out of control.

4.2.3 Intervention

The New Dictionary of Social Work (1995:77) is defining intervention as professional behaviour of a social worker to bring about change in the person-environment situation to achieve the objectives of the agreement of co-operation, which has been entered into with the client.

Howing (1999:330) argues that the focus of intervention in child abuse has been the primary caregiver, usually the mother. The goal of intervention with such parents is to assist them to deal with a range of problems associated with child abuse. Authors such as Goldstein (1994:271), Rothery (1995:81) and Palmer (1996:20) examined intervention methods that can be used in child abuse and agreed on the following methods:

- Social work with the individual;
- social work with the family;
- social work with the group;
- social work with the community;
- social work research; and
- an integrated application of these methods.

The above intervention methods are discussed below with special focus on child abuse:

4.2.3.1 Social work with the individual

The New Dictionary of Social Work (1995:8) define social work with the individual as a method of social work aiming primarily at helping individuals on a person-by-person basis to attain the fullest degree of social functioning. Social work with the individual in child abuse cases encompasses a broad range of intervention aimed at restoring, maintaining and enhancing the individual's personal and social functioning. It is mostly employed with parents/caregivers of abused children and can help such parents to:

- Enhance their ego functioning, particularly in the areas of impulse control and judgement;
- acquire better coping skills;
- develop the self-esteem and empathy that are so essential to good parenting;
- improve role functioning and interpersonal relationships;
- learn better child management techniques;
- develop more realistic and age appropriate expectations of children;
- modify long-standing behaviour patterns;
- compensate for early developmental arrests;
- gain greater self-awareness; and
- improve relationships with the community (Goldstein, 1995:40).

Social workers involved with individuals concerning child abuse can employ various intervention approaches. Authors such as Baas (1994:4), Goldstein (1995:42) and Whiteman (1997:469) agree that five main types of approaches are mostly employed in intervening concerning child abuse, namely:

- Problem solving;
- behaviour modification;
- cognitive restructuring;
- ego psychology; and
- crisis intervention.

These approaches overlap and must be used flexibly with the individuals involved.

A discussion of the above given approaches follows below:

- **Problem solving**

The basic assumption of this approach is that human existence is a continual problem-solving process. This approach is aimed at helping the person to solve whatever problems he cannot solve at the present moment and the by-product is that he will be able to solve future problems (Butrym, 1993:25).

The problem solving approach emphasises training in the development of problem solving skills. According to Durlack (1993:35) problem solving skill training has received much attention to date and may have wide applicability in cases of child abuse whereby parents/caregivers can be trained to develop skills in problem solving. This training involves providing them with the necessary skills to accurately identify a difficult situation and to effectively manage it, thereby preventing or avoiding an abuse. Kifer, Sally & Ralph (1994:360) argues that the problem solving approach have been used effectively to help parents negotiate intrafamily conflicts which could have resulted in child abuse.

Durlack (1993:35) states that the major emphasis of the problem solving approach is the training of parents in problem solving skills following specific steps, namely:

- Identifying the problem of child abuse;
- generating alternative solutions to solve the problem;
- exploring the consequences of each proposed alternative;
- choosing the best plan and implementing it; and
- evaluating the outcomes of the plan and its relevance with similar future situations of child abuse.

- **Behaviour modification**

Studies by Vasta (1992:143), Scott *et al.*, (1994:321) and Brunk (1997:175) indicate that the behaviour modification approach is predicated on a theoretical proposition that maladaptive behaviour is learned and can be unlearned under controlled situations.

Child abuse is argued to be the result of inadequately or inappropriately learned parenting

behaviour. Much intervention with parents/caregivers of abused children had led to the contemporary approaches to training parents/caregivers in developing more effective parenting strategies (Scott et al, 1994:322). There is consensus among social workers employing this approach concerning child abuse that child abuse can be accounted for in terms of specific social interactional variables such as:

- Lack of non-violent child management skills;
- inadequate knowledge concerning child behaviour, anger control deficits, over-arousal to cues of child misbehaviour; and
- limited resources for solving problems that exacerbate stress and hinder adaptive functioning (Lutzker, Jellen & Linda, 1994:65; Furniss, Muller & Roberts, 1994:866 and Brunk, 1997:175).

Intervention focus on observable behaviour, the context in which these behaviours occur, with the objective of modifying the behavioural interchanges among persons in the target system. Focus is on the individual child who has been abused, the identification of child abuse, the antecedents to child abuse and the consequences that followed the occurrence of child abuse.

An assessment of the child's behaviour in its context relative to the parent's directives and responses to that behaviour is done. Intervention therefore focuses on the training of parents to modify the manner in which they gave instructions to their children and the enhancement of the parent's skills in child management.

This intervention can affect the parent's attitudes towards their children positively and produce positive changes in the behaviour of siblings of the abused child as parents will generalise their new skills to the siblings.

Different techniques of intervention may be employed for various behavioural objectives, namely:

- Direct instruction, role-playing or modelling which can be used to train parents in parenting skills; and
- relaxation training or communication exercises can be used for the development of social skills, reduction of stress, assertiveness training or anger control training (Scott et al, 1994:330).

Behaviour changes achieved are maintained after termination through strategies such as cognitive testing regarding the level of understanding which the individuals have concerning the processes by which they have acquired their new skills. Follow-up is made at predetermined intervals focussing on identifying any regression in the acquired behavioural skills (Furniss *et al.*, 1994:869; Lutzker *et al.*, 1994:69 and Brunk, 1997:180).

- **Cognitive restructuring**

According to authors such as Fennel (1992:129), Vondracek (1995:120) and Palmer (1996:77) the cognitive restructuring approach focuses on changing the incorrect thought patterns, beliefs and attitudes of the clients which is believed to lead to lasting behaviour change.

Child abuse is addressed in terms of incorrect premises and a proneness to distorted imaginable experiences, which lead to incorrect emotions and responses to external events. One of the features which is common to the acts of abuse is the underlying emotion of anger. Anger is therefore the most evident parental response to what is seen as the child's provocative behaviour. The aims of the cognitive restructuring approach is therefore to alleviate parental anger in the face of perceived provocation by children, and to improve child management skills.

The application of this approach will help parent's to learn the following skills:

- Desirable coping skills to cope with provocation;
- the ability to give a less negative meaning to the provoking child, e.g. taking provocation as unintentional;
- relaxation techniques to have the means to alleviate the intense pressure of provocation towards immediate and impulsive action engendered by the physiological arousal accompanying the experience of anger; and
- problem solving entailing more effective ways of preventing and ameliorating perceived provocations than impulsive actions (Fennel, 1992:130; Vondracek, 1995:125 and Palmer, 1996:79).

- **Ego psychology**

Authors such as Goldstein (1995:42) and Vondracek (1995:12) agree that ego psychology deals with the relationship of personality to reality with the basic goal of supporting and strengthening the clients' ego so that they can function and cope more effectively with their problem areas. Goldstein (1995:42) gives the aims of ego psychology regarding parents of child abuse cases as follows:

- Helping parents function more comfortably in their role as parents;
- better control of behaviour and feelings;
- improving parent-child, and other interpersonal relationships;
- developing better coping skills when problems arises;
- remedying early parental developmental defects that may be part of the pattern of child abuse;
- acquiring greater understanding of the children's needs; and
- learning better ways of managing the children's needs.

Ego psychology can be provided through the provision of information, advice and direction and can focus on the following aspects:

- Child development;
- child rearing techniques;
- special problems; and
- parents' needs.

- **Crisis intervention**

Crisis intervention is defined by the New Dictionary of Social Work (1995:16) as an approach in social work which is directed towards the restoration and promotion of the social functioning of individuals who experience a crisis as a result of an unexpected and disruptive event and who do not have the problem solving abilities and resources to cope with the increased level of tension and anxiety.

Baas (1994:4) argues that child abuse is a crisis to many individuals and requires the intervention of a social worker through the employment of crisis intervention.

Authors such as Baas (1994:5) and Furniss *et al.*, (1994:866) agree that the employment of crisis intervention in child abuse cases is aimed at the following:

- Ending the abuse through the removal of the abuser or the victim of abuse from the abusive situation;
- helping the victim to deal with his emotions;
- strengthening the parents' ability to protect the child; and
- assisting the abuser, victim and other family members to establish appropriate role boundaries.

4.2.3.2 Social work with the family

The New Dictionary of Social Work (1995:25) define social work with the family as the treatment of a client involving all the members of the family in interaction, in an effort to change the problem behaviours with a view of promoting the client's and the family's social functioning.

Social work with the family is based on the assumption that a family is a system which consists of interrelated and interdependent subsystems (members) whereby change in one subsystem will lead to change or changes in the other subsystems (Goldstein, 1995:63).

In child abuse cases, the entire family system including the abused child, non abused siblings and parents is affected by the abuse of a child and is seen together by the social worker. The family is thus seen as a unit of attention and intervention will address the family as a whole. Goldstein (1995:64) gives the following advantages of seeing the family as a unit:

- The social worker can assess family interactions and the roles family members take with one another;
- the family's interaction can help the parents to learn to communicate more directly, to solve problems jointly, and to empathise with other family members including the abused child; and
- the family can learn and experiment with more effective child management techniques.

Social work with the family focuses on two goals regarding child abuse, namely:

- Support of adaptive functioning whereby the social worker can support instances of good child rearing practices on the part of parents that could help prevent or modify the abuse of the child, e.g. helping the child to do homework rather than blaming the

child for not doing homework.

- Help in problem solving in which parents are taught to solve problems.

In abusive families, members are often not able to solve problems but instead become frustrated, angry and abusive. Parents usually attack the child when he made a mistake. The social worker can help the family to listen to one another instead of attacking each other. The family is helped to solve the problem together by following the steps of the problem solving model which are as follows:

- Identifying the problem, e.g. child abuse;
- generating alternative solutions to solve the problem;
- exploring the consequences of the proposed alternatives;
- choosing the best plan and implementing it;-evaluating the outcomes of the plan and its relevance to similar future situations of child abuse;- overt behavioural change whereby the social worker intervenes directly when abusive parental behaviour occurs, e.g. a mother who hits her child in frustration might be helped to remove herself from the child's presence when she begins to feel angry. The parent might also be helped to talk to the child rather than striking her; and
- modification of systemic family processes, e.g. communication, interpersonal relationships and structure. In some instances, problems among the other family members, such as a marital conflict e.g. anger, that is displaced on the child can result in child abuse. In this case, the social worker can encourage the parents to attend to their conflict to improve their marital relationship.

4.2.3.3 Social work with the group

Social work with the group refers to one of the primary methods of social work through which a trained social group worker provides aid, in a professional way, to groups consisting of unique individuals by managing and applying the group processes, the underlying relationships and the programme media in a purposeful and skilful way (Du Preez, 1998:25). Goldstein (1997:80) adds to this definition by arguing that social work with the group involves an alliance of people who are brought together to work on a common task, to use the group experience for support and mutual aid, for educational purposes or to effect personality change. Social work with the group thus involves different types of groups that have distinctive though sometimes overlapping goals ranging from those that are supportive to those that are educational.

Goldstein (1997:89) argues that social work with the group is an effective approach in working with child abuse cases. It has been shown to be effective in its ability to provide the following:

- The opportunity for nurturance, resocialization and relating to others;
- powerful experiences in being accepted;
- the development of better communication and other interpersonal skills;
- the atmosphere in which to develop increased empathy for others, new values, attitudes and behaviour; and
- support networks that diminish the individual's sense of isolation and enhance their ability to take or offer help.

Billy (1996:193) states that social work with the group focussing on child abuse cases employ both supportive and educational goals to focus on issues such as:

- Isolation;
- feelings of hopelessness;
- interpersonal problems;
- poor socialization skills;
- poor parenting;
- poor child management skills;
- low self-esteem; and
- poor ego functioning in key areas such as impulse control.

Howing (1993:330) and Corey & Corey (1992:14) argue that social work with the group can also use self-help groups to assist abusive parents. The program of such groups involves group sessions where parents can talk about their behaviour towards their children, their values, anger, hurt feelings and any other issue that may result from a parent abusing a child.

Self-help groups for abusive parents can focus on parent education or parenting skills. Self-help groups that aim at improving parenting skills for abusive parents often focus on improving verbal communication as an alternative to physical discipline, on enhancing impulse control and social skills. Parents are taught the following skills:

- To discipline effectively through reasonable punishments;

- setting the limits of disciplining their children;
- to know the particular needs of their children;
- to give approval, affection and attention to their children; and
- not to be overly giving in such a way that their resentment builds up when the child does not return or appreciate their self sacrifice (Billy, 1996:203; Goldstein, 1997:87, and Jacobs, Harvil & Masson, 1994:384).

Howing (1993:331) adds to the use of self-help groups in child abuse cases by arguing that self-help groups for abusive parents is a component of effective intervention. This view is supported by Cohn (1999:516) who states that self-help groups are increasingly used for abusive parents and are proved to be a success. Cohn (1999:516) goes further and argue that structured, time limited parent training programs are used for educational purposes. These programs present information on the following aspects:

- Child development;
- child management;
- stress reduction; and
- anger management.

Parents are thought to benefit from the mutual sharing of coping strategies, peer feedback, support, imitating a successful learner, i.e. a parent who has overcome the same problem of child abuse, and in regaining their self-esteem as they see that they are not the only persons with the problems of child abuse.

4.2.3.4 Social work with the community

Lombard (1991:72) define social work with the community as a method of social work based on a scientific process which is directed towards achieving one or more of the following objectives:

- To satisfy the broad needs of the community and to create and maintain a balance between the needs and the resources in the community;
- to provide the community with the opportunity to exploit its strengths and potential knowledge and skills and to develop these, in order not only to be able to deal with social problems and needs but also to prevent them; and
- to effect change in the community, in group relations and the distribution of decision-

making powers.

This definition of social work with the community concurs with that given by Ross (1991:71), George (1994:29), Dunham (1994:41) and Batten (1995:3) who defined social work with the community as a conscious process of social interaction and a method of social work concerned with:

- The meeting of needs, bringing about and maintaining of adjustments of resources to needs in a community;
- helping people to deal effectively with their problems and objectives by assisting them to develop, strengthen and maintain qualities of participation, self-direction and co-operation; and
- the bringing about of changes in group and intergroup relationships and in the distribution of decision-making power.

Briscoe (1992:183), George (1994:35) and Batten (1995:13) argue that social work with the community is carried out specifically by welfare agencies which employ social workers.

According to Tzeng (1993:105) an agency can take many different approaches to offering services to abusive or potentially abusive families and increasingly rely on a broad range of community services to render services to these families. These agencies develop community based services rendering programs such as:

- Perinatal support;
- education for parents;
- early and periodic childhood screening;
- social skills training such as coping skills in times of problems; e.g. child abuse or communication skills;
- mutual aid programs;
- neighbourhood support groups;
- family support services focussing on family planning, child care or crisis care; and
- public awareness campaigns on child abuse.

Barton (1990:176) adds to the services of the community concerning child abuse by stating that communities should have crisis helplines and co-ordinating persons from where people can gain information on the most accessible and appropriate time. Such crisis helplines will have a major impact in the community as they will provide non judgmental listening and

emergency counselling for the overwhelmed parent. It can also provide referral to community resources when necessary.

Howing (1993:333) argues that social workers rendering community services concerning child abuse should perform the following functions:

- Establish linkages between the people and community resources concerned with child abuse. This occurs where people are not aware of the resources available to them e.g. child crisis centres.
- Facilitating interactions between the people with resources. This is applicable in cases where the existing resources cannot be used by the people because of problems with regard to these resources, e.g. unavailability of funds for clients. It is therefore the social worker's function to improve interaction between the clients and the resources.

4.2.3.5 Social Work Research

De Vos (1998:19) defines social work research as a scientific inquiry about a social work problem that provides an answer contributing to an increase in the body of generalisable knowledge about social work concerns. This definition implies that social work research investigates a social work problem and in the process also adds to the general underlying body of scientific knowledge available to the profession. Most research which is conducted in social work is "applied" research which aims at developing, implementing and evaluating intervention strategies. Social work research should thus focus on research which yields results that can further develop their practice and wisdom necessary for intervention and problem solving (De Vos, 1998:248). Leedy (1993:9) argues that social work research follow a process which is largely circular in configuration, beginning with a problem and ending with a resolved problem.

In following the process, a social worker can choose between a qualitative or quantitative research approach or can choose a combination of the two approaches (De Vos, 1998:38).

The process of social work research employing the quantitative approach concerning child abuse can be as follows:

- Selection of a research problem, e.g. child abuse;
- formulating questions or hypothesis;

- formulating a research design, e.g. an exploratory research design;
- collecting data e.g. by means of interviews scheduled;
- analysing data; and
- writing the research report (Rothery (1993) as quoted by De Vos, 1998:39).

4.2.3.6 The application of social work methods by means of an integrated approach

An integrated approach of social work methods refers to uniting the various methods of practice from which social work is made up, e.g. social work with the individual, family, group, community and research (Goldstein, 1994:22, Welsh, 1995:99 and De Villiers, 1996:81). The integrated approach does not detract from the individual character of the methods but aims at achieving the same goal as that which the social work profession is aiming at with each respective method. The purpose of an integrated approach is to be helpful to people as individuals, families, groups or communities.

A social worker always begins with individuals or families who have a problem or need and formulates a plan to meet the need or resolve the problem based on an assessment of the client's situation. Intervention may be directed to different systems, e.g. individual, family, group or community or to the relationships among them to resolve the problem, e.g. child abuse as discussed in this chapter under social work with the individual, the family, group, community and research.

4.2.4 Prevention

Prevention is defined by the New Dictionary of Social Work (1995:46) as a process aimed at minimising and eliminating the impact of conditions that may lead to social malfunctioning, e.g. child abuse. Gough (1993:17) argues that prevention is aimed at the rearrangement of the forces in the society against those negative factors in the life of a child.

According to authors such as Jacobsen (1992:104), Davies (1994:23) and McMurtry (1995:42) prevention can be offered at three levels, namely: primary, secondary and tertiary.

A discussion of these three levels of prevention follows below:

4.2.4.1 Primary prevention of child abuse

Primary prevention seeks to affect factors that contribute to the appearance of child abuse. It refers to efforts aimed at positively influencing parents/caregivers before abuse occurs (Gough, 1993:18 and McMurtry, 1995:44). Primary prevention thus concerns itself with reducing the incidence of new cases of child abuse before it starts. Usually these operate at the societal level through public awareness campaigns and advocacy groups and are then realized by social, legal and educational processes of change. Gelles & Cornell (1995:103) suggested the following actions for the primary prevention of child abuse:

- Elimination of the norms that legitimate and glorify child abuse in the society and family, such as the use of violence as a form of media entertainment;
- reducing violence-provoking stress created by society, such as poverty and inequality;
- incorporation of families into a network of kin and community, to reduce isolation;
- changing the sexist character of society by educational development; and
- breaking the cycle of child abuse in the family by teaching alternatives to child abuse as a way of controlling children.

The above proposals call for fundamental changes in family life and society as a whole. If they are not unrealistic, they are at least long term solutions.

Since it is so costly to mount prevention programs, social workers are devoting more time and resources to high-risk populations. The following are high-risk factors for child abuse which are considered:

- Low birth weight pre term infants;
- children of adolescent parents;
- handicapped and special needs children;
- children of mentally retarded parents;
- children of substance abusers;
- children of parents who were abused as children; and
- children of parents with few or inadequate support systems, i.e. family, friends, neighbours (Richard, 1991:170).

Children may belong to more than one of these population groups with the risk factor increasing as group membership increases.

4.2.4.2 Secondary prevention of child abuse

Secondary prevention of child abuse involves the identification of potential child abusers and treating them before child abuse can take place. It is thus a before the fact technique in its timing which attempts to direct services towards specific parents identified as having a high potential for experiencing child abuse (McMurtry, 1995:42).

The purpose of secondary prevention of child abuse is to avert the onset of child abuse. Secondary prevention can be used in maternity units e.g. by identifying parents who may later present with parenting difficulties which may result into child abuse. The aim will be to prevent the onset of child abuse by improving the birth care of these identified parents at risk (Buchanan, 1995:142).

McMurtry (1995:47) states that adult education classes should be attended by high risk parents expecting a new baby. These parents should attend prenatal classes that deal with labour, delivery, the demands of caretaking and the normal anxiety and anger engendered by babies. Once the baby is born, parenting classes should also be attended. Such classes can provide parents with a rehearsal of the types of stresses that children frequently cause. These classes are especially helpful for parents with unrealistic expectations of children's behaviours, and may focus on the following aspects:

- Stressing of discipline and counselling with a strong stand taken against hard discipline;
- exploration of alternative means of disciplining children as opposed to abusing the children; and
- difficulties experienced in child developmental phases which are usually provocative to parents, with toilet training being the worst phase which may lead to bruises and burns to the genitals and anal area.

Barton & Schmidt (1990:175) stress the importance of parent education courses as an effective technique of secondary prevention of child abuse. This view is supported by Hawkings (1993:197) who recommends a training program for parents and prospective parents which will improve the quality of child-rearing and prevent the development of child abuse. Such programs can teach parents about the following aspects:

- Nurturing;

- the needs of children at different stages;
- how parents respond to those needs;
- good parenting skills;
- family planning;
- stress management;
- conflict management;
- child development;
- health;
- personal growth; and
- the warning signs of their own potential to abuse the child.

4.2.4.3 Tertiary prevention of child abuse

Authors such as Tzeng (1992:104), Gough (1993:19) and McMurtry (1995:43) argue that tertiary prevention of child abuse refers to the services offered to families after child abuse has occurred. It is thus a reactive intervention aimed at preventing an abused child from being further abused. Prevention here focuses on keeping the families from developing abusive cycles in which children are repeatedly abused.

Tertiary prevention is rendered by the provision of treatment to the abusive families (Mouzakitis, 1995:248). Treatment is defined by the New Dictionary of Social Work (1995:103) as a helping action by the social worker in the client's problem situation which is aimed at guiding the client towards a better understanding of his problems with a view to solving them and improving his social functioning. In this study, treatment will refer to the helping action of the social worker in the abusive parent's problem situation which is aimed at guiding these parents towards a better understanding of their problems of child abuse with a view of solving them and improving their social functioning.

Tertiary prevention of child abuse will focus on the following treatment goals:

- Stopping the abuse;
- improving parental functioning;
- reducing frustration, stress and conflict within the family and the environment; and
- developing conflict management skills.

A discussion of the above treatment goals follows below:

- **Stopping the abuse**

Stopping the abuse may require several strategies such as having the parents list the types of behaviours manifested by the child prior to abuse. Objectives can be formulated to prevent a recurrence of the particular set of circumstances, such as to relate to the stress in other ways, to recognise that the child's behaviour is developmentally normal and to learn new methods for disciplining the child's undesirable behaviours.

- **Improving parental functioning**

The social worker can set objectives such as:

- Roles of family members will become appropriate, i.e. the child will no longer "parent" the adults;
- nutritious meals and snacks will be prepared for the children daily;
- the parents will hug the child each day; and
- parents and children will play a game together each day.

Strategies to achieve these objectives may include role modelling by a counsellor, homemaker or volunteers.

- **Reducing stress and conflict in the family**

In reducing stress and conflict, the following aspects may be improved:

* **Housing, income and quality of food**

Since housing, income and nutrition affect family attitudes, strategies may include obtaining public housing, getting utility service restored, seeking employment or job training, learning the basic nutrition requirements and reducing sugar intake.

* **Developing conflict management skills**

In developing conflict management skills, the family learns the following:

- To focus until a problem is defined;
- to list possible solutions; and
- to reach a consensus on the solution.

* **Self-esteem**

Improvement of self-esteem requires the family to develop interpersonal association with others, e.g. the positive interaction that occur in group modalities, positive attempts to make complimentary statements about themselves and others, listing of their personal strengths, learning to play and have fun, development of a daily routine and feeling in control of themselves and not helpless in the environment.

* **Intimacy**

Improved intimacy within the family requires learning the importance of appropriate touch, becoming trusting of others and being trustworthy, learning to respect one's spouse, sharing sexually and communicating openly and respectfully (Mouzakitis, 1995:253, and Goldstein 1995:87).

Kempe (1992:70) argues that if the situation dictates that the family will never be able to provide adequate care to the child, the only alternative is to separate the child temporarily or permanently from his family with the main aim of protecting him from further abuse. Such a child may be temporarily placed in family foster care homes or permanently in residential treatment centres such as psychiatric hospitals for severely disturbed abused children.

4.3 SUMMARY

4.3.1 Social work has its own functions for child abuse, namely:

- Identification;
- investigation;
- intervention; and

- prevention.

4.3.2 Social work service delivery is given on the basis of these functions of social work concerning child abuse as follows:

4.3.2.1 Identification which includes interviewing,

4.3.2.2 Investigation which includes parent and child assessment,

4.3.2.3 Intervention which includes social work with the individual, the family, the group, community, research and an integrated approach.

Social work with the individual mostly employ the following models:

Problem solving, Cognitive restructuring, ego psychology, behaviour modification and crisis intervention.

Social work with the family entails working with the family as a unit.

Social work with the group entails working with a group of clients who experience the same problem areas, namely: Child Abuse.

Social work with the community.

This involves the community in the satisfaction of needs or solving of problems such as child abuse.

Social work research.

Social work research focuses on social work problems with the aim of adding knowledge to the general underlying body of knowledge of the profession of social work

An integrated approach of social work methods entails uniting the various methods of social work in service delivery in child abuse.

4.3.2.4 Prevention of child abuse is given on three levels, namely:-

Primary prevention refers to efforts aimed at positively influencing parents/caregivers

before abuse occurs.

Secondary prevention refers to the efforts directed at the identification of potential child abusers and their treatment before child abuse can take place.

Tertiary prevention refers to services, which are offered to families after child abuse has occurred. It thus prevents an abused child from being further abused.

CHAPTER 5

EMPIRICAL RESEARCH

5.1 INTRODUCTION

This chapter focuses on the following aspects:

- Research methodology;
- the procedure followed in collecting data;
- the presentation of the results in tables and figures; and
- the interpretation of the results.

The above aspects are discussed below:

5.2 RESEARCH METHODOLOGY

Information regarding research methodology has been discussed in detail in Chapter one of this thesis and will not be repeated in this Chapter. For detailed information on the research methodology, the reader can utilize Chapter one.

A brief discussion of some of the aspects of research methodology is given below:

The exploratory research design was employed on the condition that there was no research which was conducted concerning the topic of this study. The main aim of employing the exploratory research design was to formulate hypothesis for future research.

Data was gathered by means of questionnaires which were administered in face-to-face interviews during October and November 2000.

The population of the study consisted of 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.

Purposive sampling was employed to get a representative sample. A sample consisting of one hundred and fifty parents/caregivers whose children were abused in the North West Province - Moretele District and fourteen social workers who are rendering services concerning child abuse in the North West Province – Moretele District were drawn. There were therefore one hundred and fifty parents/caregivers and fourteen social workers who formed the sample of the study.

The criteria to qualify for this study was as follows:

Parent/caregiver

To be regarded as a parent/caregiver, the person must be responsible for taking care of a child who is under the age of eighteen and who has been abused during 1995-1999.

Sex

Both males and females were included in the study.

Age

Parents/caregivers of any age were included in the study.

Race

Only black parents/caregivers were involved.

Residence

Parents/caregivers had to be residing in the North West Province – Moretele District.

Social worker

A person should be registered and authorized in accordance with the Social Work Act (Act 110 of 1970) and practice social work.

Employment

The social worker must be under the employment of the Department of Health and Developmental Welfare, North West Province – Moretele District and rendering services in child abuse cases.

5.3 THE PROCEDURE FOLLOWED IN OBTAINING DATA

The procedure followed in obtaining data in this study can be described as follows:

Before interviews were conducted with the respondents of the research, the Department of Health and Developmental Welfare in Moretele District received a letter informing them about the intended research, see Appendix 1.

A program was later sent to this Department informing them about the dates of the researcher's visit to interview the parents/caregivers and social workers, see Appendix 2.

A second letter was sent a month in advance to this Department confirming the researcher's date of visit, see Appendix 3.

Interviews were conducted at the parents/caregivers homes and the social workers offices during office hours. The first interview focused on the respondent's confirmation of their voluntary participation in the research by attaching signatures next to their names. An explanation for the confirmation of their voluntary participation was clearly given, see Appendix 4.

The second interview focused on the completion of the questionnaires. Before the interview itself started, a full explanation of the purpose of the research was given to the respondents. This explanation was also supported by the covering letter of the questionnaires. These explanations became very important in order to win the confidence of the respondents and also to establish a good rapport with them.

The researcher asked questions and completed the questionnaires herself. At the end of the interviews the researcher expressed her appreciation to the respondents for taking part in the study.

5.4 RESULTS

The research findings are presented graphically and in tables. The questions that do not have significant bearing on the results obtained in the study concerning the types, causes, symptoms and impact of child abuse and the nature of services rendered by social workers concerning child abuse will not be represented in graphs or tables.

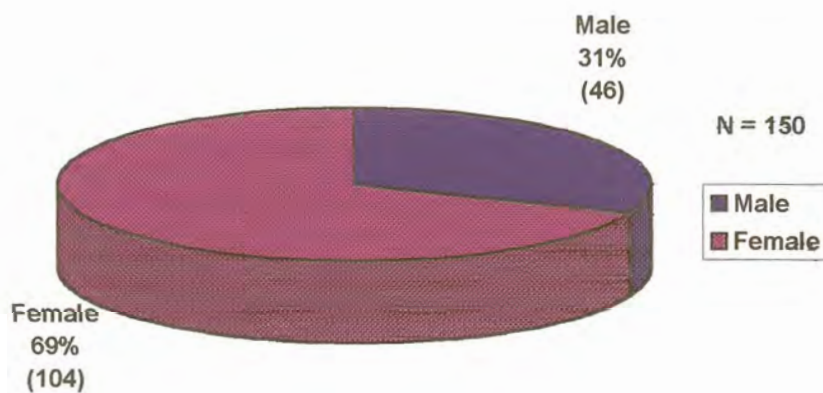
These results are also interpreted. The results obtained from this empirical study and their interpretations will now be provided below:

5.4.1 Personal details of parents/caregivers

This section was answered by all the parents/caregivers. They were requested to indicate their sex, age and marital status as indicated below:

The sex of the parents/caregivers is represented in figure 2 below:

Figure 2: Sex of the parents/caregivers



The above figure shows that 69% (104) of the parents/caregivers are females while 31% (46) are males. This is a discrepancy of 38 % respondents in the distribution of sex. This is due to the inclusion of the whole population of parents/caregivers whose children were abused.

In this study the sex of the respondents will have a significant bearing on the types of child abuse, which were experienced by the children and the symptoms which were noticed, which indicated that these children have been abused.

The age of the parents/caregivers is represented in table 1 below:

Table 1: Age of the parents/caregivers

AGE	FREQUENCY	PERCENTAGE
20-25	88	58%
26-30	30	20%
31-35	16	11%
36-40	10	7%
41-50	6	4%
TOTAL	N = 150	100%

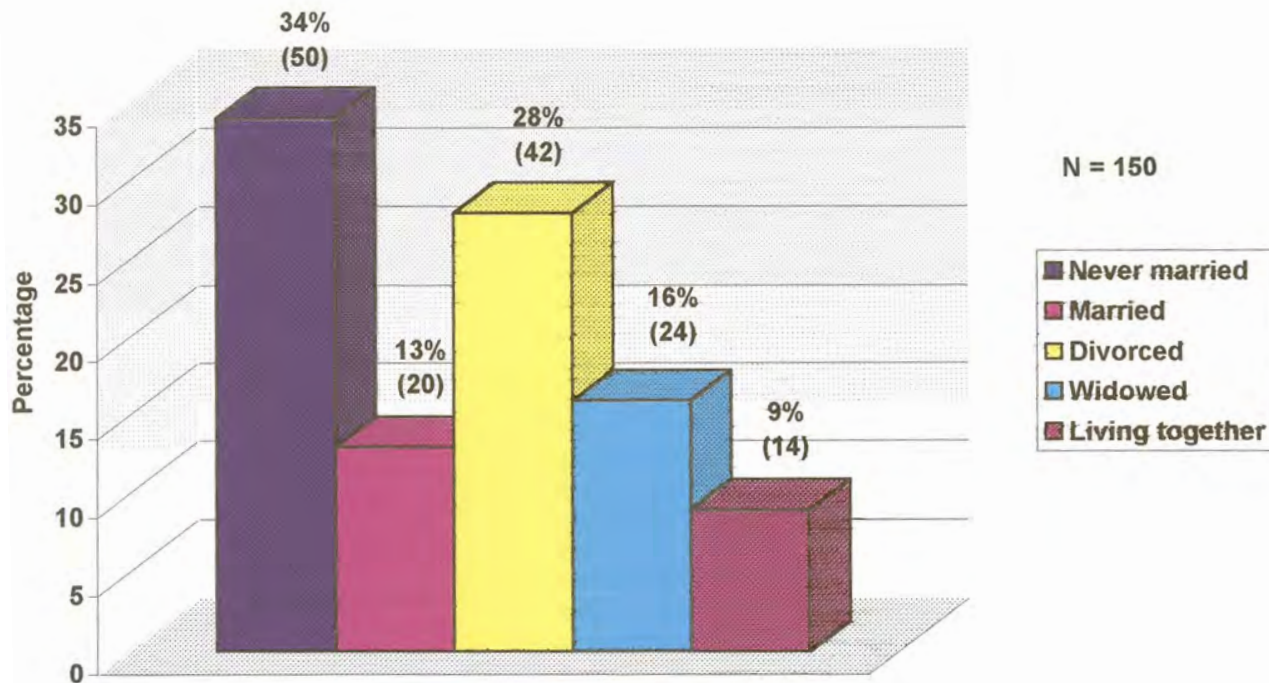
The ages of parents/caregivers range from 20 years to 50 years old. The majority of them 58% (88) is in the age group 20 – 25 years. Followed by 20% (30) in the age group 26-30 years, 11% (16) in the age group 31-35 years and 7% (10) in the age group 36-40 years. The minority 4% (6) is in the age group 41-50 years.

Considering the difference in age, as indicated in the above table, one can relate these findings to the argument by Creighton (1994:77) in which he indicates that the ages of parents determine the responsibilities that parents take towards their children in terms of fulfilling the children's needs.

This finding contradicts what is happening in practice as the parent's age does not determine their responsibility towards the children, there are young parents who exercise more responsibility to their children than elder parents.

The marital status of the parents/caregivers is represented in figure 3 below:

Figure 3: Marital status of the parents/caregivers



The above figure shows that the majority of the parents/caregivers 34% (50) are never married, 28% (42) are divorced, 16%(24) widowed, 13%(20) married and the minority 9% (14) is living together.

The above findings are attributable to the inclusion of the whole population of the parents/caregivers whose children have been abused in the North West Province. These findings will have an influence on the types and causes of child abuse that are experienced by the children in the North West Province.

5.4.2 Number of children

The number of children under the age of 21 who are under the parents/caregivers is represented in table 2 below:

Table 2: Number of children

NUMBER	FREQUENCY	PERCENTAGE
1	10	7%
2	25	17%
3	45	30%
4	70	46%
TOTAL	N = 150	100%

The number of children, under the age of 21, who are under the care of parents/caregivers range from 1 – 4. The largest percentage of parents/caregivers 46% (70) each has 4 children, 30% (45) has 3 children and 17% (25) has 2 children and the minority 7% (10) has 1 child.

The above findings correlates with the findings of Schultz (1992:12) who found that parents that have more than one child are unable to meet their role obligations regarding the children's discipline. These findings contradict what is happening in practice, as the number of children is not related to the parent's role performance regarding the children. Role performance is determined by the parent's clarity of obligations associated with particular responsibilities over the children.

5.4.3 Number of children who have been abused

All the parents/caregivers 100% (150) indicated that only one child who is under their care has been abused. This finding may be related to the practical situation in child abuse cases whereby the parents/caregivers of abused children are involved in childcare services such as prevention services. This involvement can lead to the prevention of further child abuse.

5.4.4 The child abusers

The child abusers are represented in table 3 below:

Table 3: Child abusers

CHILD ABUSERS	FREQUENCY	PERCENTAGE
Child's mother	35	23%
Child's father	16	11%
Child's stepfather	62	41%
A stranger	13	9%
Child's relative	24	16%
TOTAL	N = 150	100%

The above table indicates that the majority of child abusers are the stepfathers 41% (62), followed by the mothers 23%(35), the relatives 16%(24), the fathers 11%(16) and the minority of child abusers are strangers 9%(13).

The above findings contradict the results of the research conducted by Blumenthal (1994:6) in which most of the child abusers were the children's biological parents, i.e. their mothers and fathers.

The findings in this study agree well with Gelles's (1997:216) argument that stepfathers are greatly over represented in child abuse. These findings also correlate with the practical situation in South Africa whereby stepparents are mostly the ones who abuse their stepchildren than any other person. (South African Police Services News Letter, 1997:2)

5.4.5 The children's ages during the abuse

The children's ages during the abuse are represented in table 4 below:

Table 4: The children's ages during the abuse

AGE	FREQUENCY	PERCENTAGE
0-5	47	31%
6-10	51	34%
11-12	35	23%
16-21	17	12%
TOTAL	N = 150	100%

The majority of children 34% (51) experienced abuse at the age of 6-10 years, 31% (47) at the age of 0-5 years and 23% (35) at the age of 11-12 years. The minority of children 12%(17) experienced abuse at the age of 16-21 years.

The above findings are related to the types of child abuse as experienced by the children and correlate well with the findings by Wolf (1999:14) and with the practical situation regarding the ages of the children and the types of abuse which is experienced.

According to Wolf (1999:14) age is associated with the type of abuse as follows:

Neglect is most often reported when children are quite young (infancy to toddler) with the incidence declining with age.

Sexual abuse is relatively constant from age 3 onwards, which attests to children's vulnerability from early preschool years throughout childhood.

Physical and emotional abuse affect a sizeable proportion of all age groups with the highest rate found among adolescents (12-17years) probably because of increasing independence and parent-teen conflict.

The findings of Wolf (1999:14) correspond well with the practical situation regarding age and the type of child abuse.

5.4.6 Years in which parents/caregivers became aware of the abuse

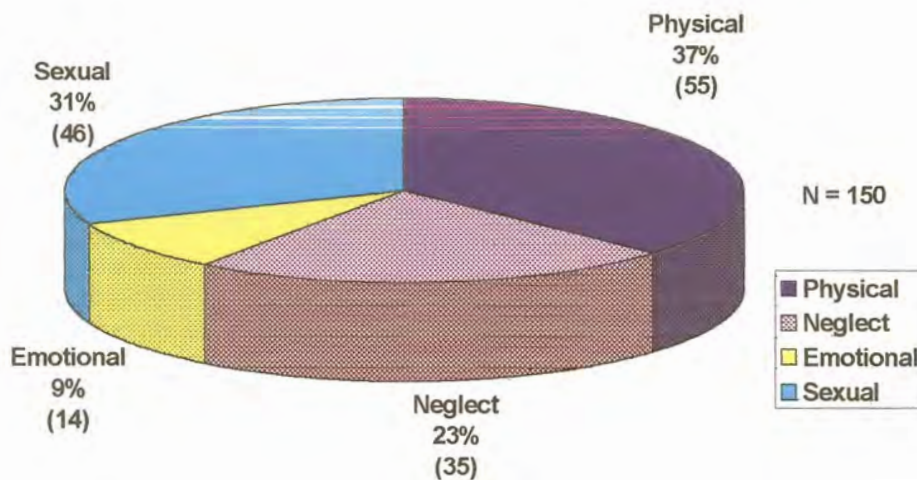
13% (20) of the parents/caregivers became aware of the abuse in 1995.
 13% (20) of the parents/caregivers became aware of the abuse in 1996.
 23% (35) of the parents/caregivers became aware of the abuse in 1997.
 23% (35) of the parents/caregivers became aware of the abuse in 1998.
 28% (40) of the parents/caregivers, which is the largest percentage, became aware of the abuse in 1999.

The years in which the parents/caregivers became aware of the abuse do not have any significant bearing on the results obtained from this research. These years were only included to indicate the periods on which the research focused.

5.4.7 Types of child abuse

The types of abuse experienced by the children are represented in figure 4 below:

Figure 4: Types of child abuse



The above figure shows that 37% (55) of the children experienced physical abuse, followed by 31% (46) who experienced sexual abuse, 23% (35) of the children experienced neglect and 9% (14) experienced emotional abuse.

The above findings contradict the results of research conducted in the United States by Wolf (1999:112) whereby it was found that neglect was experienced by 49%, physical abuse by 23%, sexual abuse by 14% and emotional abuse by 5% of the respondents.

The above findings also contradict the practical occurrence of child abuse. It is practically observed that sexual abuse is showing the largest percentages of child abuse, followed by neglect, physical abuse and then emotional abuse.

5.4.7.1 Physical abuse

This section was completed by 37% (55) of the parents/caregivers whose children experienced physical abuse. These parents/caregivers were requested to indicate the nature, location, substance or item used and the symptoms of physical abuse.

The nature of physical abuse experienced by the children are represented in table 5 below:

Table 5: Nature of physical abuse

NATURE	FREQUENCY	PERCENTAGE
Injuries	41	75%
Burns	0	0%
Poisoning	8	14%
Suffocation	6	11%
TOTAL	N = 55	100%

The majority of the children 75% (41) experienced injuries, 14% (8) experienced poisoning, while the minority 11% (6) experienced suffocation. Burns were not experienced.

The above findings correlate well with the research conducted by Stevenson (1998:5). It was found that the majority of abused children suffered injuries, namely: of the face, head and thorax, followed by those who experienced poisoning and suffocation respectively. Stevenson (1998:6) went further and indicated the following:

Injuries of the head account for more disability and death.

Household substances were used in poisoning in about 80%.

Drugs were used in 20% of the cases.

Suffocation was found in 3% of the cases.

The above findings are related to the practical situation where the majority of physical abused children suffer injuries, followed by poisoning and suffocation respectively. Burns do occur especially in rural areas during winter months, but occur at a very low rate.

- **Physical symptoms of physical abuse**

The parents/caregivers were requested to indicate both physical and behavioural symptoms, which they noticed or did not notice showing that their children have been physically abused. The following results were obtained regarding bruising:

71%(39) of the parents/caregivers noticed bruising.

29% (16) of the parents/caregivers did not notice bruising.

The above results relate well to the nature of physical abuse experienced by the abused children. The report by 71% (39) of the parents/caregivers that they noticed bruises is related to Blumenthal (1994:15) who argued that bruising is the most common symptom in physical abuse.

The following results were obtained regarding lacerations:

62% (34) of the parents/caregivers noticed lacerations.

38% (21) of the parents/caregivers did not notice lacerations.

The report that lacerations were noticed by 62% (34) of the parents/caregivers correlate with the argument by Wolf (1999:8) who stated that lacerations ranging from minor to severe ones indicate physical abuse. The above findings also

compare favourably with the practical situation as bruises and lacerations may indicate physical abuse.

The following results were obtained regarding burns:

Burns and fractures were not noticed by all, 100% (55), of the parents/caregivers.

According to Wolf (1999:9) the severity of injuries resulting from physical abuse may range from minor to severe burns or from minor broken to severe broken bones. Wolf's (1999:9) argument compares favourably with the practical situation regarding symptoms of burns and fractures but contradict the above findings as all the parents/caregivers 100% (55) indicated that they did not notice any burns nor fractures.

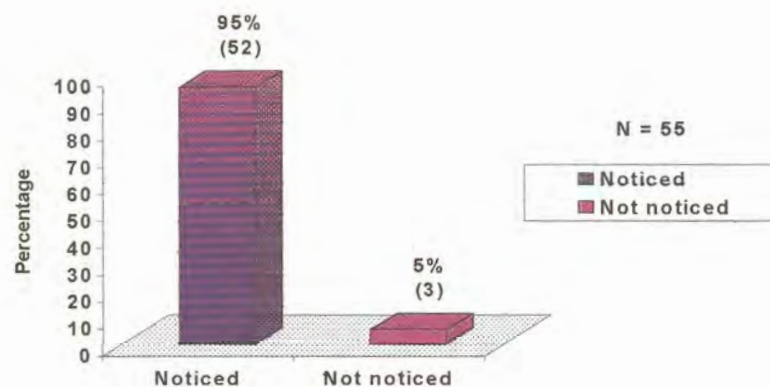
- Behavioural symptoms of physical abuse

The behavioural symptoms shown by their physically abused children who were noticed or not noticed by the parents/caregivers are discussed below:

* Fear of physical contact

The fear of physical contact as reported by the parents/caregivers is represented in figure 5 below:

Figure 5: Fear of physical contact

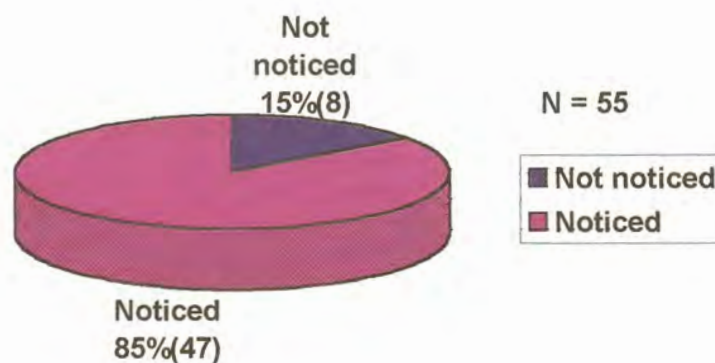


According to Aber & Barry (1994:99) physically abused children are fearful of physical contact especially by their abusers. The findings of this study correlate well with Aber & Barry's (1994:99) statement as the majority of the parents/caregivers 95% (52) indicated that they noticed the children's behavioural symptom of fearing physical contact. The minority 5% (3) indicated that they did not notice such behavioural symptoms. In practice it can be said that physically abused children avoid contact with their abusers.

* **Temper tantrums**

Temper tantrums as behavioural symptom is represented in figure 6 below:

Figure 6: Temper tantrums



Of the parents/caregivers, 84% (47) indicated that they noticed temper tantrums from their abused children and 15% (8) indicated that they did not notice temper tantrums. Therefore the majority of parents/caregivers noticed temper tantrums from their abused children.

Brooks, Gunn & Duncan (1997:115) who also found that physically abused children might show temper tantrums, support this finding. The above finding may be related to the practical situation whereby physically abused children react with temper tantrums accompanied by violence.

* **Craving for attention**

Friedrich, Jawerski & Bengston (1995:70) indicate that the majority of physically abused children crave for attention by making affectionate overtures such as hugs, kisses and physical closeness, demanding affection, exhibiting hostile dependency and engaging in any peer interactions.

These findings contradict the results of this study, as a craving for attention was not noticed by all the parents/caregivers 100% (55). In practice a physically abused child may isolate himself from humans and show negative interactions with anyone around him. This practical situation contradicts the findings of this study as discussed above.

* **Wearing long sleeved clothing**

Wearing long sleeved clothing as a behavioural symptom of physical abuse was not noticed by 100% (55) of the parents/caregivers. This finding is related to the nature and location of physical abuse, as experienced by the abused children. None of the children experienced injuries on their arms, as a result, wearing long sleeved clothing is irrelevant.

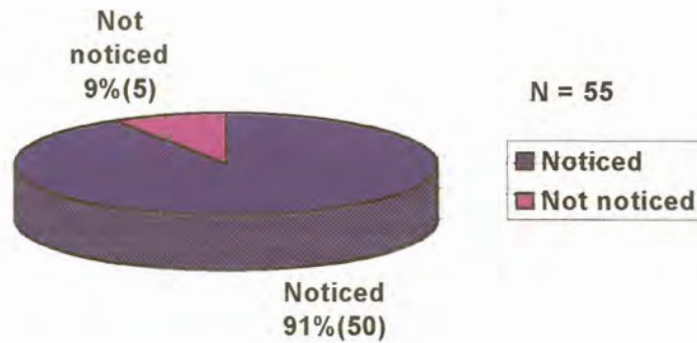
The above finding is supported by research conducted by Kendall, Jackett & Watson (1994:43) in which they argue that the bruises, lacerations, scars or broken bones cannot be concealed, they will always be visible.

In practice symptoms of physical abuse e.g. scars or bruises which are not located on the face, can be hidden by wearing clothes, e.g. long sleeved clothes if the symptoms are located on the arms, or long trousers if they are located on the legs.

* **Fearful of parents/caregivers**

Fearful of parents/caregivers as behavioural symptom, is represented in figure 7 below:

Figure 7: Fearful of parents/caregivers



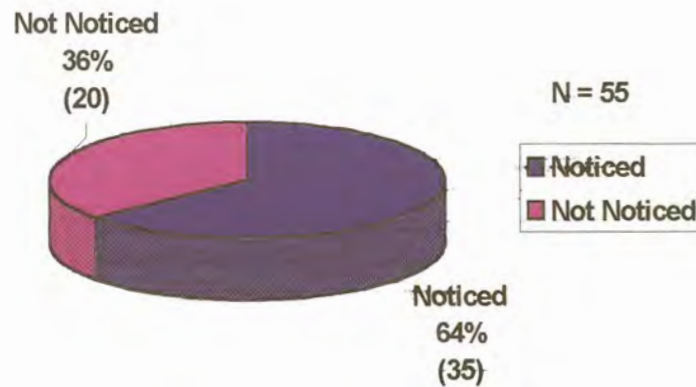
According to Goldman (1993:20) most children who are physically abused are frightened of parents and also fearful especially when the parents are the abusers in that specific case. Goldman's (1993:20) argument is related to the findings of this study as 91% (50) of the parents/caregivers indicated that they noticed the children's fearfulness of the parents/caregivers, while 9% (5) of the parents/caregivers indicated that they did not notice their children's fearfulness of the parents/caregivers.

In practice physically abused children may be fearful or not, depending on who the abuser is, e.g. if the parents/caregivers are the abuser, the child will be fearful as he will have developed mistrust in him. If the parents/caregivers are not the abuser the children will not be fearful as that parents/caregivers will be the children's resource in terms of supporting them to go through the trauma of abuse.

*** Over aggressiveness**

Over aggressiveness as behavioural symptom, is represented in figure 8 below:

Figure 8: Over aggressiveness



Of the respondents, 64% (35) indicated that they noticed over aggressiveness in their abused children and 36% (20) did not notice over aggressiveness.

This finding is supported by Aber & Barry (1994:97), Wekerle (1996:11) and Russell (1998:39) who argued respectively that physically abused children are overaggressive and always experience post traumatic stress. The above finding agree well with the practical situation whereby physically abused children may be overaggressive, which impede their recovery from abuse and they need counseling in general.

*** Withdrawal**

The parents/caregivers were requested to indicate whether they noticed or did not notice withdrawal from their abused children and all the parents/caregivers, namely 100% (55) indicated that they did not notice withdrawal from their children.

This finding contradicts the findings of the research conducted in England by Williams (1997:199) who found that 80% of the respondents withdrew from all peer interaction. The findings of this study are supported by the practical situation whereby physically abused children are not withdrawn, they still continue with their everyday activities especially when those around them give them the necessary support.

* **Sleepy in class**

According to Kendall, *et al.*, (1994:123) it is common for younger children who have been physically abused to have problems of sleeping in class. These children can also show a decline or sudden change in school performance.

These problems can be aggravated if the abuser is the schoolteacher and the child can lose interest in attending school. This view of Kendall, *et al.*, (1994:123) contradicts the findings of this study as 100% (55) of the respondents indicated that they did not notice any symptoms of their children sleeping in class as informed by the children's teachers.

The above finding may relate well to the practical situation of parents/caregivers who do not take the responsibility of taking part in their children's schooling, e.g. in terms of checking the child's performance or responding positively to the teacher's request for meetings regarding their children.

* **Arriving early at school**

All the respondents 100% (55) reported that they did not notice the symptom of arriving early at school from their children as informed by their children's teachers.

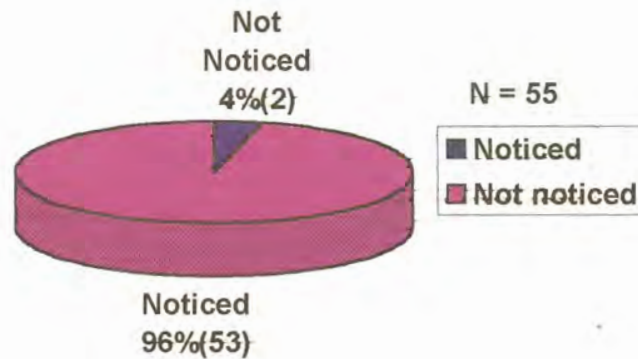
The above finding differs from the findings presented by Lotters (1992:307) that one of the major symptoms shown by physically abused children is to arrive early at school. This finding of Lotters is supported by Berndt (1998:73) in which it was indicated that about 92 % of physically abused children arrive early at school and this behaviour can continue whereby, they even arrive early at work.

The findings of this study may or may not relate with what is happening in practice. The child's early arrival at school may depend on who the abuser is, e.g. if the abuser is the parents/caregivers or someone at home, the child may arrive early at school to avoid the abuser at home. If the abuser is the schoolteacher, the child may even stay away from school to avoid the abuser.

* **Excessive school absence**

Excessive school absence as behavioural symptom, is represented in figure 9 below:

Figure 9: Excessive school absence



The majority of parents/caregivers 96%(53) reported that they have noticed the excessive school absence from their children. The minority of parents/caregivers 4% (2) reported that they did not notice this behavioural symptom.

This finding agrees well with Young's (1997:112) argument that excessive school absence was observed in 100% of physically abused children in research conducted in Canada. Young's (1997:112) view is supported by research conducted in Mozambique by Du Plessis (1993:79) who concluded that children who have been physically abused by their teachers or school mates will show excessive school absence.

The findings of this study relate well with the practical situations in which children that have been physically abused particularly by their teacher, may show signs of excessive absence from school. This is due to avoiding further abuse or contact with the abusers.



5.4.7.2 Sexual abuse

This section was answered by 31% (46) of the parents/caregivers whose children experienced sexual abuse. These parents/caregivers were requested to indicate the nature and symptoms of sexual abuse.

The nature of sexual abuse experienced by the children are represented in table 6 below:

Table 6: Nature of sexual abuse

NATURE	FREQUENCY	PERCENTAGE
Sexual contact of intimate parts	5	11%
Fondling	5	11%
Oral contact	6	13%
Anal intercourse	0	0%
Sexual intercourse	30	65%
Interfemoral	0	0
TOTAL	N = 46	100%

The majority of the children 65% (30) experienced sexual intercourse followed by 13% (6) who experienced oral contact. The minority of the children 11%(5) experienced sexual contact of intimate parts and fondling respectively.

- Physical symptoms of sexual abuse

The physical symptoms shown by their sexually abused children who were noticed or not noticed by the parents/caregivers are discussed below:

*** Pregnancy at an early age**

Pregnancy at an early age as a physical symptom of sexual abuse is represented in table 7 below:

Table 7: Pregnancy at an early age

PREGNANCY AT AN EARLY AGE	FREQUENCY	PERCENTAGE
Noticed	36	78%
Not noticed	10	22%
TOTAL	N = 46	100%

The above table indicates that 78% (36) of the parents/caregivers noticed pregnancy at an early age as a physical symptom of sexual abuse, while 22% (10) of the parents/caregivers did not notice it.

Therefore the majority of sexually abused children 78% (36) experienced pregnancy at an early age while the minority 22% (10) did not experience pregnancy at an early age.

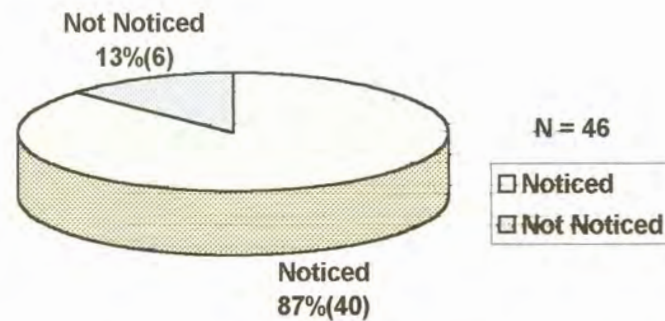
The findings of this study agree with the results of a study conducted by Medicott (1997:79) according to which the majority, of sexually abused children 92% fell pregnant at an early age.

The above findings also agree well with the practical situation of sexually abused children as most of them fall pregnant at an early age, e.g. at 12 years. This is especially occurring to children who conceal the abuse.

*** Bruises of external genitalia**

Bruises of external genitalia as a physical symptom of sexual abuse is represented in figure 10 below:

Figure 10: Bruises of external genitalia



Rosenfeld (1994:29) argues that sexually abused children show bruising and abrasions of the external genitalia which may be seen if the children have been recently abused. This argument is supported by Wooldling (1996:121) who states that bruising of the external genitalia was observed in 72% of sexually abused children in the research conducted in England.

The above findings shows that 87% (40) of the parents/caregivers indicated that they have noticed bruises of the genitalia, while 13% (6) of the parents/caregivers indicated that they did not notice bruises.

Therefore the findings of this study is supported by Rosenfeld (1994:121) and Wooldling's (1996:121) arguments.

In practice bruising of the external genitalia may be noticed in children who have experienced sexual intercourse.

*** Bleeding from external genitalia**

All the parents/caregivers 100% (46) indicated that they did not notice bleeding from the external genitalia as a physical symptom of sexual abuse of their children.

The above finding differ from the findings presented by Rosenfeld (1994:35) that bleeding from the external genitalia is one of the main symptoms of sexual abuse.

The findings of this study may relate to the practical situation of sexually abused children e.g. fondling as there will be no interference with the external genitalia to an extent that bleeding may result.

These findings can also contradict the practical situation of sexually abused children, namely where sexual intercourse have taken place whereby bleeding may occur.

* **Swollen cervix**

All the parents/caregivers 100% (46) indicated that they did not notice swollen cervix as a physical symptom of sexual abuse of their children. This finding correlates with Cauley's (1991:99) view that abnormal cervix is rarely observed among sexually abused children. The above findings contradict the practical situation as the swollen cervix can be noticed through the assistance of visual aids.

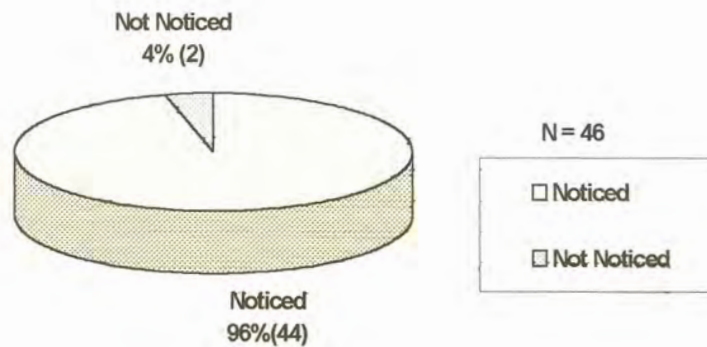
* **Red vagina**

Of the parents/caregivers, 50% (23) indicated that they noticed a red vagina as a physical symptom of sexual abuse of their children while 50 % (23) of the parents/caregivers indicated that they did not notice a red vagina. This finding that 50% (23) of the parents/caregivers indicated that they noticed a red vagina correlates with the finding that forced penetration in sexual abuse can cause damage to the vagina and is helpful in determining the possibility of sexual intercourse (Adams, Ahmed & Phillips, 1998:171).

* **Presence of semen**

Presence of semen as a physical symptom of sexual abuse is represented in figure 11 below:

Figure 11: Presence of semen



The presence of semen has been noticed by 96% (44) of the parents/caregivers and 4% (2) of the parents/caregivers did not notice the presence of semen.

The above findings correlates with Schiff's (1991:17) argument that semen may be found on the child's clothing or any loose material which may be in the clothing. Such clothing must be sent to the forensic laboratories for examination or confirmation. The findings of this study also agree with the practical situation whereby semen can be found in sexual abuse, e.g. sexual intercourse.

*** Torn bloody undergarments**

All the parents/caregivers 100% (46) indicated that they did not notice torn bloody undergarments. The above finding contradicts the findings of the research conducted by Alexander (1991:199) in which it was concluded that torn garments are almost always found at the scene where sexual abuse has occurred. In relation to practice, it can be said that the presence of torn bloody garments are noticed where sexual intercourse or forced penetration have taken place while such garments may not be found in e.g. with fondling.

*** Presence of sexually transmitted diseases**

The presence of sexually transmitted diseases as a physical symptom of sexual abuse is represented in table 8 below:

Table 8: Presence of sexually transmitted diseases

SEXUALLY TRANSMITTED DISEASE	FREQUENCY	PERCENTAGE
Noticed	24	52%
Not noticed	22	48%
TOTAL	N = 46	100%

The above table indicates that 52% (24) of the parents/caregivers noticed sexually transmitted diseases as a physical symptom of sexual abuse, while 48% (22) did not notice a sexually transmitted disease.

This finding correlates with the findings of the Center for Disease Control (1992) as quoted by Mouzakitis (1995:79) whereby it was concluded that a sexually transmitted disease in a child should be considered a sign of sexual abuse, in sexual intercourse. According to the Center for Disease Control (1992) as quoted by Mouzakitis (1995:81), 60% of children who were sexually abused (sexual intercourse) showed signs of sexually transmitted diseases such as gonorrhoea and syphilis.

In relation to practice, the presence of sexually transmitted diseases will depend on whether there was penetration by the abuser who is infected with the sexually transmitted diseases or not.

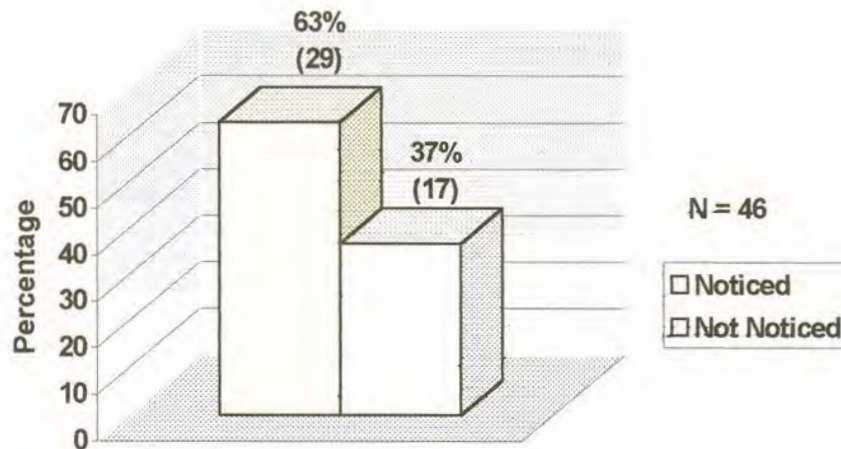
*** Vaginal discharge**

De Jong (1993:131) argues that the prevalence of vaginal discharge in victims of sexual abuse is generally felt to be lower than in adult victims of sexual abuse. This argument of De Jong (1993:131) is supporting the findings of this study as all the parents/caregivers 100%(46) indicated that they did not notice vaginal discharge as a symptom of sexual abuse. The findings of this study can be related to the practical situation whereby vaginal discharge can only be noticed when there was penetration and an infection.

* **Complaints of difficulty in urinating**

Complaints of difficulty in urinating as a physical symptom of sexual abuse are represented in figure 12 below:

Figure 12: Complaints of difficulty in urinating



Elvik & Logan (1992) as quoted by Mouzakitis (1995:117) argue that sexually abused children may present with difficulties in urinating. This difficulty results from pain over injuries of the vulva tissue. The views of Elvik & Logan (1992) as quoted by Mouzakitis (1995:117) correlate well with the findings of this research as 63% (29) of the parents/caregivers indicated that they did notice their children's difficulties in urinating, while 37% (17) did not notice this problem.

In practice the difficulty in urinating can only be noticed in children who have experienced penetration which resulted in damaging the vulva tissue. Therefore the results of this study agrees with the practical situation.

- **Behavioural symptoms of sexually abused children**

The behavioural symptoms shown by their sexually abused children who were noticed or not noticed by the parents/caregivers are discussed below.



* **Poor peer relationships**

Poor peer relationships as a behavioural symptom of sexual abuse is represented in table 9 below:

Table 9: Poor peer relationships

POOR PEER RELATIONSHIPS	FREQUENCY	PERCENTAGE
Noticed	26	56%
Not noticed	20	44%
TOTAL	N = 46	100%

The above table indicates that 56% (26) of the parents/caregivers noticed poor peer relationships, while 44% (20) of the parents/caregivers did not notice poor peer relationships.

The above findings agree with the views of Friedrich, Jawerski & Bengston (1995:73) who argued that sexually abused children may show symptoms associated with a decline in peer relationships. In relation to practice, sexually abused children may be less interested in the activities of their peer group as a result of the trauma of the abuse. The results of this study thus correlate well with the practical situation.

* **Prostitution**

All the parents/caregivers 100% (46) indicated that they did not notice prostitution as a behavioural symptom of sexual abuse. The findings of this study contradict the conclusion made by the research conducted by James & Meyerding (1997:101) whereby it is argued that prostitution is a more frequent sign of sexual abuse.

The results of this study are related to the practical situation as not all sexually abused children can engage in prostitution, especially if counselling is being given to them. It can be said that the children who engage in prostitution after they were sexually abused, choose to do so, i.e. even if they were not abused, they could engage in that behaviour.

*** Comments that the child was assaulted**

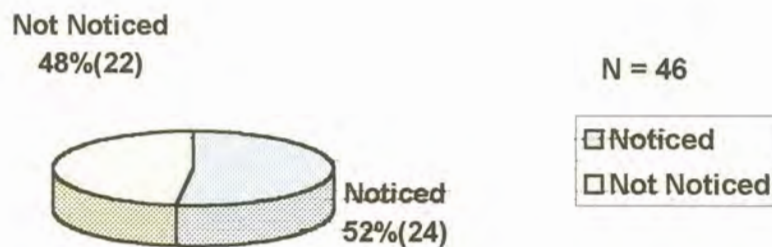
All the parents/caregivers 100% (46) indicated that they did not notice their children's comments of being assaulted. The findings of this study contradict the views of Hibbard, *et al.*, (1991:112) who argued that there is an association between sexual abuse and remarks of being sexually assaulted. According to Hibbard, *et al.*, (1991:112) remarks of being sexually assaulted were reported by 81% of the respondents.

In practice, comments of being assaulted depends on the child's age during the abuse, which can also determine the ability to recall the incidence, e.g. a toddler cannot be able to comment about the abuse, while older children can.

*** Substance abuse**

Substance abuse as a behavioural symptom of sexual abuse is represented in figure 13 below:

Figure 13: Substance abuse

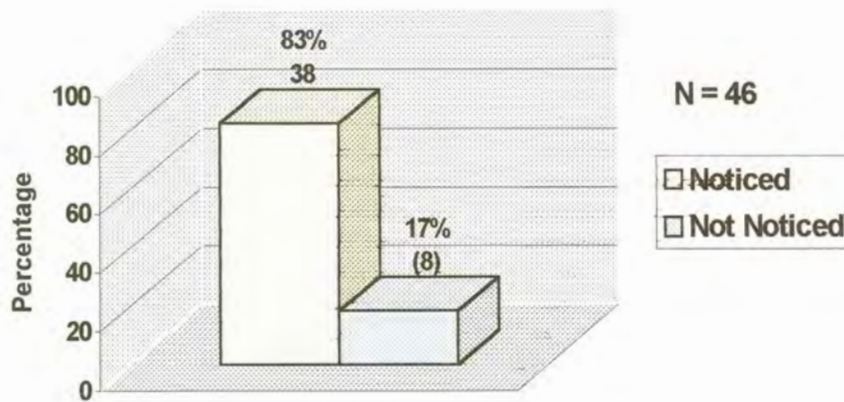


The above figure shows that 52% (24) of the parents/caregivers noticed substance abuse, while 48% (22) of the parents/caregivers did not notice substance abuse. The above findings correlate with the finding that sexually abused children show self-destructive behaviours such as substance abuse (Lindberg & Distad, 1995:79). In practice, sexually abused children can resort to substance abuse as a way of forgetting what happened to them i.e. the abuse. This can aggravate the problem as they may be abused again while being under the influence of such substances.

*** Irregular school attendance**

Irregular school attendance as a behavioural symptom of sexual abuse is represented in figure 14 below:

Figure 14: Irregular school attendance



The above figure shows that 83% (38) of the parents/caregivers noticed irregular school attendance, while 17% (8) of the parents/caregivers did not notice irregular school attendance.

The above findings differ with the findings of the research conducted by Scott & Thoner (1997:137) in which it was found that only 3% of the respondents showed irregular school attendance after being sexually abused.

In practice some children may show irregular school attendance after being sexually abused. This is especially common to those who have been abused at school. Such children may experience problems of seeing their abusers at school and resort to irregular school attendance.

Other children who have been sexually abused may not show irregular school attendance especially when they get counselling or any other help to cope with their situations at school. As a result they will enjoy going to school rather than staying away from school.

*** Engaging in delinquent acts**

All the parents/caregivers 100% (46) indicated that they did not notice any signs of engaging in delinquent acts from their abused children. This finding differ with the views of Lightcap, Kurland & Burgers (1992:211) who stated that sexually abused children present with delinquent behaviours and ultimately land into prison as sexual offenders.

The findings of this study agree with the practical situation, as not all the sexually abused children will show delinquent behaviour. Sexually abused children who receive counselling will not engage in delinquent acts, as they will be helped to deal with the trauma of the abuse. Even those who do not receive counselling who are able to deal with the abuse will not engage in delinquent acts.

*** Sleep disturbance**

Sleep disturbance as a behavioural symptom of sexual abuse is represented in table 10 below:

Table 10: Sleep disturbance

SLEEP DISTURBANCE	FREQUENCY	PERCENTAGE
Noticed	35	76%
Not noticed	11	24%
TOTAL	N = 46	100%

The above table indicates that 76% (35) of the parents/caregivers noticed sleep disturbance, while 24% (11) of the parents/caregivers did not notice sleep disturbance from their abused children. The above findings correlate with the conclusions given by Harrison & Herbert (1995:57) whereby they argue that children who have been sexually abused go through a stage of nightmares and difficulty in sleeping. In practice the older children can experience sleep disturbance.

* **Suicide attempts**

All the parents/caregivers 100% (46) indicated that they did not notice any suicide attempts as signs of sexual abuse. The above finding contradicts the finding by Waller (1991:33) in which he argued that children who have been sexually abused attempt suicide as a way of running away from the abuse. After the attempt, such children may run away from their homes to avoid their problems.

In practice, sexually abused children may attempt suicide as a way of expressing their anger and frustration. Such children do recover from the abuse through the assistance of those around them. The findings of this study therefore contradict the practical situation.

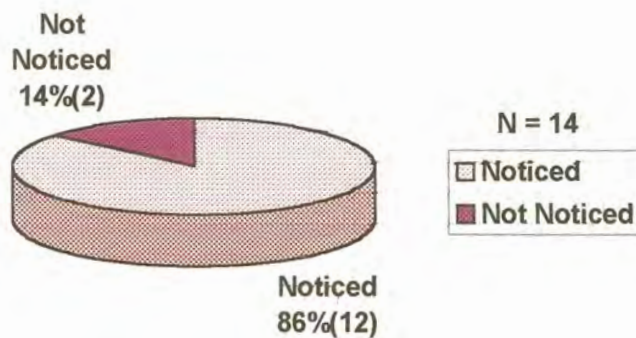
5.4.7.3 Emotional abuse

This section was completed by 9% (14) of the parents/caregivers whose children experienced emotional abuse. These parents/caregivers were requested to indicate the types of emotional abuse which were experienced by their children.

- **Rejection**

Rejection as a type of emotional abuse is represented in figure 15 below:

Figure 15: Rejection



The above figure shows that rejection was noticed by 86% (12) of the parents/caregivers, while 14% (2) of the parents/caregivers did not notice it. The

above findings correlate with the findings of Nicol (1998:77) who found that about 90% of the children he studied have been rejected.

According to Perrin & Perrin (1999:180) rejection of a child occurs when the parents/caregivers use verbal or symbolic acts that express feelings of rejection towards the child. This may be noticed when the parents/caregivers single out a specific child for criticism or punishment, refuses to help the child or routinely reject the child's ideas.

In practice rejection is noticed as a component of both spurning and denying emotional responsiveness such as showing no affection or acknowledging the child's accomplishments.

Therefore if the findings of this study are correlated to the views of Perrin & Perrin (1999:180) and to what is happening in practice. It can be concluded that 86% (12) of the parents/caregivers who noticed rejection from their abused children were able to notice that verbal or symbolic acts that express feelings of rejection towards their children were used, in the form of:

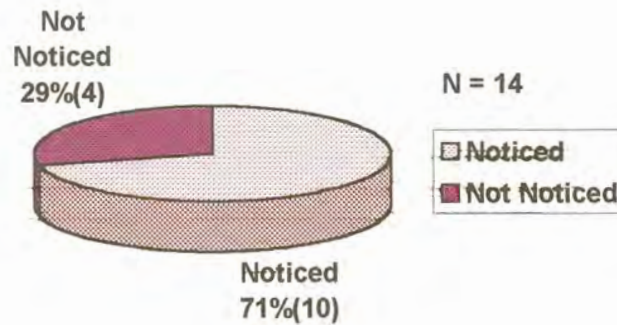
- Singling out a specific child for criticism or punishment,
- refusing to help the child,
- routinely rejecting the child's ideas, and
- showing no affection or acknowledging the child's accomplishments.

Of the parents/caregivers, 14% (2) failed to notice rejection as discussed above.

- **Ignorance**

Ignorance as a type of emotional abuse is represented in figure 16 below:

Figure 16: Ignorance



Of the parents/caregivers 71% (10) noticed ignorance, while 29% (4) did not notice ignorance. According to the findings by McGee & Wolfe (1991:7) ignorance is recognized when the parents/caregivers does not provide the necessary stimulation and responsiveness. Such as when the parents/caregivers are detached and uninvolved with the child, interacts with the child only if it is necessary, fail to express affection, caring and love towards the child and does not look at the child or call the child by name.

In practice ignorance is noticed when the parents/caregivers deprive the child from stimulation whereby the child's emotional and intellectual development is stifled. Thus if we correlate the findings of this study with the views of McGee & Wolfe (1991:7) and what is happening in practice, it can be concluded that 71% (10) of the parents/caregivers were able to notice the following signs which indicated that their children have been ignored:

- Uninvolvement with the child;
- interacting with the child only when it is necessary;
- failure to express affection, care and love towards the child;
- failure to look at the child or call the child by name; and
- depriving the child from stimulation.

Of the parents/caregivers, 29% (4) failed to notice these signs of ignorance.

- Terrorising

All the parents/caregivers 100% (14) indicated that they did not notice any terrorising experienced by their children. This finding contradicts the finding by Crittenden

(1993:192) according to which terrorising was reported by the majority of respondents as a type of emotional abuse.

In practice terrorising is noticed in the form of threats that cause extreme fear and anxiety in a child, e.g. threatening to harm or to abandon him.

- **Corruption**

All the parents/caregivers 100% (14) indicated that they noticed corruption by their children. This finding may be related to the practical situation worldwide whereby the parents/caregivers influence children by modelling, permitting or encouraging anti-social behaviour such as delinquent behaviour, substance or alcohol abuse, and indoctrinating racist values.

- **Isolation**

Isolation as a type of emotional abuse is represented in table 11 below:

Table 11: Isolation

ISOLATION	FREQUENCY	PERCENTAGE
Noticed	10	71%
Not noticed	4	29%
TOTAL	N = 14	100%

The above table indicates that 71% (10) of the parents/caregivers reported that they noticed isolation as experienced by their emotionally abused children, while 29% (4) of the parents/caregivers did not notice isolation.

The above findings correlate with the findings of Brassard, Hart & Hardy (1993:103) who argue that the majority of parents are able to notice when a child is being isolated. According to Brassard, *et al.*, (1993:103) a child is isolated when he is prevented from forming friendships and is made to believe that he is alone in the world.

The above findings are also related to the practical situation in South Africa whereby parents may prevent the child from engaging in normal social activities such as preventing the child from interacting with individuals outside the family or with other relatives. Such parents may be overprotective or too strict to the child.

If the findings of this study are correlated to the findings of Brassard, *et al.*, (1993:103) and to what is happening in practice, it can be concluded that 71% (14) of the parents/caregivers noticed that their children were prevented from forming friendships, made to believe that they are alone in the world and refused to interact with individuals outside the family or relatives.

- **Deprivation**

All the parents/caregivers 100% (14) indicated that they did not notice that their children have been deprived of affection or cognitive stimulation. This finding may be related to the practical situation whereby the majority of black parents, especially those who lack knowledge of child development are unable to notice when their children are experiencing cognitive problems.

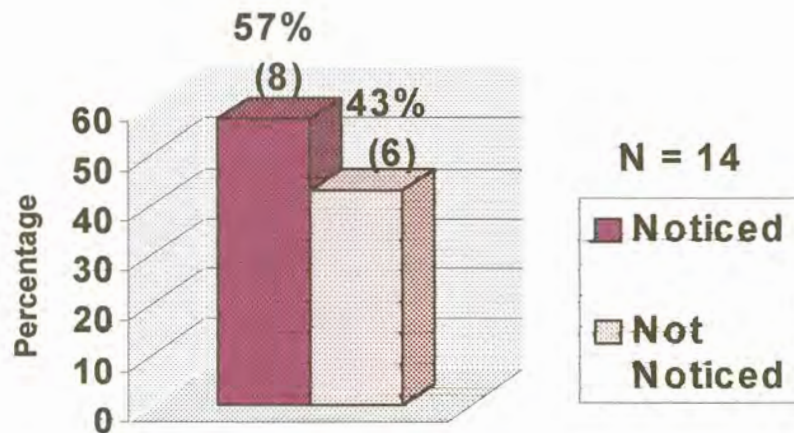
- **Accusations**

All the parents/caregivers 100% (14) indicated that they did not notice accusations as being experienced by their children. This finding contradicts what is happening in practice as the majority of children are being accused of acts that they did not commit, such as theft of money or substance abuse.

- **Insults**

Insults as a type of emotional abuse is represented in figure 17 below:

Figure 17: Insults



The above figure indicates that 57% (8) of the parents/caregivers indicated that they noticed that their children experienced insults, while 43% (6) of the parents/caregivers did not notice insults.

The above findings correlate with the results of the research conducted by Straus (1998:133) whereby the majority of emotionally abused children were insulted, e.g. they were called names. In practice a high percentage of children are being verbally abused by their parents/caregivers. These parents/caregivers may publicly humiliate, constantly criticize and continually yell or swear at their children.

If we relate the above findings with the findings of Straus (1998:133) and what is happening in practice we can conclude that 57% (8) of the parents/caregivers were able to deduce that their children were called names, humiliated, criticized and yelled or sworn at.

5.4.7.4 Neglect

This section was completed by 23% (35) of the parents/caregivers whose children experienced neglect as a type of child abuse. These parents/caregivers were requested to indicate the nature and symptoms of neglect.

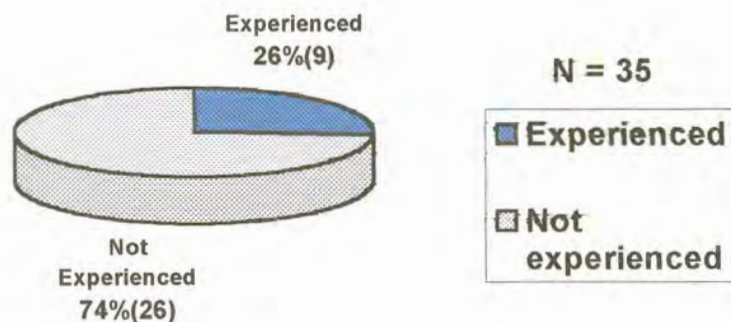
- **The nature of neglect**

The aim of this section was to determine the nature of neglect that were experienced by the children of the parents/caregivers as indicated below:

* **Educational neglect**

Educational neglect as a type of neglect is represented in figure 18 below:

Figure 18: Educational neglect



The above figure indicates that the majority of the parents/caregivers 74% (26) indicated that their children did not experience educational neglect. The minority 26% (9) indicated that their children did experience educational neglect.

The above findings contradict the findings of the study conducted in South Africa by Matube (1994:117) whereby the majority of children were educationally neglected.

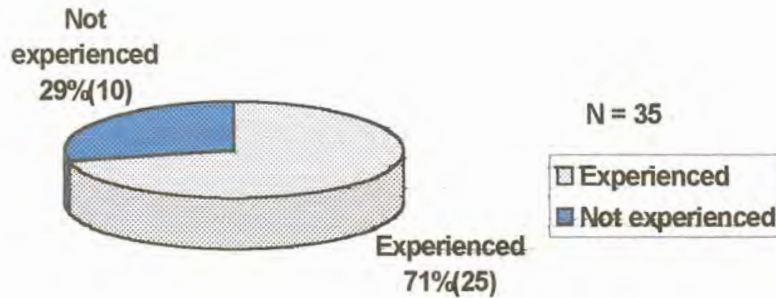
The findings of this study also contradict the practical situation of some of the black children generally, as they are experiencing educational neglect due to the parents/caregivers lack of interest as follows:

- Children of mandatory age are not enrolled in school;
- frequent and chronic truancy are permitted; and
- inattention to special educational needs is paid.

*** Lack of nutrition**

Lack of nutrition as a type of neglect is represented in figure 19 below:

Figure 19: Lack of nutrition



The above figure shows that the majority of the parents/caregivers 71% (25) indicated that their children did experience lack of nutrition, while 29% (10) of the parents/caregivers indicated that their children did not experience lack of nutrition.

The above findings correlate with the results of the research by Sovinski (1997:321) whereby the majority of children experienced lack of nutrition. According to Sovinski (1997:321) such children were not provided with a diet of quality nutritional balance.

The findings of this study also correlate with the practical situation whereby most children are experiencing lack of nutrition in which they get insufficient calories, meals do not represent the basic food groups and food is stale or spoiled. However it also sometimes happens in practice that the parents/caregivers do not have any food to give their children due to poverty, or lack of maintenance from the other parents/caregivers.

*** Lack of love**

All the parents/caregivers 100% (14) indicated that their children did not experience lack of love. Blumenthal (1994:31) argues that the lack of love is shown by self-stimulatory behaviours such as head banging, rocking, rumination, educational problems and problems of school attendance.

In practice, neglected children are seldom offered the love and affection of a caring relationship, which is one of the children's basic needs. If the results of this study are correlated with the views of Blumenthal (1994:31) and the practical situation, it can be concluded that all the neglected children did not experience lack of love as shown by self-stimulatory behaviour and lack of love and attention of a caring relationship. This means that all the children were shown the necessary love to satisfy their basic need of being loved.

*** Lack of protection**

All the parents/caregivers 100% (14) indicated that their children did not experience lack of protection. The findings of this study contradict the results of the study conducted by Blumenthal (1994:31) whereby 77% of the children reported to have lacked protection, e.g. they were predisposed to accidents by lack of attention to their safety and the absence of common protective devices such as fire guards. In practice, the majority of young children may experience lack of protection whereby parents/caregivers fail to keep to the standards of housekeeping care.

*** Lack of supervision**

Lack of supervision as a type of neglect is represented in table 12 below:

Table 12: Lack of supervision

LACK OF SUPERVISION	FREQUENCY	PERCENTAGE
Experienced	10	29%
Not experienced	25	71%
TOTAL	N = 35	100%

Of the parents/caregivers 71% (25) indicated that their children did not experience lack of supervision, while 29% (10) indicated that their children experienced lack of supervision.

According to Molosankwe (1993:123) lack of supervision is related to the parents/caregivers knowledge of the child's development. Parents/caregivers who have knowledge of their child's development provide supervision to their children while those who lack that knowledge do not provide it. However in practice lack of supervision is not related to the parents/caregivers knowledge of child development as not all the parents/caregivers who supervise their children do have knowledge of child development. Child supervision is part of child care which can be exercised by each and every parent/caregiver regardless of whether that parent/caregiver has knowledge of child development or not.

* **Inadequate shelter**

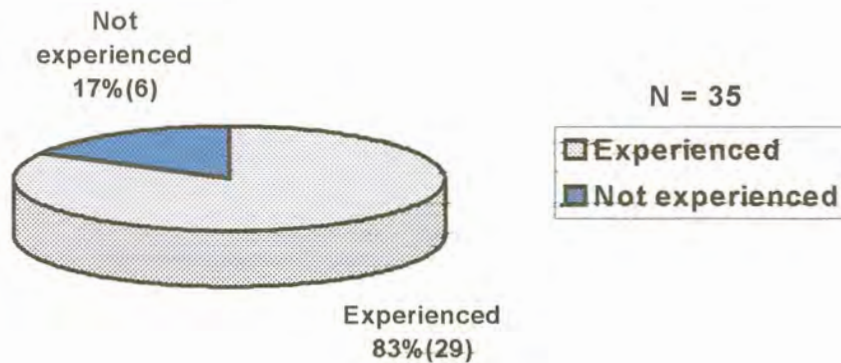
All the parents/caregivers 100% (14) indicated that their children experienced inadequate shelter. The findings of this study correlate with the findings presented by Wang & Daro (1998:211) whereby the majority of children who were studied, reported having been exposed to inadequate shelter in the form of being housed in homes that are overcrowded.

The above findings also correlate well with the practical situation of most of black children in South Africa who are exposed to inadequate shelter. The parents/caregivers do not provide a stable and permanent home; the children are homeless, live in overcrowded homes and are thrown out of the homes to the streets to be street kids.

* **Lack of clothing**

Lack of clothing as a type of neglect is represented in figure 20 below:

Figure 20: Lack of clothing



The most important findings as shown by the above figure are as follows:

Of the parents/caregivers, 83% (29) indicated that their children did experience lack of clothing, while 17% (6) of the parents/caregivers indicated that their children did not experience lack of clothing.

The above findings correlate with the findings of Crouch & Milner (1993:67) according to which lack of clothing was found to be a serious problem among children who were studied. It may happen in practice that children lack clothing because of the parents/caregivers inability to provide such clothing while on the other hand, it may be because of the parent's/caregiver's irresponsibility's towards their children's clothes whereby such children wear dirty clothing. Lack of clothing can also be attributed to lack of maintenance by the other parents/caregivers.

*** Medical neglect**

Medical neglect as a type of neglect is represented in table 13 below:

Table 13: Medical neglect

MEDICAL NEGLECT	FREQUENCY	PERCENTAGE
Experienced	29	83%
Not experienced	6	17%
TOTAL	N = 35	100%

The above table shows that 83% (29) of the parents/caregivers indicated that their children experienced medical neglect, while 17% (6) indicated that their children did not experience medical neglect.

The findings of this study correlate well with the findings of the study conducted by Hadeed & Siegel (1999:29) according to which the majority of children who were studied were medically neglected. In practice it happens that children are medically neglected such as when parents/caregivers fail to obtain a child's immunizations, do not attend to dental needs and psychological treatments.

If the findings of this study are correlated to the findings of Hadeed & Siegel (1999:29) and to what is happening in practice, it can be concluded that 83% (29) of the parents/caregivers reported that their children experienced medical neglect. They are those parents/caregivers who do not meet the child's health needs, by failing to obtain the child's immunization, do not attend to the dental needs and psychological treatment of their children.

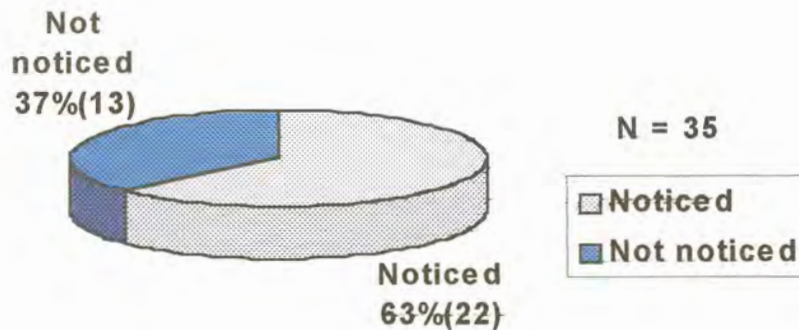
- **The physical symptoms of neglect**

The aim of this section was to determine the physical symptoms that were noticed by the parents/caregivers. These parents/caregivers were requested to indicate whether they noticed or did not notice the symptoms as indicated below:

* **Abandonment**

Abandonment as a physical symptom of neglect is represented in figure 21 below:

Figure 21: Abandonment



Of the parents/caregivers 63% (22) indicated that they noticed abandonment as a symptom of neglect, while 37% (13) of the parents/caregivers indicated that they did not notice abandonment.

The above findings correlate with the findings of Minty & Patterson (1994:93) according to which the majority of respondents indicated abandonment as being a symptom of neglect. According to Minty & Patterson (1994:93) an abandoned child is the one who is physically deserted e.g. thrown in a pit.

The above findings also correlate with the practical situation in South Africa whereby some children, especially newborns, are abandoned in hospitals after birth. Thus, if the findings of this study are correlated to the findings of Minty & Patterson (1994:93) and to what is happening in practice, it can be concluded that:

Of the parents/caregivers, 63% (22) noticed physical desertion and abandonment of newborns in hospitals.

Of the parents/caregivers, 37% (13) did not notice physical desertion and abandonment.

*** Poor personal hygiene**

All the parents/caregivers 100% (14) indicated that they did not notice poor personal hygiene as a symptom of neglect.

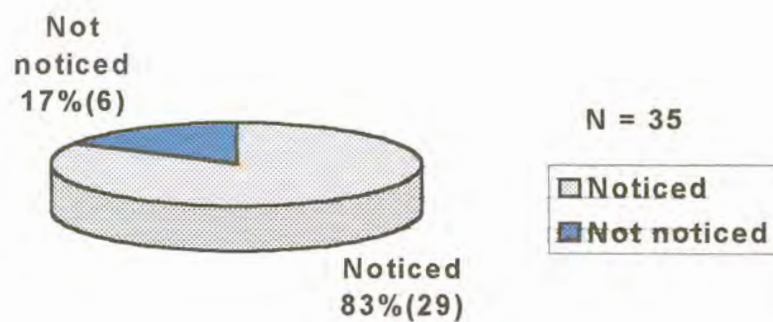
This finding contradicts the idea of Myers (1992:81) according to which it is found that poor personal hygiene in the form of infrequent bathing, poor dental hygiene and poor sleeping arrangements for children were reported by the majority of the respondents as being symptoms of neglect.

The above findings also contradict the practical situation as most of the children who are neglected show signs of poor personal hygiene.

* **Inadequate clothing**

Inadequate clothing as a physical symptom of neglect is represented in figure 22 below:

Figure 22: Inadequate clothing



The above figure indicates that the majority of the parents/caregivers 83%(29) indicated that they noticed inadequate clothing, while the minority 17% (6) indicated that they did not notice inadequate clothing. According to Ney (1994:123) the child who is inadequately dressed is the one who is not appropriately dressed according to the weather and does not change clothes regularly.

In practice it happens that children are not adequately clothed due to the parents/caregivers economic position such as being without any income, and it also happens due to the parents/caregivers carelessness.

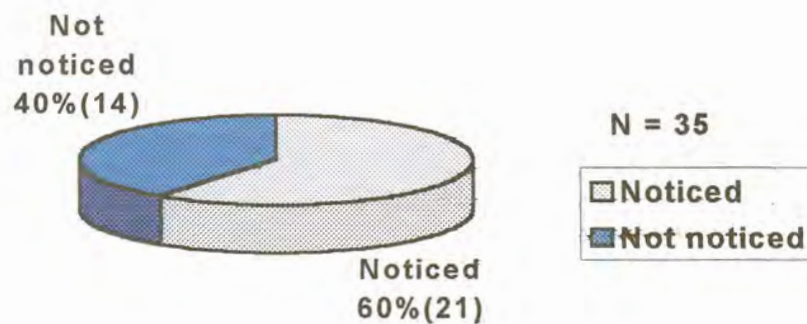
Therefore if the findings of this study are correlated with the findings of Ney (1994:123) and the practical situation, it can be concluded that 83% (29)

parents/caregivers noticed that their children were not appropriately dressed for the weather, did not change clothes regularly and were not adequately clothed due to different circumstances such as a lack of income to buy clothes or carelessness.

* **Absence of medical care**

Absence of medical care as a physical symptom of neglect is represented in figure 23 below:

Figure 23: Absence of medical care



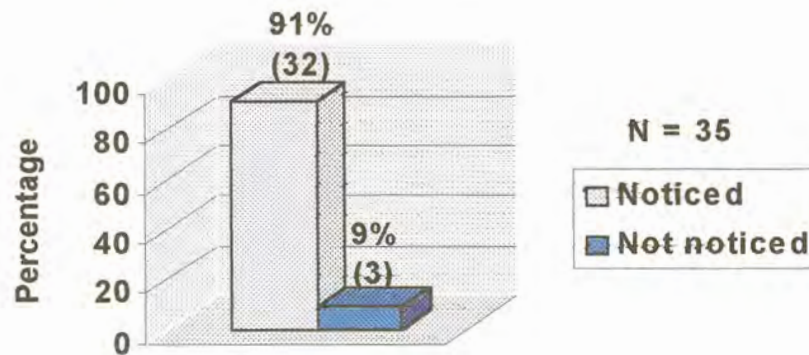
The above figure indicates that the majority of the parents/caregivers 60% (21) noticed the absence of medical care, while the minority of the parents/caregivers 40% (14) did not notice the absence of medical care.

The above findings are related to the views of Birchall & Hallet (1995:211) according to which failure to provide medical attention when the child is not well is one of the main symptoms of neglect. It happens in practice that parents/caregivers fail to provide medical attention to the child when the child is not well, e.g. the parents/caregivers may not report medical problems in their children such as recurring diarrhoea or infected ears.

* **Being hungry**

Being hungry as a physical symptom of neglect is represented in figure 24 below:

Figure 24: Being hungry



According to Stevenson (1998:139) being hungry is one of the symptoms of neglect. The above figure indicates that 91% (32) of the parents/caregivers indicated that they noticed that their children were hungry, while 9% (3) indicated that they did not notice their children being hungry.

Therefore Stevenson's (1998:139) assertion is supported by the findings of this study as indicated by the majority of respondents. In practice children who are hungry roam the streets and parks with the intention of getting food.

- **Behavioural symptoms of neglect**

The aim of this section was to determine behavioural symptoms that were noticed by the parents/caregivers. These parents/caregivers were requested to indicate whether they noticed or did not notice the symptoms as indicated below:

*** Falling asleep at school**

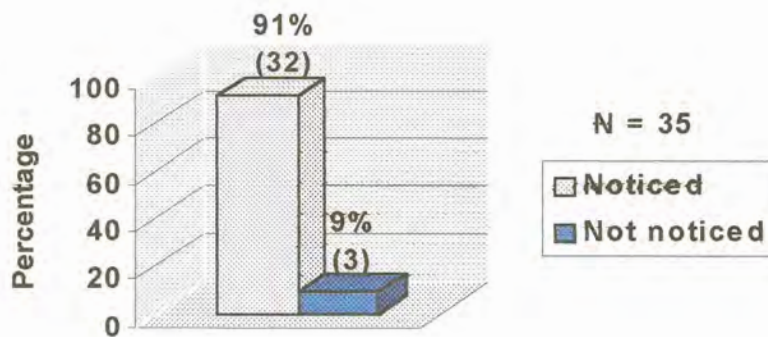
All the parents/caregivers 100% (14) indicated that from the information of the children's teachers their children did not fall asleep at school. The findings of this study contradict the results of the study by Stevenson (1998:144) according to which neglected children were reported to fall asleep at school. This symptom of falling asleep was also manifested in the children's school performance in which they performed very poor.

In practice, neglected children may fall asleep at school as a result of different circumstances, e.g. being hungry or sick. The above finding contradicts the practical situation.

*** Begging for food**

Begging for food as a behavioural symptom of neglect is represented in figure 25 below:

Figure 25: Begging for food



According to Robinson (1996:93) begging for food is one of the most important symptoms indicating child neglect. The above figure indicates that 91% (32) of the parents/caregivers noticed their children begging for food as a symptom of neglect. Of the parents/caregivers, 9% (3) did not notice their children begging for food.

Therefore Robinson's (1996:93) assertion is supported by the finding of this study as indicated by the majority of respondents.

In practice children can beg for food as a result of neglect, e.g. when they are not given enough food.

*** Irregular school attendance**

Irregular school attendance as a behavioural symptom of neglect is represented in table 14 below:

Table 14: Irregular school attendance

IRREGULAR SCHOOL ATTENDANCE	FREQUENCY	PERCENTAGE
Noticed	18	51%
Not noticed	17	49%
TOTAL	N = 35	100%

The above table indicates that the majority of parents/caregivers, namely 51% (18) noticed irregular school attendance, while the minority of parents/caregivers 49% (17) did not notice it.

The above findings correlate with the findings of Straus (1998:93) whereby the majority of the children were found to attend school irregularly as a sign of being neglected. It happens in practice that neglected children show frequent and chronic truancy as manifestations of neglect.

*** Use of drugs**

All the parents/caregivers 100% (35) indicated that they did not notice their children using drugs. The findings of this study contradict the views of Scott & Thoner (1991:98) who argued that neglected children show self-destructive behaviour such as drug abuse.

However in practice the use of drugs is not related to neglect, as not only children who are neglected use drugs. The use of drugs may be related to various factors such as friendship influence and/or missocialization.

*** Engaging in delinquent acts**

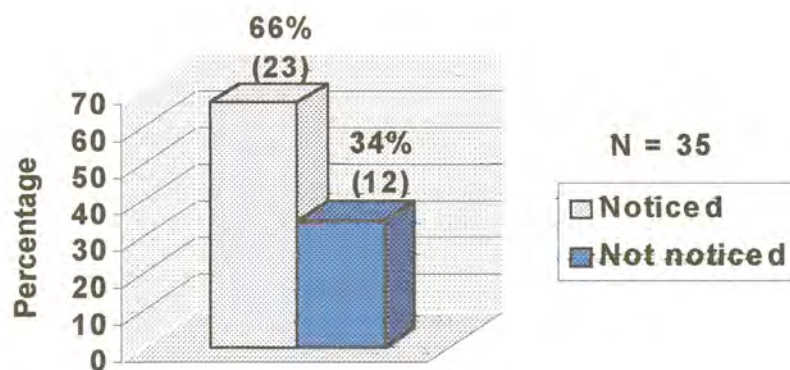
All the parents/caregivers 100% (35) indicated that they did not notice their children engaging in delinquent acts as a symptom of neglect. According to Stevenson (1998:166) neglect encourages the children to engage in illegal behaviours such as stealing. Practically neglect, e.g. the lack of nutrition can foster delinquency as the child can steal money with the intention of buying food.

Therefore the findings of this study contradict the views of Stevenson (1998:166) and the practical situation as indicated above.

*** Failing to thrive as an infant**

Failing to thrive as an infant as a behavioural symptom of neglect is represented in figure 26 below:

Figure 26: Failing to thrive as an infant



The majority of the parents/caregivers 66% (23) noticed failure to thrive as an infant as a behavioural symptom of neglect, compared to the minority 34% (12) of the parents/caregivers who did not notice failure to thrive as an infant.

The above findings correlate with the findings of Blumenthal (1994:32) whereby the majority of the children below three years experienced the problem of failure to thrive due to receiving inadequate calories. In practice, most of the infants may show this symptoms as a result of the parents/caregivers ignorance, misguided views about the quantity or type of food required by children or faulty feeding techniques or preparation of formulas.

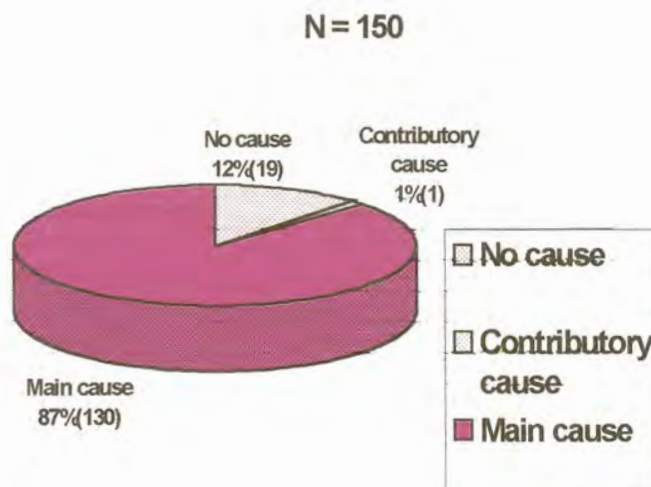
5.4.8 The causes of child abuse

This section was answered by all the parents/caregivers, namely: 150 respondents. The aim of this section was to determine the causes of child abuse. These parents/caregivers were requested to indicate the factors, which they view as being the main cause, contributory cause and no cause of child abuse as indicated below:

5.4.8.1 Lack of mothering imprints

Lack of mothering imprints as a cause of child abuse is represented in figure 27 below:

Figure 27: Lack of mothering imprints



The most significant results from the above figure are as follows: The lack of mothering imprints has been found to be the main cause of child abuse in 87% (130) of the parents/caregivers, in 1% (1) lack of mothering imprints is a contributory cause

and in 12% (19) mothering imprints was not indicated as being a cause of child abuse.

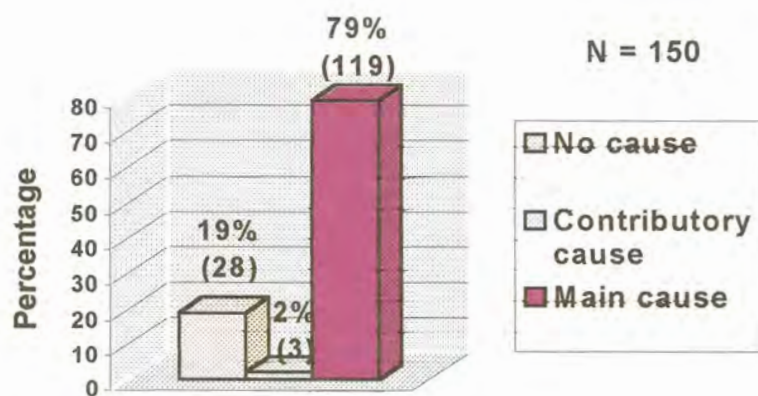
The above findings are related to the argument by Justice & Justice (1993:25) according to which these authors saw the lack of mothering imprints as the basic dynamic of the potential to abuse children. According to Justice & Justice (1993:25) lack of mothering imprints is said to be experienced by a person who has been reared in a way that precluded the experience of being mothered and nurtured. As parents they cannot mother and nurture their own children, instead they abuse them.

The finding that 12% (19) of the parents/caregivers reported that lack of mothering imprints has not been a cause of child abuse may be related to the practical situation whereby parents/caregivers have adequate psychological understanding of their parental roles and do not abuse their children. These parents/caregivers have the ability to nurture and mother their children.

5.4.8.2 Excessive expectations towards the child

Excessive expectations towards the child as a cause of child abuse is represented in figure 28 below:

Figure 28: Excessive expectations towards the child



The above figure indicates that excessive expectations towards the child have been the main cause of child abuse in 79% (119) of the parents/caregivers, 2%(3) of the parents/caregivers indicated that excessive expectations towards the child have been the contributory cause and 19% (28) of the parents/caregivers indicated that excessive expectations have been no cause of child abuse.

The above findings of 79% (119) of excessive expectations towards the child as a main cause of child abuse and the 2% (3) of being a contributory factor correlate with the findings of Blumenthal (1994:7), according to which parents/caregivers who abuse children have high expectations towards these children. Such expectations may be inconsistent with the developmental stages of the children.

In practice it also happens that parents/caregivers may have unrealistic expectations and negative perceptions regarding their children. These parents/caregivers often regard their children as being bad, slow or difficult to discipline. They may view the child's behaviour as it is intended to annoy them. A parent/caregiver may expect a child to be toilet trained at an unreasonable early age and may also interpret the child's continual lack of training as deliberate misbehaviour. The parent/caregiver may abuse the child physically by burning the child and/or confining the child to the toilet for longer periods.

The finding that 19% (28) of parents/caregivers who indicated that excessive expectations towards the child was not a cause of child abuse correlates with the situation of parents/caregivers who have excessive expectations towards their children but do not abuse them. This may be due to the point that they have knowledge of how to deal positively with a child who does not meet their excessive expectations rather than abusing the child.

5.4.8.3 Parental role reversal

Parental role reversal as a cause of child abuse is represented in table 15 below:



Table 15: Parental role reversal

PARENTAL ROLE REVERSAL	FREQUENCY	PERCENTAGE
Main cause	126	84%
Contributory cause	4	3%
No cause	20	13%
TOTAL	N = 150	100%

The above table indicates that parental role reversal is found to be the main cause of child abuse in 84% (126) of the parents/caregivers, in 3% (4) of the parents/caregivers a contributory cause and in 13% (20) of the parents/caregivers no cause of child abuse.

The above findings that parental role reversal is in 84% (126) of the parents/caregivers a main cause and in 3% (4) a contributory cause is related to the argument of Schroeder (1996:88), according to which parents/caregivers who reverse their roles with those of children almost always abuse these children. These parents/caregivers expect the child to act like adults and give the parents/caregivers love and care rather than vice-versa.

Helfer (1997:43) adds to Schroeder's (1996:88) argument by stressing that the parental role reversal determines child abuse and when supporting factors such as illegitimacy, unwanted children or handicapped children are present, these children become at a very high risk of abuse.

This can also be correlated to the practical lives of most parents/caregivers who reverse roles with those of their children due to various reasons such as being an unwanted child. Such parents/caregivers may transfer the role of childcare to the child and if the child is unable to fulfil this role, the child may be abused.

5.4.8.4 Scapegoating

Scapegoating as a cause of child abuse is represented in table 16 below:

Table 16: Scapegoating

SCAPEGOATING	FREQUENCY	PERCENTAGE
Main cause	128	85%
Contributory cause	7	5%
No cause	15	10%
TOTAL	N = 150	100%

The majority of the parents/caregivers 85% (128) indicated that scapegoating is a main cause of child abuse, 5% (7) of the parents/caregivers indicated that scapegoating is a contributory cause and 10% (15) of the parents/caregivers indicated that it is no cause.

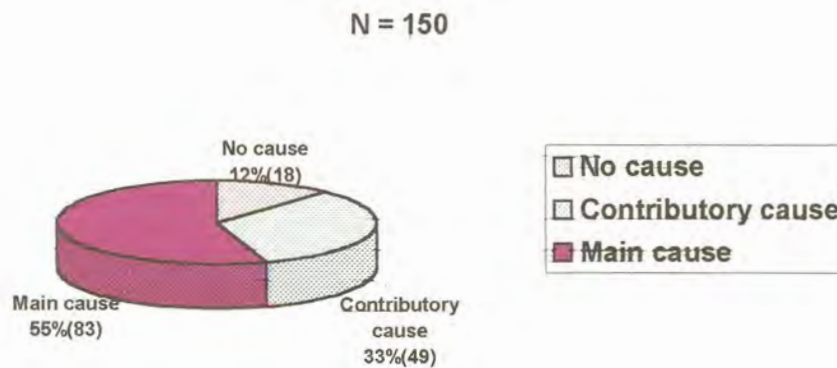
The above findings that scapegoating is in 85% (128) of the parents/caregivers a main cause and in 5% (7) a contributory cause is related to the views of Justice & Justice (1993:29). These authors argued that scapegoating is another behaviour which is always cited as resulting in child abuse.

In practice, scapegoating does cause child abuse in situations where the parents take out their frustrations on a child. It can also happen in practice that scapegoating is not related to child abuse, e.g. in situations where the parents/caregivers are able to handle their frustrations without involving their children. This practical situation can therefore be supporting the finding that 10% (15) of the parents/caregivers reported scapegoating as no cause of child abuse.

5.4.8.5 Immature parents

Immature parents as a cause of child abuse is represented in figure 29 below:

Figure 29: Immature parents



Of the parents/caregivers 55% (83) indicated the immaturity of parents/caregivers as a main cause of child abuse, and 33% (49) of the parents/caregivers indicated the immaturity of parents/caregivers as a contributory cause while 12% (18) indicated immaturity as no cause.

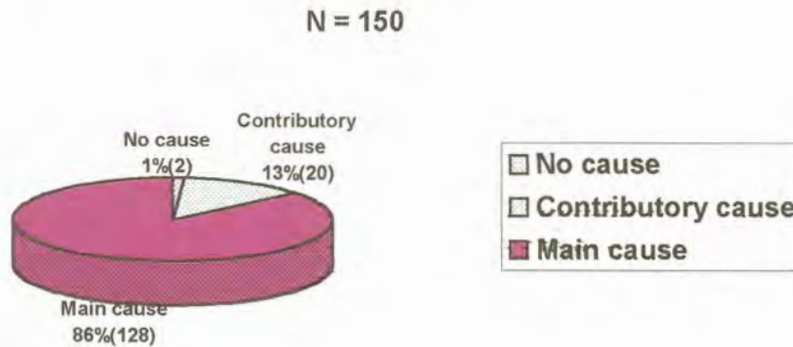
The above findings correlate with what Gelles (1993:111) found whereby abusing parents/caregivers were found to have personality deficits ranging from immaturity to poor emotional control. In practice, parents/caregivers who did not develop the abilities to love are immature and can abuse their children. They may also have learned to abuse their children if they themselves were abused as children.

The finding that 12%(18) of the parents/caregivers indicated immaturity as no cause of child abuse may be related to the practical situation in which immature parents/caregivers accept their immaturity and do not permit it to have an impact on their children. These parents/caregivers may also involve themselves in programs that may help them to cope well with their children instead of abusing them.

5.4.8.6 Mental illness

Mental illness as a cause of child abuse is represented in figure 30 below:

Figure 30: Mental illness



Mental illness have been found to be the main cause of child abuse in 86% (128) of the parents/caregivers, 13% (20) of the parents/caregivers indicated mental illness as a contributory cause and 1% (2) of the parents/caregivers did not indicate mental illness as a cause.

The above findings respectively contradict the idea of Justice & Justice (1993:31) according to which the overwhelming majority of parents/caregivers who abuse their children are not mentally ill.

In relation to the practical situation, mental illness does cause child abuse either as a main or contributory cause. This is based on the view that the majority of abusing parents/caregivers may be psychotic, neurotic or experience organic brain dysfunctions that are included in the psychiatric definition of mental illness.

Therefore the findings of this study that mental illness is the main cause and contributory cause of child abuse as indicated by the parents/caregivers is supported by the practical situation of most of the cases of child abuse.

5.4.8.7 Lack of social skills

All the parents/caregivers 100% (150) indicated that the lack of social skills was not a cause of child abuse. This finding differ with the views of Sedlak (1996:91) according to which failure of parents/caregivers to acquire social skills to adequately parent

their children is related to the occurrence of child abuse. Such parents/caregivers are seen as lacking the social skills as to gain little satisfaction from their roles as parents/caregivers.

In practice lack of social skills does cause child abuse either as the main or contributory cause when parents/caregivers are frequently ignorant of child development and expect behaviours which are too advanced from the child in relation to his developmental stage. This practical situation is therefore supported by the findings of this study.

5.4.8.8 Lack of child rearing skills

All the parents/caregivers 100% (150) indicated the lack of child rearing skills as a main cause of child abuse. This finding is related to the views of Cantwell (1993:67) who pointed out that child abuse results from the parent's/caregiver's lack of knowledge of child rearing skills which can be indicated by the lack of knowledge when the parents/caregivers are:

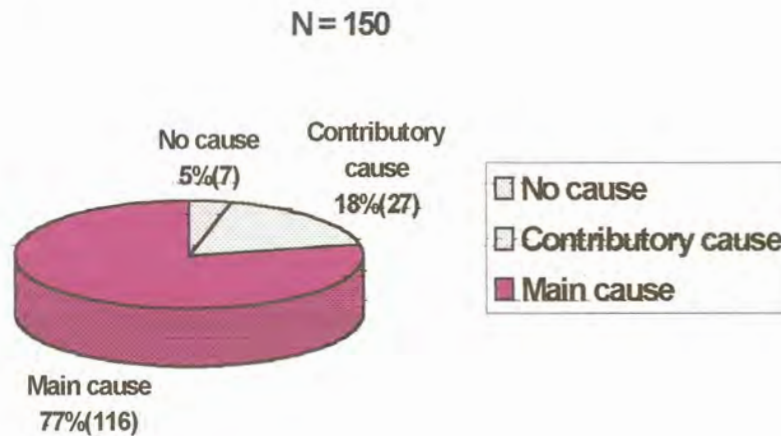
Unaware of the developmental stages of children; and
failing to learn and understand the children's needs and that these children have their own rights.

These findings are also related to the practical situation as most of the parents/caregivers who abuse their children, especially emotionally are those who lack skills of rearing their children. This is clearly reflected in the social worker's caseloads of child abuse.

5.4.8.9 Poverty

Poverty as a cause of child abuse is represented in figure 31 below:

Figure 31: Poverty



Poverty was indicated by the majority of parents/caregivers 77% (116) as being the main cause of child abuse and by 18% (27) of the parents/caregivers as being a contributory cause. The minority of the parents/caregivers 5% (7) indicated poverty as no cause of child abuse.

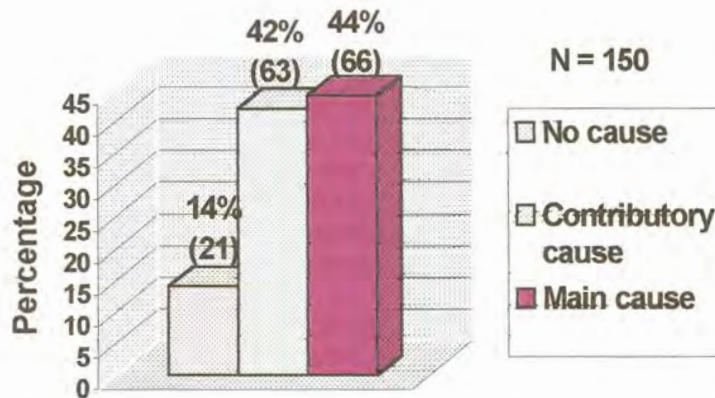
The above findings correlate with the findings of Perrin & Perrin (1999:73) according to which poverty and child abuse were found to be having a causal relationship. It was found that there were high incidences of child abuse amongst the poor (Perrin & Perrin, 1999:73). This finding is supported by Mouzakitis (1995:79) who argued that the vast fatalities of children occur amongst the poor.

However in practice, child abuse can occur in families, who do not experience poverty. This is based on the view that poverty and child abuse are not related as there are other casual factors except poverty, e.g. a well to do parent can abuse the child due to occupational stress. Therefore the finding of this study that only 5% (7) of the parents/caregivers indicated poverty as no cause of child abuse, is supported by the practical situation of most of the child abuse cases.

5.4.8.10 Poor education

Poor education as a cause of child abuse is represented in figure 32 below:

Figure 32: Poor education



Of the parents/caregivers, 44% (66) indicated poor education as the main cause, 42% (63) as a contributory cause, while 14% (21) indicated it as no cause.

The above findings correlate with the views of Blumenthal (1994:8) who stated that most of the abusers are educationally delayed, have little concept of child development and lack knowledge of the basic requirements of normal child care.

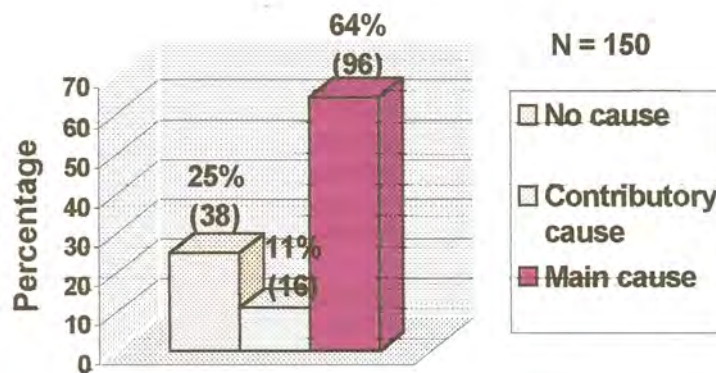
In practice it also happens that parents/caregivers who have poor education, e.g. on the stages of child development abuse their children by having excessive expectations towards the child that do not correlate with the child's developmental stage. However, in practice it also happens that poor education in general does not cause child abuse. Even illiterate parents do not abuse their children, while highly educated parents/caregivers such as teachers, abuse children.

Therefore the findings of this study that the minority of parents/caregivers 14% (21) indicated poor education as not being a cause of child abuse is supported by the practical situation of parents/caregivers who have poor education but do not abuse their children.

5.4.8.11 Occupational stress

Occupational stress as a cause of child abuse is represented in figure 33 below:

Figure 33: Occupational stress



Occupational stress has been indicated by 64% (96) of the parents/caregivers as the main cause of child abuse, by 11% (16) of the parents/caregivers as a contributory cause, while 25% (38) of the parents/caregivers indicated occupational stress as no cause of child abuse.

The findings of this study are related to the results of the study conducted by Fontana (1991:99) whereby it was found that there is a significant relationship between occupational stress and child abuse. Fontana (1991:99) also argued that as job stress increases, so does child abuse.

In practice, occupational stress can lead to child abuse. This is based on the view that occupational stress contributes to the uninhibited discharge of aggressive and destructive impulses towards the child whereby minor child misbehaviour may be viewed as a challenge against the parent and thus trigger abuse.

However, it also happens in practice that parents/caregivers who experience occupational stress do not abuse their children because they are able to handle it positively without it impacting on their children. Therefore the finding of this study that occupational stress is not a cause of child abuse as reported by 25% (38) of the respondents is supported by this practical situation of parents/caregivers who are able to handle their job stress.

5.4.8.12 Inferior health status of the child

All the parents/caregivers 100% (150) indicated that the inferior health status of a child was not a cause of child abuse. This finding contradicts what Mouzakitis (1995:79) indicated about the inferior health status of children and child abuse. According to Mouzakitis (1995:79) children whose health is inferior are at a risk of child abuse, they are more likely to receive poor care than healthy children. However, Justice & Justice (1993:37) argued that the targeting of the child with an inferior health status for abuse depends on the cultural appraisal of the child as discussed below:

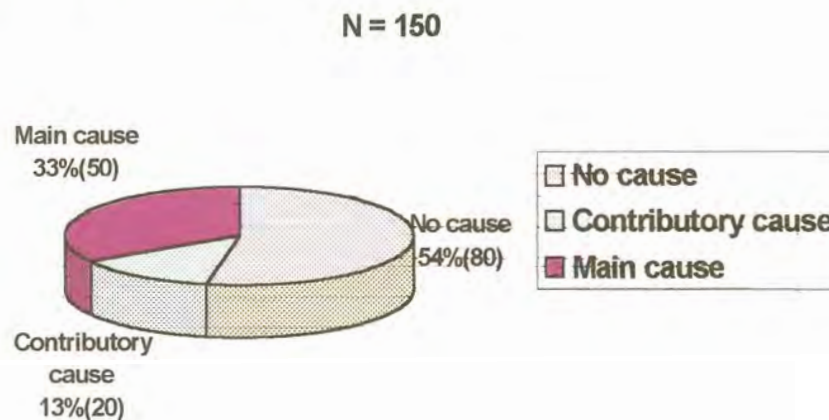
In societies where the child with an inferior health status is seen as an indication of a supernatural gift, the child is awarded special status and care; and in a society where the child is seen as a burden or non-human, that child is not cared for adequately and may be abused.

In practice, the treatment of a child with an inferior health status depends on whether the parents/caregivers accept the child or not. When the child is accepted, the child will be cared for properly, while when the child is not accepted the child will be seen as a burden and may be abused, e.g. a physically disabled child may be locked in a room for a whole day, indicating neglect.

5.4.8.13 Overcrowding

Overcrowding as a cause of child abuse is represented in figure 34 below:

Figure 34: Overcrowding



According to Justice & Justice (1993:82) the conditions in the home play a role in the occurrence of child abuse. Child abuse is more likely to occur in a crowded home that is inadequate to house all of its members, e.g. where about 25 people are housed in a four roomed house. The views of Justice & Justice (1993:82) are supported by the minority of parents/caregivers as indicated by the above figure whereby 33% (50) and 13% (20) of the parents/caregivers respectively reported overcrowding to have been a main and contributory cause of child abuse.

The majority of parents/caregivers namely 54% (80) indicated overcrowding as no cause of child abuse. This finding therefore contradicts the views of Justice & Justice (1993:82) as discussed above.

In practice overcrowding may be strongly associated with child abuse. This is based on e.g. the inadequate sleeping space in overcrowded homes whereby parents may share a bed with children who are still wetting their bed. This child may wet the bed when sleeping with the parent/caregiver after which the parent/caregiver may be angry and abuse the child, e.g. physically by punishing him or may lock the child out of the house during the night; as an indication of neglect.

5.4.8.14 Alcohol abuse

Alcohol abuse as a cause of child abuse is represented in table 17 below:

Table 17: Alcohol abuse

ALCOHOL ABUSE	FREQUENCY	PERCENTAGE
Main cause	87	58%
Contributory cause	45	30%
No cause	18	12%
TOTAL	N = 150	100%

Alcohol abuse is indicated by the majority of parents/caregivers 58% (87) as being the main cause of child abuse and by 30% (45) as a contributory cause, while the minority 12% (18) indicated alcohol abuse as no cause. The above findings that

alcohol abuse is the main and contributory cause of child abuse as indicated above, may be related to the findings of Chaffin, Kellerner & Hollenberg (1996:113) which indicated that alcohol abuse plays a significant role in the onset as well as in the continuation of child abuse.

Alcohol abuse does contribute to child abuse in practice, e.g. a large number of the social worker's case load consists of cases of child abuse caused by alcohol abuse. A large number of cases reported for criminal charges are also due to alcohol abuse. Alcohol abuse therefore changes a person's behaviour and attitude to the extent that he/she engages in unplanned actions that may have negative effects on the children.

However, it also happens in practice that parents/caregivers who abuse alcohol do not abuse their children. This can be parents/caregivers who do not allow their misbehaviours, e.g. of abusing alcohol to have an impact on their children. The finding of this study that 12% (18) of the parents/caregivers indicated alcohol abuse as no cause of child abuse is therefore supported by this practical situation.

5.4.8.15 Drug abuse

Drug abuse as a cause of child abuse is represented in table 18 below:

Table 18: Drug abuse

DRUG ABUSE	FREQUENCY	PERCENTAGE
Main cause	60	40%
Contributory cause	50	33%
No cause	40	27%
TOTAL	N = 150	100%

Drug abuse is indicated by the majority of parents/caregivers 40% (60) as being the main cause of child abuse and by 33% (50) as a contributory cause while the minority 27% (40) indicated drug abuse as no cause.

The above findings may be related to the views of Milner & Dopke (1997:72) who argued that parents/caregivers who abuse drugs such as cocaine become typical child abusers as they are unable to control their anger, they are hostile, have low frustration tolerance and low self-esteem.

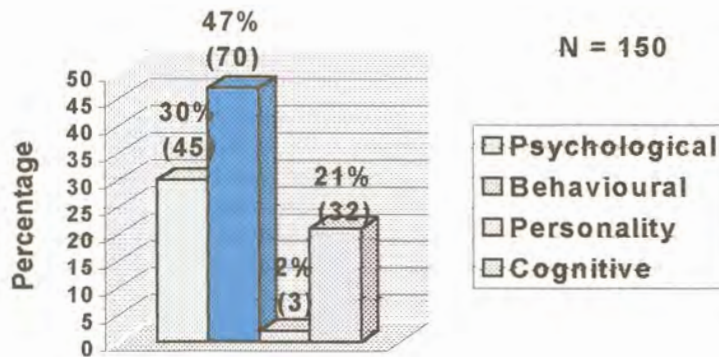
In practice parents/caregivers who abuse drugs such as dagga may abuse their children sexually and may end up in prison.

5.4.9 The impact of child abuse

All the parents/caregivers namely 150 respondents answered this section. The aim of this section was to determine the nature of the impact which child abuse is having on the abused child as indicated below:

The impact of child abuse is represented in figure 35 below:

Figure 35: The impact of child abuse



The majority of the parents/caregivers 47% (70) indicated that child abuse had a behavioural effect on their abused children followed by 30% (45) of the parents/caregivers who indicated that child abuse had psychological effects on their abused children and 21% (32) of the parents/caregivers indicated that child abuse had cognitive effects, while 2% (3) of the parents/caregivers indicated that child abuse had personality effects.

The finding that child abuse has been indicated by the majority of the parents/caregivers 47% (70) as having had behavioural effects on their abused children is related to the argument of Mouzakitis (1995:107) whereby distinct patterns of behaviour were observed from the abused children, namely:

- Destructive behaviour in which children destroyed property;
- disobeyed rules;
- assaulted the other children;
- had limited ego functions; and
- reacted to their parents/caregivers with recriminations.

In practice, abused children do experience behavioural problems shown by their violent affection or restlessness.

The above finding that child abuse had psychological effects on the abused children as indicated by 30% (45) of the parents/caregivers correlates with the findings of Mouzakitis (1995:103) according to which child abuse, especially physical abuse has psychological impacts on the victims. Ego disorganization, narcissistic injury and severe panic often accompany such psychological impacts.

In practice, it happens that abused children show psychological impairment accompanied by feelings of helplessness and compulsion to repeat the trauma which is manifested through post-traumatic stress.

The finding that 21% (32) of the parents/caregivers indicated that child abuse had cognitive effects on their abused children correlates well with what Hurley's (1996:79) research found. According to Hurley (1996:79), one of the consequences of child abuse is the compromised ability for learning as shown by 20% of the children he studied. Authors such as Gregg (1992:21), Martin (1994:33) and Rodeneffer (1996:121) have noted the increased incidence of mental retardation among abused children due to cerebral damage, unpredictable non-nurturing environments, impaired stimulation and anxiety.

However, in practice, abused children may demonstrate above-average or even superior intelligence, explaining this phenomenon as the children's need to acquire information to be perceived as capable and to sublimate their aggressive and libidinal drives into learning.

The finding that the minority i.e.2% (3) of the parents/caregivers indicated that child abuse had personality effects on their abused children contradicts the views of Holter (1991:111), according to which the majority of abused children experienced personality disorganization due to the abuse, e.g. they did not develop basic trust and were frequently involved in abusive adolescent relationships.

In practice, it happens that abused children may show a variety of personality traits and act as chameleons in their attempt to adjust to various situations and environments.

5.4.10 The questionnaire for social workers

The questionnaire was compiled for all the 14 social workers that are rendering social work services concerning child abuse. The aim was to determine the nature of services rendered by these social workers concerning child abuse in order to formulate guidelines for social workers rendering services concerning child abuse. The information, which was gathered, is as follows:

5.4.10.1 Personal details of the social workers

The sex of the social workers is represented in table 19 below:

Table 19: Sex of the social workers

SEX	FREQUENCY	PERCENTAGE
Male	1	7%
Female	13	93%
TOTAL	N = 14	100%

The above table indicates that 13 (93%) of the social workers are females, while 1 (7%) of the social workers is male. There is a discrepancy in the distribution of sex which is due to the inclusion of the whole population of the social workers who render social work services concerning child abuse in Moretele District. The sex of the

social workers as discussed above, does not have any significant bearing on the results of this research.

5.4.10.2 Areas of service delivery

The aim of this section was to determine the areas in which the social workers are rendering services and the number of social workers in each area.

The areas of service delivery are represented in table 20 below:

Table 20: Areas of service delivery

AREAS	FREQUENCY	PERCENTAGE
Cyferskuil	1	7%
Ga-Maubane	1	7%
Makapanstad	5	36%
Stinkwater	4	29%
Temba	3	21%
TOTAL	N = 14	100%

The above table indicates that the majority of social workers 36% (5) render services in Makapanstad, followed by 29% (4) in Stinkwater, 21% (3) in Temba and the minority 7% (1) in Cyferskuil and Ga-Maubane respectively.

The areas of service delivery and the number of social workers in each area do not have any significant bearing on the results obtained from this research.

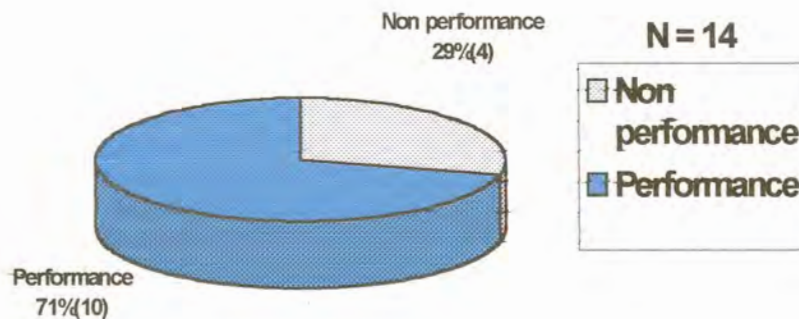
5.4.10.3 Performance of social work functions

The social workers were requested to indicate the functions that they perform in their service delivery concerning child abuse. The results were as follows:

- **Identification**

The performance of identification as a function of social work is represented in figure 36 below:

Figure 36: The performance of identification



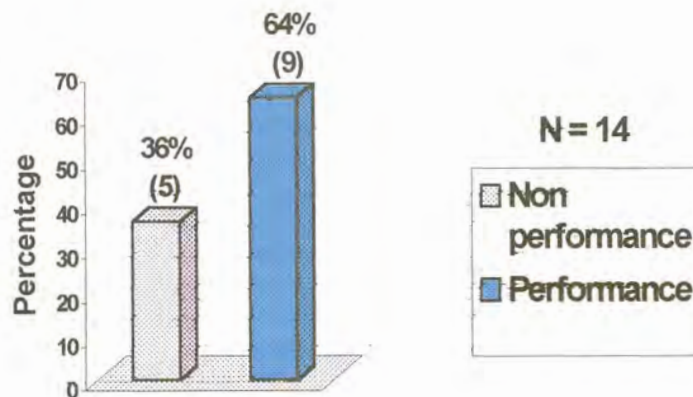
According to Richard (1991:156) identification is the first function of social work in child abuse which must be performed before any other function. The views of Richard (1991:156) can be related to the findings of this study according to which the majority of social workers 71% (10) indicated that they do perform the function of identification, while 29% (5) of the social workers indicated that they do not perform the function of identification in their service delivery.

In practice it may happen that all the social workers perform the function of identification whereby they may start with a case at the beginning until its' termination. This practical situation therefore supports the findings of this study. In practice, it also happens that social workers do not perform identification in which they do not start with the case at the beginning but enter into the process of service delivery at the middle of the case.

- **Investigation**

Investigation as a function of social work is represented in figure 37 below:

Figure 37: Investigation



The above figure indicates that 64% (9) of the social workers perform investigation, while 36% (5) do not perform investigation as a function of social work.

The above findings correlate with the findings of Richard (1991:160) whereby the majority of social workers indicated the performance of investigation through the assessment of the child, parents/caregivers and the family circumstances.

In relation to the practical situation most social workers do perform investigation as the basis to effective planning to resolve the case. This allows them to use their knowledge of family dynamics, human development and environmental factors when making decisions regarding intervention on the various types of child abuse.

There may also be social workers who may not perform investigation such as when the social worker is not available at the time when investigation must be done, e.g. when the social worker is on leave.

- Intervention

All the social workers 100% (14) indicated that they perform intervention as a function of social work. This finding may be related to the views of Molosankwe (1993:79) according to which *intervention is the core of service delivery*. Intervention is directed at bringing about change in the person-environment situation and can be directed at an individual, family, group, community or by research.

In practice intervention is performed by almost all the social workers rendering services concerning child abuse. The focus is the parents or primary caregiver with the goal of assisting them to deal with a range of problems associated with child abuse. Non-performance of intervention therefore shows non-involvement in service delivery concerning child abuse.

- **Prevention**

All the social workers 100% (14) indicated that they do prevent child abuse. This finding is related to the views of Gough (1993:12) who argue that prevention of child abuse must be performed at all times. The prevention must be aimed at the rearrangement of forces in society, against those negative factors in the life of the child. Prevention can be offered at three levels namely: primary, secondary and tertiary (Jacobsen, 1992:104; Davies, 1994:23 & McMurtry, 1995:42).

In relation to practice, most social workers do offer preventative services on all three levels as discussed above.

5.4.10.4 The employment of social work methods

The social workers were requested to indicate the extent to which they employ the different social work methods in their service delivery concerning child abuse. They had to indicate whether they employ such methods always, sometimes or never employ them as indicated below:

- **Social work with the individual**

All the social workers 100% (14) indicated that they always render social work services with the individual. The aim of social work with the individual is to help individuals on a person-to-person basis to attain the fullest degree of social functioning.

The above finding can be related to the views of Goldstein (1995:40) who argued that social workers who render services concerning child abuse, render the services to

the individuals to help them restore, maintain and enhance their individual, personal and social functioning.

Goldstein (1995:40) went further and argued that social work with the individual is mostly employed with parents/caregivers of abused children and can help such parents/caregivers to:

- Enhance their ego functioning particularly in the areas of impulse control and judgement;
- acquire better coping skills;
- develop the self-esteem and empathy that are so essential to good parenting;
- improve role functioning and interpersonal relationships;
- learn better child management techniques;
- develop more realistic and age appropriate expectations of children;
- modify long-standing behaviour patterns;
- compensate for early developmental arrests;
- gain greater self-awareness; and
- improve relationships with the community.

In practice, social work with the individual is provided to both parent/caregiver and the abused child. This is based on the perspective that focus on the parent/caregiver of abused children may have an insufficient impact on many abused children. Focus on the abused child takes that child's needs into consideration and this contributes to effective service delivery concerning child abuse.

- **Social work with the family**

All the social workers 100% (14) indicated that they always employ social work with the family in their service delivery in child abuse cases. This finding may be related to the views of Goldstein (1995:53) who argued that the entire family should be involved as child abuse affects all the family members. The involvement of the entire family is based on the assumption that a family is a system that consists of interrelated and interdependent subsystems (members) whereby change in one subsystem will lead to change or changes in the other subsystems.

In practice, the entire family system, including the abused child, non-abused siblings and parents/caregivers is affected by the abuse of the child and is seen together by

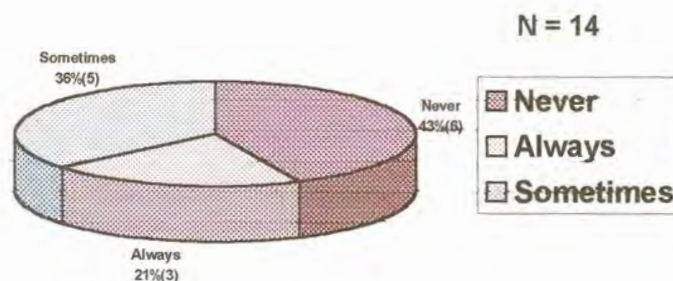
the social workers. The family is therefore seen as a unit of attention and intervention addresses the family as a whole. The involvement of the whole family has the following advantages:

- Family interactions and the roles of the family members in child abuse are easily assessed;
- family interaction can help to solve problems and to empathise with the abused child and other family members; and
- the family can learn and experiment with more effective child management techniques.

- **Social work with the group**

Social work with the group as a method of social work is represented in figure 38 below:

Figure 38: Social work with the group



Of the social workers, 21% (3) indicated that they always employ social work with the group, 36% (5) of the social workers indicated that they sometimes employ the method and 43% (6) of the social workers indicated that they never employ the method.

The finding that only the minority 21% (3) of the social workers employ social work with the group contradicts with the findings of Justice & Justice (1993:73) who found

that 90% of the respondents always employ social work with the group in their service delivery.

This finding also differs with the views of Goldstein (1997: 89) who argued that social work with the group is an effective approach in rendering services concerning child abuse.

The finding that 36% (5) of the social workers sometimes employ social work with the group may be related to Goldstein's (1997:89) argument regarding the effectiveness of this method. According to Goldstein (1997:89) social work with the group has been shown to be effective in its ability to provide the following:

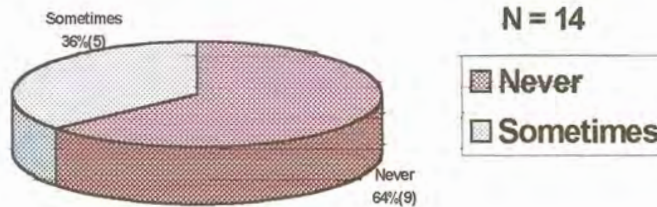
- The opportunity for nurturing, socialization and relating to others;
- powerful experiences in being accepted;
- the development of better communication and other interpersonal skills;
- the atmosphere in which to develop increased empathy for others, new values, attitudes and behaviour; and
- support networks that diminish the individual's sense of isolation and enhance their ability to take or offer help.

The finding that 43% (6) of the social workers never employ social work with the group can be correlated to the practical situation. Most social workers do not employ this method due to various reasons such as a lack of cooperation from the potential group members, inability to reach the group venue and/or lack of time to attend group meetings.

- **Social work with the community**

Social work with the community as a method of social work is represented in figure 39 below:

Figure 39: Social work with the community



Of the social workers, 64%(9) indicated that they never employ social work with the community, while 36% (5) of the social workers indicated that they employ social work with the community, some of the time.

The finding of this study contradicts the views of Tzeng (1993:106) who argued that most welfare agencies rely on community services to render services to abusive families. This social work with the community includes crisis help lines and coordinating persons who provide information on child abuse.

The findings of this study correlate well with the practical situation of the majority of social workers, as they do not employ social work with the community in their service delivery concerning child abuse due to shortage of time to conduct programs. This means that the majority of social workers still place emphasis on social work with the individual.

Service delivery concerning child abuse is therefore hindered as no objectives, which could be achieved by social work with the community, are achieved.

- Social work research

The employment of social work research is represented in table 21 below:

Table 21: Social work research

SOCIAL WORK RESEARCH	FREQUENCY	PERCENTAGE
Always	10	71%
Sometimes	4	29%
TOTAL	N = 14	100%

Of the social workers, 71% (10) always employ social work research and 29% (4) of the social workers sometimes employ social work research. The finding that the majority of social workers employ research is related to the views of Green (1992:77) who argue that most of the social workers conduct research to develop, implement and evaluate intervention strategies, therefore increasing the body of generalized knowledge about social work concerning child abuse.

The findings of this study can also be related to the practical situation whereby research is conducted to investigate social problems and to add to the knowledge base of social work.

5.4.10.5 An integrated application of these methods

All the social workers indicated that they do not integrate the methods in their service delivery. This finding can be related to the practical situation whereby most of the social workers do not integrate the methods. This might be attributed to their lack of training in the integration of the methods.

5.4.10.6 Approaches employed in social work with the individual

The social workers were requested to indicate the nature and extent of the approaches they use in social work with the individual in their service delivery concerning child abuse as indicated below:

- Problem solving

All the social workers 100% (14) indicated that they always use problem solving as an approach in their intervention concerning child abuse. Butrym (1993:25) argues that the aim of the problem solving approach is to help a person to solve problems, which the person cannot solve at present.

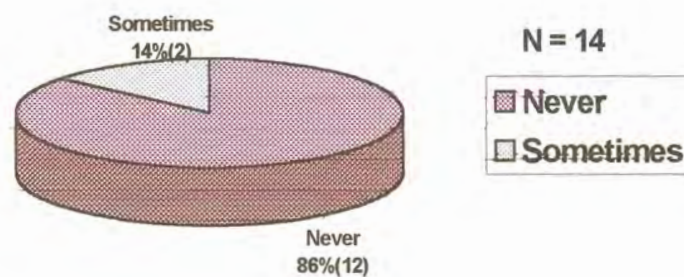
This approach therefore emphasises training in the development of problem solving skills. If the finding of this study is related to the views of Butrym (1993:25) it can be concluded that the social workers' aim is to help the parents/caregivers to develop problem solving skills, which can be used in future.

In practice it happens that social workers employ the problem solving approach to help the clients to be independent in solving problems.

- Behaviour modification

Behaviour modification as an approach is represented in figure 40 below:

Figure 40: Behaviour modification



Of the social workers, 86% (12) indicated that they *never employ behaviour modification*, while 14% (2) of the social workers indicated that they do *sometimes employ behaviour modification*.

Vasta (1992:144) argued that the behaviour modification approach is based on a theoretical proposition that maladaptive behaviour is learned and can be unlearned under controlled situations. Vasta (1992:144) went further and indicated that this approach is mostly employed in service rendering concerning child abuse on the basis that child abuse is the result of inadequately or inappropriately learned parenting behaviour.

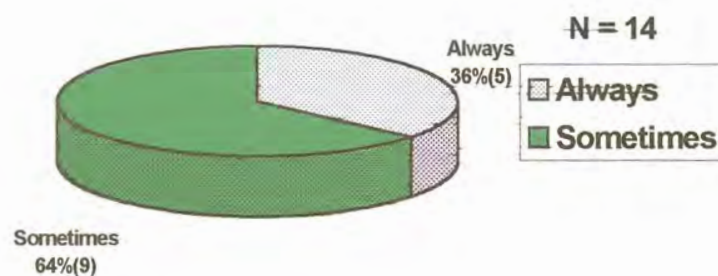
The findings of this study contradict with the views of Vasta (1992:144) as none of the social workers indicated that they always employ the behaviour modification approach in their service delivery concerning child abuse.

In practice, the majority of social workers do not employ the behaviour modification approach to help parents/caregivers to change their parenting styles which are causal or contributory factors towards child abuse, due to the point that they may lack knowledge and skills of employing this approach.

- Cognitive restructuring

Cognitive restructuring as an approach is represented in figure 41 below:

Figure 41: Cognitive restructuring



The cognitive restructuring approach focuses on changing the incorrect thought patterns, beliefs and attitudes of the clients which is believed to lead to lasting behavioural change. Child abuse is addressed in terms of incorrect premises and a proneness to distorted imaginable experiences that lead to incorrect emotions and

responses to external events (Fennel, 1992:129; Vondracek, 1995:120 & Palmer, 1996:77).

The application of this approach will help parents/caregivers to learn the following skills:

- Desirable coping skills to cope with provocation;
- the ability to give less negative meaning to the provoking child;
- relaxation techniques to have the means to alleviate the intense pressure of provocation; and
- problem solving skills to prevent perceived provocations (Fennel, 1992:130; Vondracek, 1995:125 & Palmer, 1996:79).

Of the social workers, 36% (5) indicated that they some of the time employ cognitive restructuring and 64% (9) of the social workers indicated that they employ cognitive restructuring some of the time.

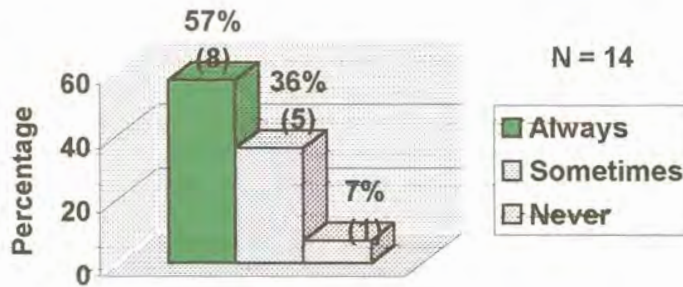
The findings of this study correlate with the views of Fennel (1992:129,130), Vondracek (1995:120,125) & Palmer (1996:77,79) regarding the employment of the cognitive restructuring model as discussed above.

In practice, social workers do employ the cognitive restructuring approach to restructure the parents/caregivers irrational thoughts regarding their parenting / caregiving styles.

- **Ego psychology**

Ego psychology as an approach is represented in figure 42 below:

Figure 42: Ego psychology



Of the social workers, 57% (8) indicated that they always employ ego psychology and 36% (5) of the social workers indicated that they sometimes employ ego psychology some of the time, while 7% (1) of the social workers indicated that they never employ ego psychology.

The above findings agree with Goldstein's (1995:42) & Vondracek's (1995:12) views that social workers use ego psychology to deal with the relationship of personality to reality with the goal of supporting and strengthening the client's ego so that they can function and cope more effectively with their problem areas.

According to Goldstein (1995:42) the employment of ego psychology with parents concerning child abuse should aim at the following:

- Helping parents/caregivers to function more comfortably in their role as parent/caregiver;
- better control of behaviour and feelings;
- improvement of parent –child relationship;
- development of better coping skills when a problem arise;
- remedying early parental developmental defects that may be part of the pattern of child abuse;
- acquiring of greater understanding of the children's needs; and
- bearing better ways of managing the children's needs.

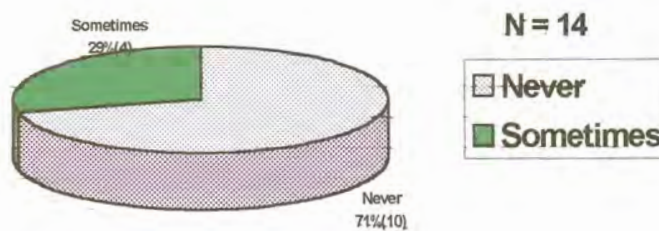
In practice, ego psychology can be employed to provide information, advice and direction to parents/caregivers regarding child development, child-rearing techniques, special problems and parents' needs.

If the findings of this study are related to the views of Goldstein (1995:42) and what is happening in practice it may be concluded that the social workers that employ ego psychology are those who have the aims as outlined by Goldstein (1995:42).

Crisis intervention

Crisis intervention as an approach is represented in figure 43 below:

Figure 43: Crisis intervention



According to Haas (1994:4) child abuse is a crisis to many individuals and requires the intervention of a social worker through the employment of crisis intervention.

Crisis intervention is aimed at the following:

- Ending the abuse through the removal of the abuser or the victim from the abusive situation;
- helping the victim to deal with the emotions;
- strengthening the parent's/caregiver's ability to protect the child; and
- assisting the abuser, victim and other family members to establish appropriate role boundaries (Haas, 1994:5 & Furniss, *et al.*, 1994:866).

Of the social workers, 29% (4) indicated that they sometimes employ crisis intervention some of the time, while 71% (10) of the social workers indicated that they never employ crisis intervention.

The result of this study that 71 % (10) of the social workers never employ crisis intervention contradicts with the views of Haas (1994:5) & Furniss, *et al.*, (1994:866)

as discussed above. The finding that 29% (4) of the social workers do employ crisis intervention partly supports these views.

In practice, crisis intervention should be employed in child abuse cases with the main aim of helping the victim to deal with the emotions.

5.4.10.7 Prevention services offered

The social workers were requested to indicate the nature of prevention services that is offered, that is whether they do offer such services, if it is possible or not possible, applicable or not applicable as discussed below:

Reducing the incidence of child abuse before it starts

This entails the primary prevention of child abuse through its reduction before the abuse starts. All the social workers 100% (14) indicated that they do reduce the incidence of child abuse before the abuse starts.

This finding means that all the social workers are rendering primary prevention of child abuse. The finding of this study may be related to the views of Gough (1993:18) & McMurtry (1995:44) who argued that primary prevention seeks to affect factors that contribute to the appearance of child abuse.

In practice, it happens that social workers prevent child abuse on a primary level through public awareness campaigns and advocacy groups with a view of breaking the cycle of child abuse in the society as a whole.

Factors taken into consideration to reduce the incidence of child abuse before the abuse starts.

The social workers were requested to indicate the factors, which they are taking into consideration when reducing the incidence of child abuse before the abuse starts as discussed below:

- **Low birth weight pre-term infants**

All the social workers 100% (14) indicated that they do not take low birth weight pre-term infants as an etiological factor into consideration in their prevention services.

The above finding is contradicting the views of Siegel (1993:71) according to which he argued that premature or low birth weight infants is one of the factors which must be taken into consideration for successful primary prevention. This view is based on the assumption that prematurity predisposes an infant to anoxia, which in turn causes irritability and fussiness.

Another view is that infants who weigh less at birth may have subtle dysfunctions of the central nervous system, which results in restlessness and distractibility.

In practice, low-birth weight pre term infants is taken into consideration as a causal factor to child abuse. In the primary prevention of child abuse is based on the following factors:

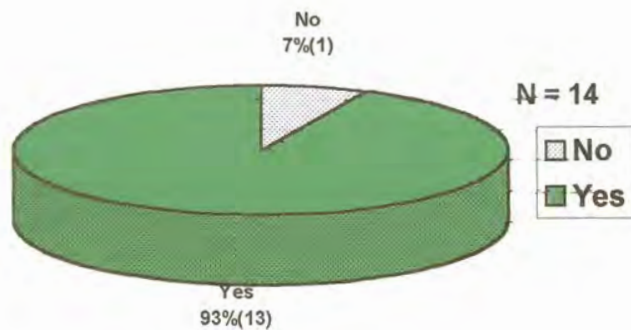
- Biological factors are potential contributors to abuse; and
- low birth weight infants are more difficult to care for than full-term infants, e.g. they are fussy and irritable and therefore frustrating for the parents/caregivers to care for.

Therefore the consideration of low birth weight pre term infants in the prevention of child abuse help the social workers to plan programs that can help parents/caregivers to develop insight into the needs of these infants and how to respond if such children show behaviours resulting from their situations.

- **Children of adolescent parents**

The consideration of children of adolescent parents as a factor in primary prevention is represented in figure 44 below:

Figure 44: Consideration of children of adolescent parents



Of the social workers, 93% (13) indicated that they do consider children of adolescents as a casual factor in their prevention of child abuse, while 7% (1) indicated that they do not consider children of adolescents as a casual factor.

The above findings support the views of Mouzakitis (1995:45) according to which the majority of abusive parents are young and have had little opportunity to learn parenting skills. These parents/caregivers have lack of knowledge and unrealistic expectations about children. Their cognitive immaturity seem to impede the development of realistic expectations of child rearing and produces self-centeredness that prevents them from giving the child's needs preference over their own.

In practice, social workers do consider children of adolescent parents/caregivers as an etiological factor and in their prevention on the basis that these parents/caregivers have had little chance to rehearse the role of parents/caregivers. Prevention programs therefore focus on helping these parents/caregivers to develop parenting/caregiving skills.

- Children with special needs

According to Steele (1995:173) children with special needs, such as handicaps, mental retardation or physical illnesses are at greater risk of being abused than normal children. This factor should be considered in the prevention of child abuse.

This view of Steele (1995:173) contradicts with the findings of this study as all the social workers indicated that they do not consider children with special needs in their prevention of child abuse.

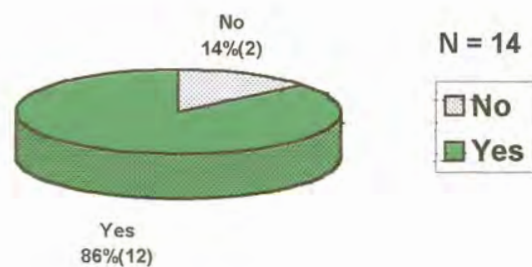
The findings of this study can be related to the practical situation whereby the majority of parents/caregivers cope well with the task of caring for children with special needs such as handicapped children.

However, it also happens in practice that children with special needs are targeted for child abuse, e.g. when the child is seen as a burden by the parents/caregivers, such a child may not be cared for adequately and may be abused. In this case, prevention strategies will consider the needs of these children to reduce child abuse.

- Children of mentally retarded parents

The consideration of children of mentally retarded parents as a factor in prevention is represented in figure 45 below:

Figure 45: Consideration of children of mentally retarded parents



According to Delnero (1994:169) people who abuse their children are sick or mentally ill. Therefore children in families where one or both of the parents are mentally ill seem to be at a risk of abuse. Of the social workers, 86% (12) indicated that they do consider children of mentally retarded parents as a factor in the prevention of child

abuse, while 14%(2) of the social workers indicated that they do not consider children of mentally retarded parents as a factor in the prevention of child abuse.

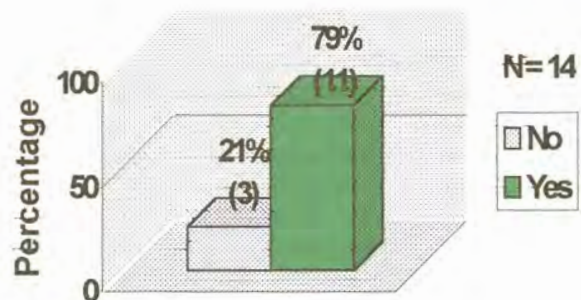
The findings of this study correlate well with the views of Delnero (1994:169) according to which parental mental illness is related to child abuse. In practice, the mental illness of the parents applies to only a fraction of abusive parents.

In practice, it also happens that parental mental retardation is followed by child abuse. In this situation, prevention will consider parental mental retardation and implement diagnosis and treatment plans to determine when and how the child's safety is to be assured. If the mentally ill parent is more abusive during these episodes, decisions to remove either the child or the mentally ill parent can be made.

- Children of substance abusers

The consideration of children of substance abusers as a factor in prevention is represented in figure 46 below:

Figure 46: Children of substance abusers



Of the social workers, 79% (11) indicated that they consider children of substance abusers in their prevention of child abuse and 21% (3) of the social workers indicated that they do not consider children of substance abusers in their prevention of child abuse. Therefore the majority of social workers consider children of substance abusers in the prevention of child abuse.

This finding correlates well with what Harrington (1995:89) found, whereby parental substance abuse was the most important factor, which determines prevention of child abuse. Parental substance abuse was recognised as an integral component of the multi - problem abusive families. This abuse played a significant role in the onset as well as the continuation of child abuse. Prevention strategies were therefore based on it whereby public education, early detection and treatment programs that meet the special needs of the chemically dependent parents were offered.

In practice, substance abuse is related to child abuse during pregnancy whereby the fetus is vulnerable to the damaging effects of maternal substance abuse. This substance abuse also leads to child abuse in later years, e.g. during adolescence in which the parents who abuse substances may abuse their children when under the influence of these substances.

Prevention of child abuse can therefore consider children of substance abusers and intervention may focus on insight development regarding substance abuse and its consequences.

- **Children of parents who were abused as children**

All the social workers 100% (14) indicated that they consider children of parents who were abused as children, in their prevention of child abuse. This finding correlates with the views of Wolf (1999:82) according to which prior abuse perpetuates a cycle of abuse across generations.

Adults who abuse their children were abused as children as they learned through experiences with their own parents that violence is an acceptable method of child rearing. Prevention must therefore focus on the parents's insight into their own past experiences, support services and/or parental education on effective parenting.

In practice the victims of child abuse may grow up to be perpetrators of child abuse, therefore warranting the need to consider the children of parents who were abused as children in the prevention of child abuse. In practice it may also happen that the victims of child abuse do not abuse their children.

- **Children of few support systems**

All the social workers 100% (14) indicated that they do not consider children of few support systems in the prevention of child abuse. This finding contradicts the findings by Mouzakitis (1995:256) whereby it was found that prevention programs were centered on the family's lack of support from the extended family and the community.

The findings of this study also contradict the practical situation of the majority of social workers as their prevention does consider the family's support systems, e.g. outside contacts with friends, the extended family, the neighborhood and social agencies which provide needed assistance. Therefore prevention can focus on maximizing social support systems and the building of family support and cohesion.

- **The identification of potential child abusers**

All the social workers 100% (14) indicated that they focus on the identification of potential child abusers in the prevention of child abuse. According to Katz (1995:178) the identification of potential child abusers involves the secondary prevention of child abuse whereby services are targeted to specific high-risk groups with the aim of avoiding the continued spreading of child abuse. It can therefore be concluded that all the social workers of this study focus on secondary prevention of child abuse by identifying potential child abusers.

The findings of this study correlate with the practical situation of the majority of social workers whereby they focus on secondary prevention of child abuse in their service delivery concerning child abuse.

5.4.10.7 Focal aspects in the identification of potential child abusers

The aim of this section was to determine the aspects on which the social workers are focusing in the identification of potential child abusers. These aspects are discussed below:

- **Nurturing**

Nurturing as a focal aspect in the identification of potential child abusers is represented in table 22 below:

Table 22: Nurturing

NURTURING	FREQUENCY	PERCENTAGE
Focus	7	50%
Not focus	7	50%
TOTAL	N = 14	100%

The above table indicates that 50% (7) of the social workers focus on nurturing in the prevention of child abuse, while 50% (7) of the social workers indicated that they do not focus on nurturing in the prevention of child abuse.

This finding that 50% (7) of the social workers focus on nurturing correlates with the views of Barry (1994:15). This author argued that the prevention of child abuse should also put an effort on the parent's capacity to nurture as the likelihood of child abuse increases when the parent's capacity to nurture decreases.

This finding also correlates with what is happening in practice. Whereby the social workers' focus on the mothering imprints of parents/caregivers as the basic dynamic of the potential to abuse on the basis that a person who has been reared in a way that precluded the experience of being mothered and nurtured cannot mother or nurture his own children.

- The needs of children at different stages

All the social workers 100% (14) indicated that they do not focus on the needs of children at different stages. This finding contradicts with the views of Barry (1994:79) according to which parents/caregivers who abuse their children have lack of knowledge about the needs of children at different stages and fail to meet these needs.

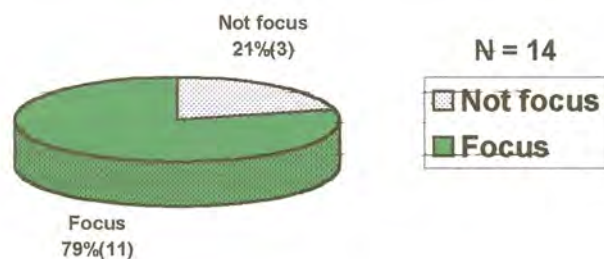
The finding of this study also contradicts the practical situation. Social workers do focus on the needs of children at different stages, on the basis that parents/caregivers lack knowledge of such needs, and need to be assisted to gain knowledge of these needs.

Social workers in general are therefore playing the role of advocate for children by picking up on the needs of children as a group and focusing on what is good for all children and therefore reducing child abuse on a secondary level.

- **Good parenting skills**

Good parenting skills as a focal aspect in the identification of potential child abusers is represented in figure 47 below:

Figure 47: Good parenting skills



According to Mills (1992:93) good parenting skills include positive interactions with the children and effective control of unwanted child behaviour. Werner (1993:17) adds to these skills by arguing that decreasing negative or punitive management techniques is part of good parenting skills.

Authors such as Reidy (1991:140), Morris (1993:99) & Patterson (1995:132) agree that the parent's lack of knowledge of good parenting skills is relevant to the majority of cases concerning child abuse and that prevention should be targeted towards this aspect with a view of improving these skills.

The above figure indicates that 79% (11) of the social workers indicated that they focus on good parenting skills as an aspect in the prevention of child abuse, while 27% (3) of the social workers indicated that they do not focus on good parenting skills as an aspect in the prevention of child abuse.

The finding that 79% (11) of the social workers focus on good parenting skills correlates well with the views of Reidy (1991:140), Morris (1993:99) and Patterson (1995:132) that the parents'/caregivers' lack of knowledge of parenting skills should be the focal aspect in the prevention of child abuse.

In practice, it also happens that social workers focus on the parent's lack of knowledge of parenting skills and reducing child abuse.

- **Family planning**

All the social workers 100% (14) indicated that they focus on family planning in the prevention of child abuse. This finding is related to the findings by Davoren (1991:137) according to which the timing of the child's arrival helped to reduce the rate of child abuse in England. According to Davoren (1991:137), family planning reduced the rate of child abuse as parents avoided the tragedy of unwanted children and were ready for the responsibilities of parenthood when they had children.

In practice, family planning is an aspect which can reduce child abuse in terms of controlling the number of children to have in consideration of the high cost of living. Widespread family planning education can be more effective in preventing child abuse on a secondary level.

- **Stress management**

According to Barry (1994:151) and Ellis (1997:79) the experience of stress is a major factor to be considered in the prevention of child abuse. Poverty, poor housing, unemployment or insufficient money may generate stress. These factors may weaken a person's psychological mechanism of self-control and contribute to the uninhibited discharge of aggressive and destructive impulses towards children.

All the social workers 100% (14) indicated that they focus on stress management in the prevention of child abuse. The findings of this study therefore relate well with the views of Barry (1994:151) and Ellis (1997:79) according to which focus should be on stress in the prevention of child abuse.

The above finding also correlates well with the practical situation as social workers are involved in programs of stress management with potential child abusers with a view of training them to develop stress management skills, which can also enhance childrearing skills.

- **Child development**

All the social workers 100% (14) indicated that they do not focus on child development in the prevention of child abuse. This finding contradicts the views of Mouzakitis (1995:173) who argued that lack of knowledge of child development is the first aspect to be considered in the prevention of child abuse.

The above finding is also contradicting the practical situation as the social workers focus on the parent's knowledge of child development on the basis that lack of knowledge of child development is associated with an increased risk of child abuse. The increasing parental knowledge of child development can be related to a decrease of child abuse.

- **Health**

All the social workers 100% (14) indicated that they focus on health in the prevention of child abuse. This finding correlates well with the views of Barry (1994:159) and Berne (1997:59) according to which health problems such as physical disabilities of a parent or child are factors present in families involved in about 80% of the cases of child abuse in the United States of America.

In practice, the health of the child is an aspect, which is seriously considered in the prevention of child abuse. This is based on the experience that some of the handicapped children are abandoned after birth while others are well cared for.

child prior to abuse, formulation of objectives to prevent a recurrence of those behaviours or to relate to stress in other ways.

In relation to the practical situation, stopping the abuse becomes one of the treatment goals when parents/caregivers are helped to assume responsibilities for the abuse rather than denying their involvement or scapegoating the children.

- **Improving parental functioning**

Mouzakitis (1995:250) argued that parental functioning is improved by setting the following objectives:

- Roles of family members will become appropriate, e.g. the child will no longer parent the adults;
- the parents will hug the children every day; and
- nutritious meals and snacks will be prepared for the children daily.

All the social workers, 100% (14), indicated that they focus on the improvement of parental functioning as a goal of treatment in the prevention of child abuse. If the findings of this study are correlated with the views of Mouzakitis (1995:250), it can be concluded that all the social workers focus on improving parental functioning by setting the following objectives:

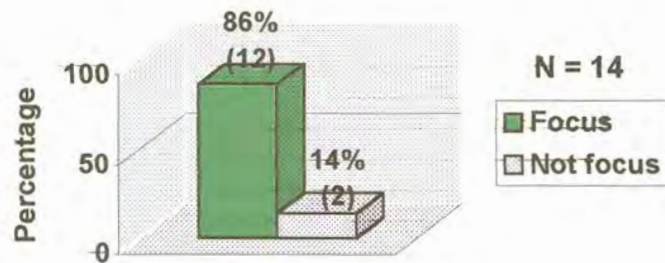
- Appropriate roles of family members;
- parents hugging the children every day; and
- preparation of nutritious meals and snacks for children on a daily basis.

In practice, parental functioning is a goal of treatment which is achieved by strategies such as role modeling by a social worker, homemaker and volunteers.

- **Reducing stress**

Reducing stress as a goal of treatment in the prevention of child abuse is represented in figure 49 below:

Figure 49: Reducing stress



Of the social workers, 86% (12) indicated that they focus on reducing stress in the prevention of child abuse, while 14% (2) of the social workers indicated that they do not focus on reducing stress in the prevention of child abuse.

The above findings that 86% (12) of the social workers focus on reducing stress correlate with the findings by Dreyer (1994:93). Dreyer (1994:93) focuses on the stressors such as low self-esteem, low income and poor conflict management skills with the main aim of improving self-esteem increasing income and developing conflict management skills.

The development of conflict management skills as a goal of treatment is represented in table 23 below:

Table 23: Development of conflict management skills

NURTURING	FREQUENCY	PERCENTAGE
Focus	10	71%
Not focus	4	29%
TOTAL	N = 14	100%

The above table indicates that 71% (10) of the social workers indicated that they focus on the development of conflict management skills as a goal of treatment in the prevention of child abuse, while 29% (4) of the social workers indicated that they do not focus on the development of conflict management skills.

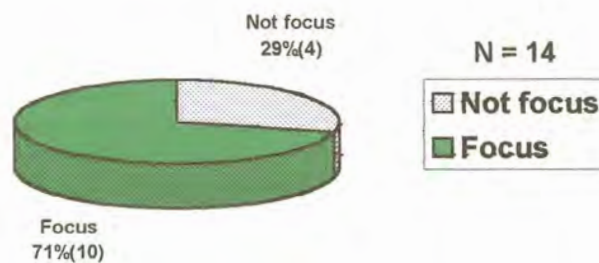
According to Haas (1999:73) in developing conflict management skills the family learns to focus until the problem is defined, list possible solutions and reach a consensus on the solution in developing conflict management skills.

In practice, learning the problem solving skills which can be used to resolve future problem areas can develop conflict management skills. Therefore if the findings of this study are correlated to the findings of Haas (1994:73) and to what is happening in practice, it can be concluded that 71% (10) of the social workers who focus on the development of conflict management skills, learn to focus until the problem is defined, list possible solutions and reach consensus on the solution and learn problem solving skills. The social workers, 29% (4) who do not focus on developing conflict management skills are not involved in teaching families to focus on the problem, and on developing problem solving skills.

- Improvement of self-esteem

Improvement of self-esteem as a goal of treatment in the prevention of child abuse is represented in figure 50 below:

Figure 50: Improvement of self-esteem



Of the social workers, 71% (10) indicated that they focus on the improvement of self-esteem as a goal of treatment in the prevention of child abuse, while 27% (4) of the social workers indicated that they do not focus on the improvement of self-esteem.

The above findings may be related to the argument of Pollak (1996:91) according to which the prevention of child abuse should be centered on the improvement of self-esteem whereby the following objectives may be envisaged:

- The development of interpersonal associations within the family and with others;
- the development of self-control; and
- learning to play and have fun.

In practice, the improvement of self-esteem contributes to the reduction of child abuse as a person becomes able to relate with others and to understand the type of person he is, which include the likes, dislikes, personal strengths and feelings.

- **Improvement of intimacy**

All the social workers, 100% (14), indicated that they do not focus on the improvement of intimacy as a goal of treatment in the prevention of child abuse.

This finding contradicts with the views of Mouzakitis (1995:290) according to which the improvement of intimacy is one of the goals of treatment in the prevention of child abuse. In relation to the practical situation, the improvement of intimacy in terms of becoming trustworthy and respecting others is the goal of treatment in the prevention of child abuse. This goal is usually achieved when the whole family is involved in treatment.

5.5 SUMMARY

The exposition of how the research was executed was given, the focus was on research methodology and the procedure followed in collecting data.

The research findings are analysed, interpreted, discussed and represented in tables and figures.

5.5.1 The most important findings

The types of child abuse that were experienced by the children are physical abuse, sexual abuse, emotional abuse and neglect.

Of the parents/caregivers, 37% (55) indicated that their children experienced physical abuse and 31% (46) sexual abuse and 9% (14) emotional abuse while 23% (35) experienced neglect.

5.5.2 Findings concerning the parents/caregivers

The parents/caregivers were 150 whereby 69% (104) are females and 31% (46) are males.

The parents'/caregivers' ages range from 20 years to 50 years old.

Of the parents/caregivers, 34% (50) were never married, 13% (20) are married, 28% (42) are divorced, 16% (24) widowed and 9% (14) are living together.

The parents/caregivers have between 1 and 4 children, whereby only one child under their care has been abused between the ages of 0 to 21 years during the years 1995 to 1999.

The child abusers were indicated as strangers, the children's mothers, - fathers, - stepfathers and -relatives.

5.5.3 Findings concerning physical abuse

Of the parents/caregivers, 37% (55) indicated that their children experienced physical abuse, namely: injuries, poisoning and suffocation.

The majority of the parents/caregivers noticed bruising and lacerations as physical symptoms of physical abuse, while the minority did not notice bruising and lacerations.

The following behavioural symptoms were noticed by the majority of parents/caregivers:

- Fear of physical contact;
- temper tantrums;
- fearful of parents/caregivers;
- over aggressiveness; and
- excessive school absence.

The following behavioural symptoms were not noticed by the parents/caregivers:

- Craving for attention;
- wearing long sleeved clothing;
- withdrawal;
- sleepy in class; and
- arriving early at school.

5.5.4 Findings concerning sexual abuse

Of the parents/caregivers, 31% (46) indicated that their children experienced sexual abuse, namely: sexual intercourse, oral contact, fondling and sexual contact of intimate parts.

The following physical symptoms of sexual abuse were noticed by the majority of parents/caregivers:

- Pregnancy at an early age;
- red vagina;
- presence of semen;
- presence of sexually transmitted diseases;
- complaints of difficulty in urinating;
- bruises of external genitalia; and
- bleeding from external genitalia;
- the following physical symptoms were not noticed:
- swollen cervix;
- torn bloody undergarments; and
- vaginal discharge.

The following behavioural symptoms of sexual abuse were noticed by the majority of parents/caregivers:

- Poor peer relationships;
- substance abuse;
- irregular school attendance; and
- sleep disturbance.

The following behavioural symptoms were not noticed by all the parents/caregivers:

- Prostitution;

- comments that the child was assaulted;
- engaging in delinquent acts; and
- suicide attempts.

5.5.5 Findings concerning emotional abuse

Of the parents/caregivers, 25% (14) indicated that their children experienced emotional abuse.

The following types of emotional abuse were noticed by the majority of parents/caregivers:

- Rejection;
- ignorance;
- corruption;
- isolation; and
- insults.

The following types of emotional abuse were not noticed by all the parents/caregivers:

- Terrorising;
- deprivation; and
- accusations.

5.5.6 Findings concerning neglect

Of the parents/caregivers, 64% (35) indicated that their children experienced neglect, namely:

The following types of neglect were experienced by the majority of children:

- Lack of nutrition;
- inadequate shelter
- lack of clothing; and
- medical neglect.

The following types of neglect were not noticed by the majority of parents/caregivers:

- Educational neglect;
- lack of love;

- lack of protection;
- lack of supervision;
- poor personal hygiene; and
- absence of medical care.

The majority of parents/caregivers noticed begging for food as a behavioural symptom of neglect.

The following behavioural symptoms of neglect were not noticed by the majority of the parents/caregivers;

- Falling asleep at school; and
- irregular school attendance.

5.5.7 Findings concerning the causes of child abuse

The majority of the parents/caregivers indicated the following factors as the main causes of child abuse:

- lack of mothering imprints;
- excessive expectations towards the child;
- parental role reversal;
- scapegoating;
- immature parents;
- mental illness;
- lack of child rearing skills;
- poverty;
- poor education;
- occupational stress;
- alcohol abuse; and
- drug abuse.

The minority of parents/caregivers indicated the following as contributory causes to child abuse:

- Lack of mothering imprints;
- excessive expectations towards the child;
- parental role reversal;
- scapegoating;
- immature parents;

- mental illness;
- lack of child rearing skills;
- poverty;
- poor education;
- occupational stress;
- alcohol abuse; and
- drug abuse.

The majority of parents/caregivers indicated the following factors as no causes of child abuse:

- Lack of social skills;
- inferior health status of the child; and
- overcrowding.

5.5.8 Findings concerning the impact of child abuse on the abused child

Child abuse had behavioural effects on the majority of children followed by psychological effects.

Child abuse had cognitive and personality effects on the minority of children.

5.5.9 Findings concerning social work service delivery

There were 14 social workers that are rendering social work services in child abuse cases.

Their areas of service delivery were as follows:

- Cyferskuil and Ga-Maubane with one social worker respectively;
- Makapanstad with five social workers;
- Stinkwater with four social workers; and
- Temba with three social workers.

5.5.10 Findings concerning the performance of social work functions

The majority of social workers reported the performance of the following functions:

- Identification;
- investigation;

- intervention; and
- prevention.

5.5.11 Findings concerning the employment of social work methods

The majority of social workers indicated that they always employ the following social work methods in their service delivery:

- Social work with the individual;
- social work with the family; and
- social work research.

The majority of social workers indicated that they never employ the following methods in their service delivery:

- Social work with the group;
- social work with the community; and
- an integrated application of the methods.

5.5.12 Findings concerning the approaches in social work with the individuals

The majority of social workers indicated that they always employ the following approaches in their service delivery:

- Problem solving; and
- ego psychology.

The majority of social workers indicated that they never employ behaviour modification and crisis intervention in their service delivery.

The majority of social workers indicated that they do employ cognitive restructuring some of the time in their service delivery.

5.5.13 Findings concerning primary prevention services

All the social workers are offering primary prevention services.

The majority of social workers indicated that they do consider the following factors in the primary prevention of child abuse:

- Children of adolescent parents;
- children of mentally retarded parents;

- children of substance abusers; and
- children of parents who were abused as children.

The majority of social workers indicated that they do not consider the following factors in the primary prevention of child abuse:

- Low birth weight;
- children with special needs; and
- children of few support systems.

5.5.14 Findings concerning secondary prevention services

All the social workers indicated that they do offer secondary prevention of child abuse in terms of the identification of potential child abusers.

The majority of social workers indicated that they focus on the following aspects:

- Nurturing;
- good parenting skills;
- family planning;
- stress management; and
- health.

The majority of social workers indicated that they do not focus on the following factors:

- The needs of children at different stages; and
- child development.

5.5.15 Findings concerning prevention services after child abuse has occurred

The majority of social workers indicated that they focus on the following goals after child abuse has occurred:

- Stopping the abuse;
- improving parental functioning;
- reducing stress;
- development of conflict management skills; and
- improvement of self-esteem.

The majority of social workers indicated that they do not focus on the improvement of intimacy in their prevention services after child abuse has occurred.

CHAPTER 6

GUIDELINES FOR SOCIAL WORKERS RENDERING SERVICES CONCERNING CHILD ABUSE

6.1 INTRODUCTION

Social work service delivery in child abuse needs to be enhanced with a view of reducing the rate of child abuse, which is increasing on a daily basis. Social work service delivery in child abuse cases can be enhanced through the formulation of guidelines for social workers. This chapter focuses on the formulation of guidelines for social workers rendering services in child abuse cases, on the basis of the theory empirical research and the researcher's practical experience.

6.2 SOCIAL WORK GUIDELINES CONCERNING CHILD ABUSE

Information on the theoretical orientation of child abuse, its causes and impact, has been discussed in detail in Chapter two to three, while information of social worker service delivery in child abuse has been discussed in Chapter four and will not be repeated in this Chapter. For detailed information on child abuse and social worker service delivery, the reader can utilize these chapters.

Guidelines, which have been formulated, are as follows:

The social workers rendering services concerning child abuse need to be knowledgeable of the nature of child abuse and social work functions employed in rendering services concerning child abuse. These aspects are discussed below:

6.2.1 Knowledge of the nature of child abuse

Social workers need to know the following aspects of child abuse:

6.2.1.1 The definition of child abuse

Child abuse refers to the physical or mental injury, sexual abuse or negligent maltreatment of a child under the age of eighteen in which the child's health or welfare is harmed or threatened.

Knowledge of this definition will enhance the social worker's service delivery, as it will serve as their basic point of departure.

6.2.1.2 The child abusers

Children can be abused by a variety of people, including; strangers, school teachers, parent-biological, stepparents or adoptive parents, family relatives-uncles or grandparents. It appears as if the children's stepfathers are the highest abusers in number, followed by the children's mothers, relatives, fathers and then strangers. This knowledge can help the social workers in planning their intervention and they should focus on all the possible child abusers in their service rendering, e.g. in the prevention of child abuse.

6.2.1.3 The types of child abuse

There are various types of child abuse which can be experienced by children. The following is a guideline for the types of child abuse:

- Physical abuse which refers to any non-accidental action that causes physical injury to child.
- Sexual abuse which refers to contacts between the child and an adult whereby the child is being used for sexual stimulation of the adult.
- Emotional abuse which refers to the failure to provide an emotionally satisfying environment in which the child can thrive and develop.
- Neglect which refers to failure to provide the child with the necessities of life which are deemed essential for developing a child's physical, intellectual and emotional capacities.

The findings of this study indicated that physical abuse is experienced by the highest

number of children, followed by sexual abuse, neglect and then emotional abuse. This might be attributed to the point that the symptoms of physical abuse are easily identifiable as compared to e.g. emotional abuse. However, the social workers need to focus on all the types of child abuse disregarding the rates as experienced.

- **The nature of physical abuse**

The following is a guideline for the nature of physical abuse. Physical abuse includes the following:

- Injuries which can be located on any part of the child's body, e.g. on the face, head or body, depending on the abuse;
- burns which can show the following patterns:
 - * cigarette burns ;
 - * burns on the buttocks; or
 - * contact burns from being pressed to a hot source such as a stove.
- poisoning whereby a variety of drugs or household substances are used;
- suffocation whereby children are smothered in terms of placing a hand, a pillow or any item over the child's mouth and nose until he dies;

According to this study injuries were experienced by the highest number of children, followed by poisoning and then suffocation. Burns are not experienced. Although burns are not experienced, it is a need that social workers should focus on it .

- **The nature of sexual abuse**

The following is a guideline for the nature of sexual abuse:

- Sexual contacts of intimate parts, e.g. the penis, vagina, anus or pelvic-area;
- fondling of either the abuser or the abused;
- oral genital contact;
- sexual intercourse;
- anal intercourse;
- interfemoral in which the penis is placed between the child's legs; and
- sexual assault which includes rape.

This study indicated that sexual intercourse has been experienced by the highest number of children, followed by oral genital contacts, fondling and sexual contacts of intimate parts. Anal intercourse and interfemoral are not experienced.

It is necessary that the social workers focus on all the types of sexual abuse disregarding whether it is experienced or not.

- **The nature of emotional abuse**

The following is the guideline for the nature of emotional abuse:

- Rejection which refers to behaviours that constitute abandonment;
- isolating whereby the child is cut off from normal social experiences;
- ignoring whereby the child is deprived of stimulation for emotional development;
- terrorising whereby the child receives extreme punishment; and
- corrupting in which the child is encouraged to engage in antisocial behaviour.

According to the findings of this study rejection, ignorance, corruption and isolation are noticed while terrorising is not noticed.

Social work service rendering concerning child abuse should focus on all the types of emotional abuse even on those which are not noticed due to the point that it is difficult to notice emotional abuse.

- **The nature of neglect**

The following is a guideline for the nature of neglect:

- Poor nutrition in which the child receives inadequate food;
- lack of love whereby the child is not given the attention of a caring relationship;
- lack of protection meaning that the child is predisposed to accidents;
- lack of supervision in which young children are left unsupervised for longer

periods;

- inadequate shelter whereby the child is housed in an unsafe house;
- lack of clothing whereby a child wear ill-fitting clothes;
- lack of medical treatment in which the parent fails to provide care for the child's medical problems;
- poor hygiene whereby the child is unwashed; and
- educational neglect in which the parent fails to ascertain the child's attendance in school.

The findings of this study indicated that lack of nutrition, inadequate shelter, lack of clothing and medical neglect have been experienced. While educational neglect, lack of love, lack of protection and lack of supervision were not experienced. The social workers need to focus on all these types of neglect and to confirm whether the situation is neglect or poverty.

6.2.1.4 The symptoms of the types of child abuse

Each type of child abuse has its own symptoms according to which it can be identified. There are both physical and behavioural symptoms.

- Physical symptoms of physical abuse

Physically abused children can show bruising and lacerations. It appears as if bruising and lacerations are being noticed as physical symptoms of physical abuse. It is therefore necessary for social workers to focus on bruising and lacerations in their service rendering concerning child abuse. This can enhance their service rendering.

- Behavioural symptoms of physical abuse

The following is a guideline for the behavioural symptoms of physical abuse:

- Fear of physical contact;
- temper tantrums;
- withdrawal;
- craving for attention;

- wearing long sleeved clothing;
- overly aggressive;
- sleepy in class;
- fearful of parents;
- arriving early at school; and
- excessive school absence.

According to this study the following behavioural symptoms of physical abuse are experienced: fear of physical contact, temper tantrums, fearful of parents, over aggressiveness and excessive school absence, while craving for attention, wearing long sleeved clothes, sleepy in class, withdrawal and arriving early at school are not experienced. Although all the symptoms are not noticed all the symptoms should be considered in service delivery.

- **Physical symptoms of sexual abuse**

The following is a guideline for the physical symptoms of sexual abuse:

- Pregnancy at an early age;
- bruises of external genitalia;
- bleeding from external genitalia;
- swollen cervix;
- red vagina;
- the presence of semen;
- torn bloody garments;
- the presence of sexually transmitted diseases;
- vaginal discharge; and
- complaints of difficulty in urination.

This study indicated that the following physical symptoms of sexual abuse are noticed: pregnancy at an early age, bruises of external genitalia, red vagina, presence of semen, presence of sexually transmitted diseases and complaints of difficulty in urination. Bleeding from the external genitalia, swollen cervix, torn bloody garments and vaginal discharge are not noticed. The social workers should focus on all these symptoms in cooperation with the medical staff for effective service rendering concerning child abuse.

- **Behavioural symptoms of sexual abuse**

The following is a guideline for the behavioural symptoms of sexual abuse:

- Poor peer relationships;
- prostitution;
- comments that the child was assaulted;
- substance abuse;
- irregular school attendance;
- engaging in delinquent acts;
- sleep disturbance; and
- suicide attempts.

The following behavioural symptoms of sexual abuse are found to be noticed: poor peer relationships, substance abuse, irregular school attendance and sleep disturbances while prostitution, comments that the child has been assaulted, engaging in delinquent acts and suicide attempts are not noticed.

- **Physical symptoms of neglect**

The following is a guideline for the physical symptoms of neglect:

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

Inadequate clothing and absence of medical care are noticed while abandonment, poor personal hygiene and being hungry are not noticed. It should be determined whether a symptom such as inadequate clothing amounts to neglect or to poverty as this symptom can be indicating either neglect or poverty.

- **Behavioural symptoms of neglect**

The following is a guideline for the behavioural symptoms of neglect:

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

This study indicated that begging for food and irregular school attendance are noticed while falling asleep at school, use of drugs, engaging in delinquent acts and failing to thrive as an infant are not noticed. However the social workers need to focus attention on all the behavioural symptoms of neglect for effective service rendering concerning child abuse.

6.2.1.5 The causes of child abuse

Child abuse is caused by a variety of factors which can be classified under different models. The following is a guideline for the causes of child abuse:

- The psychodynamic model which attributes the causes of child abuse to parental inadequate psychological functioning and understanding of parental roles. This model includes the following causal factors:
 - * Lack of mothering imprint;
 - * excessive expectations towards the child;
 - * parental role reversal;
 - * scapegoating;
 - * immature parents; and
 - * mental illness.
- The learning model which attributes child abuse to the lack of learning certain skills to employ when interacting with children, e.g. child rearing skills.

- The environmental model which take account of external factors as causing child abuse. This model includes the following factors;
 - * Occupational stress;
 - * poor education;
 - * poverty;
 - * alcohol abuse;
 - * drug abuse;

 - * overcrowding;
 - * poor housing;
 - * unemployment; and
 - * social isolation.

- The biosocial model which considers the causes of child abuse from the standpoint of child factors such as the inferior health status of the child or child handicap.

- The psychosocial system model which regards child abuse as resulting from a combination of various stress factors, e.g. the interaction of the psychodynamic and environmental factors.

The following factors from different models has been indicated as the main and contributory causes of child abuse:

- Lack of mothering imprints;
- excessive expectations from the child;
- parental role reversal;
- scapegoating;
- immature parents;
- mental illness;
- lack of child rearing skills;
- poverty;
- poor education;
- occupational stress;
- alcohol abuse; and

- drug abuse.

Lack of social skills, inferior health status and overcrowding are not indicated as the causes of child abuse. Although all the factors are not indicated as the causes of child abuse in this study, the social workers rendering services concerning child abuse should focus on all these factors for effective service rendering.

6.2.1.6 The impact of child abuse on the abused child

Child abuse can have various negative effects on the abused child. The following is a guideline for the negative impact of child abuse on the abused child

- Psychological ;
- Behavioural;
- cognitive; and
- personality effects.

According to the findings of this study child abuse has all the negative effects as mentioned above, on the abused child, as a result the impact of child abuse should be the main focal aspect in rendering services concerning child abuse.

6.3 SOCIAL WORK FUNCTIONS IN SERVICE RENDERING CONCERNING CHILD ABUSE

Social workers rendering services concerning child abuse need to know that there are specific functions which are performed to manage child abuse. Such functions are as follows:

- Identification;
- investigation;
- intervention; and
- prevention.

A discussion of these functions as guidelines for social work service delivery concerning child abuse is given below;

6.3.1 Identification

Child abuse must be identified before intervention of any kind can be rendered. Identification includes interviewing people involved in child abuse, e.g. the child, parents, all the adults in the home and witnesses with a view of understanding the situation.

The following is a guideline for what the social workers should do when interviewing the parents. They should:

- Select interviews appropriate to the situation;
- conduct the interview in private;
- tell the parents why the interview is taking place;
- be direct, honest and professional;
- tell the parents that the interview is confidential;
- reassure the parents of the support of the program;
- tell the parents if a report has been made or will be made; and
- advise them of the worker's legal responsibilities to report.

The social workers should not:

- Try to prove abuse or neglect by accusations or demands;
- display horror, anger, or disapproval of parents, child or situation;
- focus on family matters unrelated to the specific situation; and
- place blame on the parents or child.

When interviewing the child who can understand the interview, the social workers should:

- Make sure the interviewer is someone the child trusts;
- conduct the interview in private;
- sit next to the child, not across the table or desk;
- tell the child that the interview is confidential;
- conduct the interview in the language that the child understands;
- ask the child to clarify words or terms that are not understood; and

- tell the child of any future action that will be required.

The social workers should not:

- Allow the child to feel in trouble or at fault;
- criticise the child's choice of words or language;
- suggest answers to the child;
- probe or press for answers which the child is not willing to give;
- display horror, shock or disapproval of parents, child or the situation;
- force the child to remove clothing;
- conduct the interview in a group of interviewers; and
- leave the child alone with a stranger.

According to the findings of the study identification as a function of child abuse is performed when rendering services concerning child abuse. The performance of this function should be encouraged as it forms the basis of service delivery concerning child abuse.

6.3.2 Investigation

Investigation focuses on the assessment of the abused child, the parents, and the circumstances surrounding the abuse with the aim of planning intervention to solve the problem in question. Social workers who are doing assessment are required to have knowledge of family dynamics, human development and environmental factors for making decisions regarding intervention and of each type of abuse, i.e. physical, sexual, emotional and neglect in terms of having its own different character and dynamic pattern.

The following is a guideline for the issues which should be explored:

- Determining the degree of risk to the child in making decisions to allow him to remain in the abusive situation.
- Special considerations should be taken into account in decision making, namely: e.g. in the case of physically abusive parents, the major emphasis is on the parents' reaction to the injuries incurred. The following are important: the family's attitude towards corporal punishment and the role this may have

played in the injury, the ease with which the parents lose control of their behaviour and the amount of stress required to trigger this and the role of the non-abusive spouse in abuse.

In cases of neglect, the social worker first needs to know what caused the parents to neglect their children. He/she must try to discover which needs of the parents caused them to turn away from the child. Secondly, it is also important to know which needs of the parent interfere with nurturing the child, and lastly a distinction between environmental stress and psychological stress must be made.

In cases of emotional abuse, professionals agree that there must be an action or series of actions or omissions by the parents that can be shown to have caused emotional harm or injury. Qualified mental health professionals can only determine the cause and extent of injury.

An assessment of sexually abusive parents must evolve from considerations of very complex issues of both parents such as relationship with the abused child, e.g. is he/she a stepchild or not, interaction between the parent and the child and/or type of housing in which they are accommodated.

In assessing an abused child focus should be on the child's role in the parent/child interaction that resulted in abusive or neglected actions and on the extent of harm to the child. This data is basic for treatment planning. Individual variations in data obtained generally reflect the age of the child. With the age factor in mind, the social worker surveys the psychosocial functioning of the children relative to their own development, to their family and to the particular abusive incident. There are several core issues when assessing children as well as special issues relevant to particular age groups as discussed below:

The special issues of infancy are the degree of attachment between parent or parent surrogate and the child and developmental delays. Physically abused infants as well as neglected infants often demonstrate failure to thrive and show developmental delays.

In evaluating the pre-school child, it is important to note whether the child is a problem child, i.e. a child whose developmental delay manifests in provocative behaviour, such as rigidity, negativism and hyperactivity. These children often

become targets of abuse or neglect. Normal developmental tasks of this period such as separation and toilet training can over stress the inadequate parent, resulting in abuse. Precocious separation or hyper maturity is sometimes secondary to abuse and neglect and may mask a significant lack of depth in interpersonal relations.

Latency or school age children who presented developmental delays or personality traits such as difficult toilet training and negativity in their pre-school period may now manifest refusal to attend school. At this stage problems such as school failure, poor peer relations and cranky behaviour at home play a role in abuse. Childhood depression is another prevalent result of abuse and neglect. The social worker is dealing with children at this age who may defend the parent out of fear of loyalty and may be guarded.

Adolescents are more likely to report abuse or neglect than younger children either to the school authority, police or social workers. These adolescents want help but not at the expense of alienating parents or destroying the family. They are more subject to guilt feelings about the effects of the report on their parents. Changing their minds or their stories regarding abuse manifests this ambivalence. The adolescent may be out of control and actually be of an age to victimise the parents but whatever the provocation for parental abuse, the abusing parent is also out of control.

The function of investigation is performed in service rendering concerning child abuse as indicated by the findings of the study. The performance of this function should be enhanced as it is necessary for planning intervention.

6.3.3 Intervention

Intervention is defined as professional behaviour of a social worker to bring about change in the person-environment situation to achieve the objectives of the agreement of co-operation, which has been entered into with the client, e.g. the parents.

The goal of intervention with such parents is to assist them to deal with a range of problems associated with child abuse. Various methods of intervention that can be used in service delivery concerning child abuse has been identified as follows;

- Social work with the individual;
- social work with the family;
- social work with the group;
- social work with the community;
- social work research; and
- an integrated application of these methods.

Social workers who are rendering services concerning child abuse can choose among these intervention methods or integrate them in consideration with the specific case being dealt with.

The following is a guideline for the employment of the methods of intervention in rendering services concerning child abuse;

6.3.3.1 Social work with the individual

The New Dictionary of Social Work (1995:8) define social work with the individual as a method of social work aiming primarily at helping individuals on a person-by-person basis to attain the fullest degree of social functioning. Social work with the individual in child abuse cases encompasses a broad range of intervention aimed at restoring, maintaining and enhancing the individual's personal and social functioning. The following is a guideline for the benefits of employing social work with the individual for parents:

- To enhance their ego functioning, particularly in the areas of impulse control and judgement;
- to acquire better coping skills;
- to develop the self-esteem and empathy that are so essential to good parenting;
- to improve role functioning and interpersonal relationships;
- to learn better child management techniques;
- to develop more realistic and age appropriate expectations of children;
- to modify long-standing behaviour patterns;
- to compensate for early developmental arrests;
- to gain greater self-awareness; and
- to improve relationships with the community .

Social workers involved with individuals in rendering services concerning child abuse can employ various intervention approaches which are mostly employed in rendering services concerning child abuse.

The following is a guideline for approaches which can be employed:

- Problem solving;
- behaviour modification;
- cognitive restructuring;
- ego-psychology; and
- crisis intervention.

These approaches overlap and must be used flexibly with the individuals involved.

A choice can be made among these approaches. A discussion of the above given approaches follows below:

- **Problem solving**

The basic assumption of this approach is that human existence is a continual problem solving process. This approach is aimed at helping the person to solve whatever problems he cannot solve at the present moment and the by-product is that he will be able to solve future problems.

The major emphasis of the problem solving approach is the training of parents in problem solving skills following specific steps. The following is a guideline for the steps to be followed:

- Identifying the problem of child abuse;
- generating alternative solutions to solve the problem;
- exploring the consequences of each proposed alternative;
- choosing the best plan and implementing it; and
- evaluating the outcomes of the plan and its relevance with similar future situations of child abuse.

The findings of this study indicated that the problem solving approach is being

employed with the parents when rendering services concerning child abuse. The employment of this approach should also be employed with any person who is involved in child abuse, e.g. the child as victim, the abuser or child's family.

- **Behaviour modification**

The behaviour modification approach is predicated on a theoretical proposition that maladaptive behaviour is learned and can be unlearned under controlled situations.

Child abuse is argued to be the result of inadequately or inappropriately learned parenting behaviour and much intervention with parents/caregivers of abused children had led to the contemporary approaches to training parents/caregivers in developing more effective parenting strategies.

Intervention focuses on observable behaviour, the context in which these behaviours occur, with the objective of modifying the behavioural interchanges among persons in the target system. Focus is on the individual child who has been abused, the identification of child abuse, the antecedents to child abuse and the consequences that followed the occurrence of child abuse.

An assessment of the child's behaviour in its context relative to the parent's directives and responses to that behaviour is done. Intervention therefore focus on the training of parents to modify the manner in which they gave instructions to their children and the enhancement of the parent's skills in child management.

This intervention can affect the parent's attitudes towards their children positively and produce positive changes in the behaviour of siblings of the abused child as parents will generalise their new skills to the siblings.

Different techniques of intervention may be employed for various behavioural objectives, namely:

- Direct instruction, role-playing or modelling can be used to train parents in parenting skills; and
- relaxation training or communication exercises can be used for the development of social skills, reduction of stress, assertiveness training or anger control training.

Behaviour changes achieved are maintained after termination through strategies such as cognitive testing regarding the level of understanding which the individuals have concerning the processes by which they have acquired their new skills. Follow-up is made at predetermined intervals focussing on identifying any regression in the acquired behavioural skills (Furniss et al, 1994:869; Lutzker et al, 1994:69 and Brunk, 1997:180).

According to the findings of this study the behaviour modification approach is being employed when rendering services concerning child abuse. The employment of this approach should be encouraged to continue as child abuse can be seen as negative behaviour which is learned and can be unlearned.

- **Cognitive restructuring**

According to authors such as Fennel (1992:129), Vondracek (1995:120) and Palmer (1996:77) the cognitive restructuring approach focuses on changing the incorrect thought patterns, beliefs and attitudes of the clients which it is believed to lead to lasting behaviour change.

Child abuse is addressed in terms of incorrect premises and a proneness to distorted imaginable experiences, which lead to incorrect emotions and responses to external events. One of the features which is common to the acts of abuse is the underlying emotion of anger. Anger is therefore the most evident parental response to what is seen as the child's provocative behaviour. The aims of the cognitive restructuring approach is therefore to alleviate parental anger in the face of perceived provocation by children, and to improve child management skills.

The following is a guideline for skills which parents can learn:

- Desirable coping skills to cope with provocation;
- the ability to give a less negative meaning to the provoking child, e.g. taking provocation as unintentional;
- relaxation techniques to have the means to alleviate the intense pressure of provocation towards immediate and impulsive action engendered by the physiological arousal accompanying the experience of anger; and

- problem solving entailing more effective ways of preventing and ameliorating perceived provocations than impulsive actions.

It appears as if the cognitive restructuring approach is not employed on a regular basis in rendering services concerning child abuse. This can have a negative impact on service delivery as child abuse is mostly perpetrated by parental anger which can be dealt with by the employment of the cognitive restructuring approach.

- **Ego psychology**

Authors such as Goldstein (1995:42) and Vondracek (1995:12) agree that ego psychology deals with the relationship of personality to reality with the basic goal of supporting and strengthening the clients' ego so that they can function and cope more effectively with their problem areas. The following is a guideline for the aims of ego psychology in service rendering concerning child abuse with parents:

- Helping parents function more comfortably in their role as parents;
- better control of behaviour and feelings;
- improving parent-child, and other interpersonal relationships;
- developing better coping skills when problems arises;
- remedying early parental developmental defects that may be part of the pattern of child abuse;
- acquiring of greater understanding of the children's needs; and
- learning better ways of managing the children's needs.

Ego psychology can be provided through the provision of information, advice and direction and can focus on the following aspects:

- Child development;
- child rearing techniques;
- special problems; and
- parents' needs.

The findings of this study showed that ego psychology is employed on a regular basis when rendering services concerning child abuse. The employment of this approach should be encouraged to continue and to include all the role players in

child abuse with a view of supporting their ego and helping them to function and cope more effectively with their problem areas.

- **Crisis intervention**

Crisis intervention is defined by the New Dictionary of Social Work (1995:16) as an approach in social work which is directed towards the restoration and promotion of the social functioning of individuals who experience a crisis as a result of an unexpected and disruptive event and who do not have the problem-solving abilities and resources to cope with the increased level of tension and anxiety.

The following is a guideline for the aims of crisis intervention:

- Ending the abuse through the removal of the abuser or the victim of abuse from the abusive situation;
- helping the victim to deal with his emotions;
- strengthening the parents' ability to protect the child; and
- assisting the abuser, victim and other family members to establish appropriate role boundaries.

According to the findings of this study crisis intervention is not employed on a regular basis in rendering services concerning child abuse, which can have a negative impact to service rendering concerning child abuse as child abuse is regarded as a crisis which needs intervention through crisis intervention. Social workers rendering services concerning child abuse need to employ crisis intervention in order to render effective services concerning child abuse.

6.3.3.2 Social work with the family

The New Dictionary of Social Work (1995:25) define social work with the family as the treatment of a client involving all the members of the family in interaction, in an effort to change the problem behaviours with a view of promoting the client's and the family's social functioning.

In service delivery concerning child abuse, the entire family system including the abused child, non abused siblings and parents is affected by the abuse of a child and is seen together by the social worker. The family is thus seen as a unit of attention

and intervention will address the family as a whole. The following advantages can be achieved by seeing the family as a unit:

- The social worker can assess family interactions and the roles family members take
- with one another;
- the family's interaction can help the parents to learn to communicate more directly;
- to solve problems jointly, and to empathise with other family members including the abused child; and
- the family can learn and experiment with more effective child management techniques.

Social work with the family focuses on two goals regarding child abuse, namely:

- Support of adaptive functioning whereby the social worker can support instances of good child rearing practices on the part of parents that could help prevent or modify the abuse of the child, e.g. helping the child to do homework rather than blaming the child for not doing homework.
- Help in problem solving in which parents are taught to solve problems.

In abusive families, members are often not able to solve problems but instead become frustrated, angry and abusive. Parents usually attack the child when he made a mistake. The social worker can help the family to listen to one another instead of attacking each other. The family is helped to solve the problem together by following the steps of the problem solving model.

The following is a guideline for the steps to be followed in the problem solving approach:

- Identifying the problem, e.g. child abuse;
- generating alternative solutions to solve the problem;
- exploring the consequences of the proposed alternatives;
- choosing the best plan and implementing it;
- evaluating the outcomes of the plan and its relevance to similar future situations of child abuse;
- overt behavioural change whereby the social worker intervenes directly when abusive parental behaviour occurs, e.g. a mother who hits her child in

frustration might be helped to remove herself from the child's presence when she begins to feel angry. The parent might also be helped to talk to the child rather than striking her; and

- modification of systemic family processes, e.g. communication, interpersonal relationships and structure. In some instances, problems among the other family members, such as a marital conflict e.g. anger, that is displaced on the child can result in child abuse. In this case, the social worker can encourage the parents to attend to their conflict to improve their marital relationship.

The findings of this study indicates that social work with the family is performed on a regular basis when rendering services concerning child abuse. For effective service rendering concerning child abuse social work with the family should be integrated with the other methods of intervention.

6.3.3.3 Social work with group

Social work with the group involves an alliance of people who are brought together to work on a common task, to use the group experience for support and mutual aid, for educational purposes or to effect personality change. Social work with the group thus involves different types of groups that have distinctive though sometimes overlapping goals ranging from those that are supportive to those that are educational.

Social work with the group is an effective approach in rendering services concerning child abuse as has been shown to be effective in its ability to provide the following:

- The opportunity for nurturance, resocialization and relating to others;
- powerful experiences in being accepted;
- the development of better communication and other interpersonal skills;
- the atmosphere in which to develop increased empathy for others, new values, attitudes and behaviour; and
- support networks that diminish the individual's sense of isolation and enhance their ability to take or offer help.

The following is a guideline for the issues on which to focus when employing social work with the group:

- Isolation;
- feelings of hopelessness;
- interpersonal problems;
- poor socialization skills;
- poor parenting;
- poor child management skills;
- low self-esteem; and
- poor ego functioning in key areas such as impulse control.

The following is a guideline of the skills which the parents can be taught when employing social work with the group:

- To discipline effectively through reasonable punishments;
- setting the limits of disciplining their children;
- the particular needs of their children;
- to give approval, affection and attention to their children; and
- not to be overly giving in such a way that their resentment builds up when the child does not return or appreciate their self sacrifice.

The findings of this study showed that social work with the group is not employed which may be due to lack of skills of social workers in this regard. It is necessary that social workers rendering services concerning child abuse employ social work with the group which may be of assistance in covering a broader scope in service delivery concerning child abuse.

6.3.3.4 Social work with the community

Lombard (1991:72) define social work with the community as a method of social work based on a scientific process which is directed towards achieving one or more of the following objectives:

- To satisfy the broad needs of the community and to create and maintain a balance between the needs and the resources in the community;
- to provide the community with the opportunity to exploit its strengths and

- potential knowledge and skills and to develop these, in order not only to be able to deal with social problems and needs but also to prevent them; and
- to effect change in the community, in group relations and the distribution of decision-making powers.

Social work with the community can offer services to abusive or potentially abusive families and increasingly rely on a broad range of community services to render services to these families to achieve the above mentioned objectives.

The following is a guideline of programs which can be rendered:

- Prenatal support;
- education for parents;
- early and periodic childhood screening;
- social skills training such as coping skills in times of problems; e.g. child abuse or communication skills;
- mutual aid programs;
- neighbourhood support groups;
- family support services focussing on family planning, child care or crisis care; and
- public awareness campaigns on child abuse.

The following is a guideline for the functions to be performed by social workers employing social work with the community:

- Establish linkages between the people and community resources concerned with child abuse. This occurs where people are not aware of the resources available to them e.g. child crisis centres.
- Facilitating interactions between the people with resources. This is applicable in cases where the existing resources cannot be used by the people because of problems with regard to these resources, e.g. unavailability of funds for clients. It is therefore the social worker's function to improve interaction between the clients and the resources.

The results of this study showed that social work with the community is not employed which might be due to lack of skills in using this method. The employment of social work with the community is necessary for service rendering concerning child abuse either alone or integrated with the other methods which can contribute to the

reduction of the social workers' high case loads.

6.3.3.5 Social work research

De Vos (1998:19) defines social work research as a scientific inquiry about a social work problem that provides an answer contributing to an increase in the body of generalisable knowledge about social work concerns. This definition implies that social work research investigates a social work problem and in the process also adds to the general underlying body of scientific knowledge available to the profession. Most research which is conducted in social work is "applied" research which aims at developing, implementing and evaluating intervention strategies. Social work research should thus focus on research which yields results that can further develop their practice and wisdom necessary for intervention and problem solving (De Vos, 1998:248).

A process of research consisting of different stages and steps can be followed. In following the process, a social worker can choose between a qualitative or quantitative research approach or can choose a combination of the two approaches (De Vos, 1998:38).

The following is a guideline for the steps to be followed in the quantitative approach in rendering services concerning child abuse:

- Selection of a research problem, e.g. child abuse;
- formulating questions or hypotheses;
- formulating a research design, e.g. an exploratory research design;
- collecting data, e.g. by means of interviews schedules;
- analysing data; and
- writing the research report.

It appears as if social work research is employed in rendering services concerning child abuse. This method should be integrated with the other methods for effective service delivery concerning child abuse.

6.3.3.6 The application of social work methods by means of an integrated approach

An integrated approach of social work methods refers to uniting the various methods of practice from which social work is made up, e.g. social work with the individual, family, group, community and research (Goldstein, 1994:22, Welsh, 1995:99 and De Villiers, 1996:81). The integrated approach does not detract from the individual character of the methods but aims at achieving the same goal as that which the social work profession is aiming at with each respective method. The purpose of an integrated approach is to be helpful to people as individuals, families, groups or communities.

A social worker can begin with individuals or families who have a problem or need and formulates a plan to meet the need or resolve the problem based on an assessment of the situation. Intervention may be directed to different systems, e.g. individual, family, group or community or to the relationships among them to resolve the problem, e.g. child abuse as discussed in this chapter under social work with the individual, the family, group, community and research.

It is clear that an integration of the methods is not employed as shown by the results of the study, which might contribute to ineffective service rendering concerning child abuse. The integration of the methods is a necessity in service rendering concerning child abuse as it can involve one client throughout intervention who can also benefit from all the integrated methods.

6.3.4 Prevention

Prevention is defined by the New Dictionary of Social Work (1995:46) as a process aimed at minimising and eliminating the impact of conditions that may lead to social malfunctioning, e.g. child abuse. Prevention can be offered at three levels, namely: primary, secondary and tertiary.

6.3.4.1 Primary prevention of child abuse

Primary prevention seeks to affect factors that contribute to the appearance of child abuse. It refers to efforts aimed at positively influencing parents/caregivers before

abuse occurs. Primary prevention thus concerns itself with reducing the incidence of new cases of child abuse before it starts. Usually these operate at the societal level through public awareness campaigns and advocacy groups and are then realised by social, legal and educational processes of change.

The following is a guideline for actions in the primary prevention of child abuse:

- Elimination of the norms that legitimate and glorify child abuse in the society and family, such as the use of violence as a form of media entertainment;
- reducing violence-provoking stress created by society, such as poverty and inequality;
- incorporation of families into a network of kin and community, to reduce isolation;
- changing the sexist character of society by educational development; and
- breaking the cycle of child abuse in the family by teaching alternatives to child abuse as a way of controlling children.

Social workers are devoting more time and resources to high-risk populations. These are guidelines for high-risk factors to be considered:

- Low birth weight pre term infants;
- children of adolescent parents;
- handicapped and special needs children;
- children of mentally retarded parents;
- children of substance abusers;
- children of parents who were abused as children; and
- children of parents with few or inadequate support systems, i.e. family, friends or neighbours (Richard, 1991:170).

According to the results of this study primary prevention is done. The social workers need to know that children may belong to more than one of these population groups with the risk factor increasing as group membership increases when they focus on the high-risk factors according to populations.

6.3.4.2 Secondary prevention of child abuse

Secondary prevention of child abuse involves the identification of potential child abusers and treating them before child abuse can take place. It is thus a before the fact technique in its timing which attempts to direct services towards specific parents identified as having a high potential for experiencing child abuse (McMurtry, 1995:42).

The purpose of secondary prevention of child abuse is to avert the onset of child abuse.

Barton & Schmidt (1990:175) stress the importance of parent education courses as an effective technique of secondary prevention of child abuse. This view is supported by Hawkings (1993:197) who recommends a training program for parents and prospective parents which will improve the quality of child-rearing and prevent the development of child abuse. The following is a guideline for the aspects which the programs can teach parents:

- Nurturing;
- the needs of children at different stages;
- how parents respond to those needs;
- good parenting skills;
- family planning;
- stress management;
- conflict management;
- child development;
- health;
- personal growth; and
- the warning signs of their own potential to abuse the child.

The findings of this study indicated that secondary prevention is done with a view of reducing the number of potential abusers. This can contribute to effective service rendering concerning child abuse.

6.3.4.3 Tertiary prevention of child abuse

Tertiary prevention of child abuse refers to the services offered to families after child abuse has occurred. It is therefore a reactive intervention aimed at preventing an

abused child from being further abused. Prevention here focuses on keeping the families from developing abusive cycles in which children are repeatedly abused.

Tertiary prevention is rendered by the provision of treatment to the abusive families. The following is a guideline for treatment goals:

- Stopping the abuse;
- improving parental functioning;
- reducing frustration, stress and conflict within the family and the environment; and
- developing conflict management skills.

According to the findings of this study tertiary prevention is done with a view to preventing the repeated abuse of children.

6.4 SUMMARY

6.4.1 Guidelines for social workers rendering services concerning child abuse are necessary for enhancing service delivery.

6.4.2 Guidelines has been formulated and focused on the following aspects:

- The nature of child abuse which included the following:
 - * The definition of child abuse;
- * the child abusers;
 - * the types of child abuse;
 - * the nature of the types of child abuse;
 - * the symptoms of the types of child abuse;
 - * the causes of child abuse; and
 - * the impact of child abuse on the abused child.
- Social work service rendering concerning child abuse which included the following:
 - * Social work functions performed in rendering services concerning child

abuse, namely:

- ** Identification;
- ** investigation;
- ** intervention; and
- ** prevention on the primary, secondary and tertiary levels.

* Social work methods employed during intervention, namely:

- ** Social work with the individual;
- ** social work with the family;
- ** social work with the group;
- ** social work with the community;
- ** social work research; and
- ** an integrated application of these methods.

* Social work approaches, namely:

- ** Problem solving;
- ** behaviour modification;
- ** cognitive restructuring;
- ** ego psychology; and
- ** crisis intervention.

CHAPTER 7

GENERAL SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

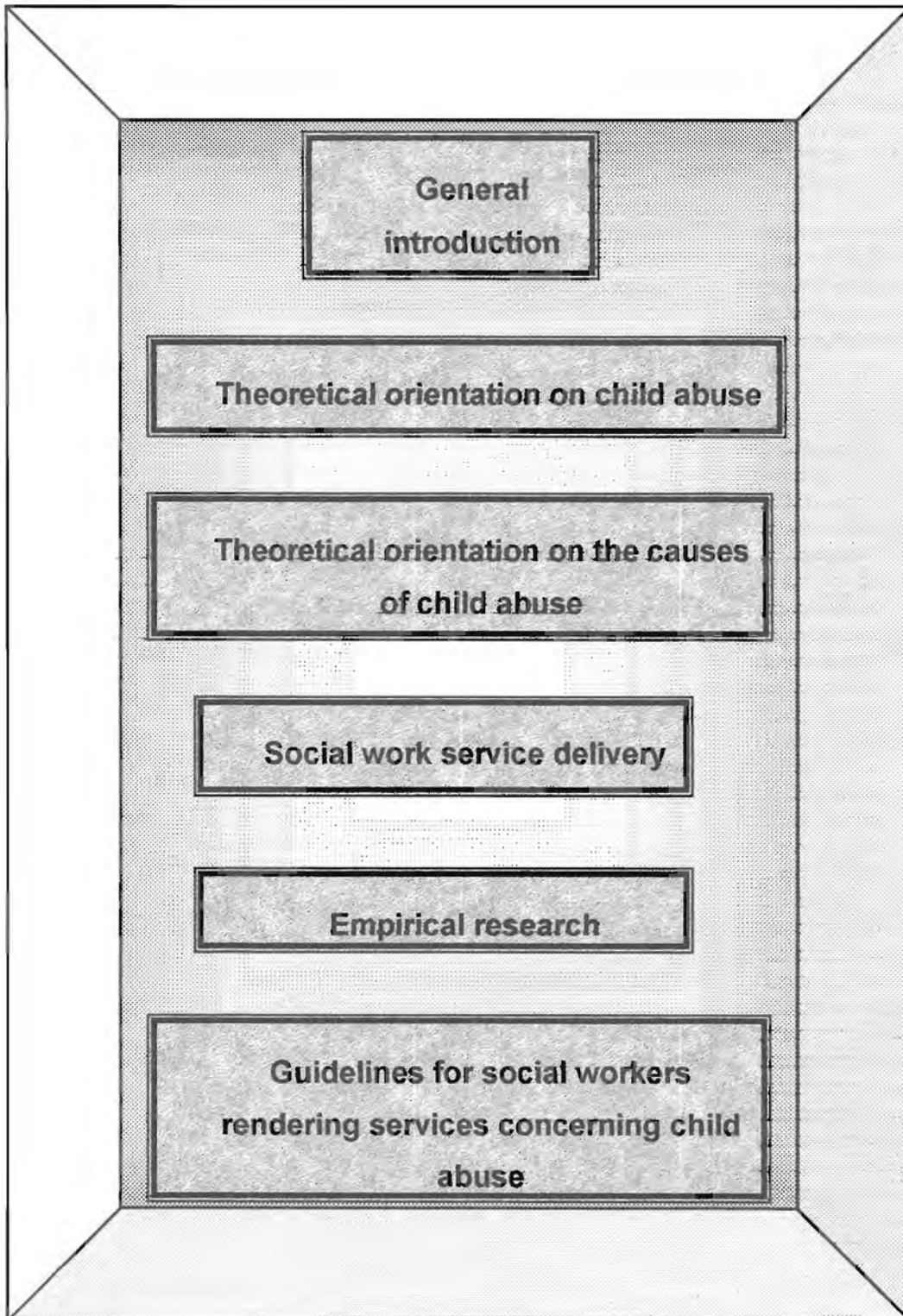
7.1 INTRODUCTION

The phenomenon of child abuse occurs worldwide and draws widespread attention within 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 which is against their rights.

The rate of child abuse is escalating on a daily basis and is therefore attracting the attention of the helping professions, particularly social workers who are supposed to render social work services, but lack guidelines. This study covered a broad range of factors related to the types, nature, causes, symptoms and the impact of child abuse and the nature of social work services rendered by social workers concerning child abuse.

The primary focus of this chapter is to highlight the themes of the study by means of a summary, conclusions and recommendations. The major themes of this study are schematically represented in figure 51 below:

Figure 51: Major Themes



7.2 GENERAL INTRODUCTION

7.2.1 Summary

Chapter one provided an introduction to the study. This chapter included the following: the motivation for the choice of the subject, problem formulation, aims and objectives of the study, the questions asked, research approach, type of research, research design, research procedure and strategy, the pilot study which included literature study, consultation with experts, feasibility of the study and pilot test of questionnaires, description of the research population, sampling, sampling method, ethical issues, definition of key concepts, problems encountered and the overview of the contents of the study.

- The aim of the study

The aim of this study was to formulate guidelines for social workers rendering services concerning child abuse.

This aim was met by means of the study.

- The objectives of the study

The objectives of the study included:

- * Objective 1: To gather information about the types, causes, symptoms and impact of child abuse among black children in the North West Province.
- * Objective 2: To gather information about the nature of services rendered by social workers concerning child abuse.
- * Objective 3: To gather information about the methods employed by social workers rendering services concerning child abuse.
- * Objective 4: To gather information about the approaches employed by social workers rendering services concerning child abuse.
- * Objective 5: To formulate guidelines for social workers rendering services concerning child abuse based on the gathered information.

These objectives were achieved in this study.

- **The questions for this study**

The questions for this study were formulated as follows:

- * Question 1: What are the types of child abuse that occur in the North West Province?
- * Question 2: What are the causes of child abuse in the North West Province?
- * Question 3: Which symptoms of child abuse are enough to identify an abused child?
- * Question 4: What is the impact of child abuse on the abused child?
- * Question 5: What is the nature of social work services rendered by social workers concerning child abuse?
- * Question 6: Which methods are employed by social workers in their service rendering concerning child abuse?
- * Question 7: Which approaches are being employed by social workers in their service rendering concerning child abuse?

These questions were answered by the findings of the study.

7.2.2 Conclusions

Social work literature and existing research on child abuse in the North West Province is scarce, as a result, there is no existing guidance for the current research. Therefore literature and research studies from South Africa, England and the United States of America were relied upon.

The rate of child abuse is growing on a daily basis as reflected by the number of child abuse cases handled by social workers between the years 1995 – 1999.

Since the study was the first to be conducted in the North West Province, an exploratory design was utilised.

The Department of Health and Developmental Social Welfare focuses on service delivery to families, including families of abused children. Social workers employ a variety of methods and approaches in their intervention are dependent upon the clients' problem areas and needs. It is therefore important for social workers to employ a variety of methods and approaches for effective service rendering

concerning child abuse.

This study can hopefully make a contribution to the social work profession concerning child abuse in terms of the formulation of guidelines for social workers rendering services concerning child abuse.

7.2.3 Recommendations

- Further research need to be conducted on child abuse and social work service rendering concerning child abuse, to increase literature on child abuse in the North West Province, and focus on the abused child as this research focused on the parents/caregivers of abused children.
- The rate of child abuse needs to be reduced by any strategy, e.g. through the provision of information to children regarding child abuse, community lectures, etc.
- The community should be informed about the symptoms of the different types of child abuse. This will enable them to be able to identify an abused child as early as possible and to report it to the authorities.

This chapter fulfilled part of the aim of the study: to formulate guidelines for social workers rendering services concerning child abuse. It also fulfilled part of the first objective: to gather information about the types, causes, symptoms and impact of child abuse.

7.3 THEORETICAL ORIENTATION OF CHILD ABUSE

7.3.1 Summary

Chapter two focused on the theoretical orientation of child abuse, which included the following aspects:

- The rights of children whereby the violation is regarded as child abuse.
- The types of child abuse whereby four types were determined, namely: physical abuse, sexual abuse, emotional abuse and neglect. Physical abuse is the highest type which have been experienced, followed by sexual abuse, neglect and then emotional abuse.

- The nature of the types of child abuse were determined, together with both physical and behavioural symptoms as discussed below:

- * **The nature of physical abuse**

Physical abuse included injuries, poisoning and suffocation.

- * Physical symptoms of physical abuse:
 - Bruising and lacerations were noticed as physical symptoms of physical abuse.
- * Behavioural symptoms of physical abuse which were noticed included the following:
 - Fear of physical contact,
 - temper tantrums;
 - fearful of parents;
 - over aggressiveness; and
 - excessive school absence.
- * Behavioural symptoms of physical abuse which were not noticed included the following:
 - Craving for attention;
 - wearing long sleeved clothes;
 - withdrawal;
 - sleepy in class; and
 - arriving early at school.

- * **The nature of sexual abuse**

The following sexual abuse were noticed:

- Sexual contact of intimate parts;
- fondling;
- oral contact; and
- sexual intercourse.

Anal intercourse and interfemoral were not noticed.

- * Physical symptoms of sexual abuse noticed by the majority of

parents/caregivers.

The majority of parents/caregivers noticed the following physical symptoms of sexual abuse:

- Pregnancy at an early age;
- bruises of external genitalia;
- red vagina;
- presence of semen;
- presence of sexually transmitted diseases; and
- bleeding from the external genitalia.

Swollen cervix, torn bloody undergarments, vaginal discharge and complaints of difficulty in urinating, were not noticed by parents/caregivers.

* **Behavioural symptoms of sexual abuse**

The majority of parents/caregivers noticed the following behavioural symptoms of sexual abuse:

- Poor peer relation;
- substance abuse;
- irregular school attendance; and
- sleep disturbance.

All the parents/caregivers did not notice the following behavioural symptoms of sexual abuse:

- Prostitution;
- comments that the child was assaulted;
- engaging in delinquent acts; and
- suicide attempts.

* **The nature of emotional abuse**

The following types of emotional abuse were noticed:

- Rejection;
- ignorance;
- corruption;
- isolation; and
- insults.

All the parents/caregivers did not notice terrorising, deprivation and accusations.

* **The nature of neglect**

The following types of neglect were noticed:

- Lack of nutrition;
- inadequate shelter;
- medical neglect; and
- lack of clothing.

The following types of neglect were not noticed:

- lack of love;
- educational neglect;
- lack of protection;
- lack of supervision;
- poor personal hygiene; and
- absence of medical care.

This chapter fulfilled part of objective 1 which is: to gather information on the types, causes, symptoms and impact of child abuse.

7.3.2 Conclusion

- There are four types of child abuse in the North West Province – Moretele District namely: physical abuse, which is the highest in occurrence, followed by sexual abuse, neglect and then emotional abuse.
- Each type of child abuse has its own physical and behavioural symptoms.

7.3.3 Recommendations

- The four types of child abuse should be recognised as the types of child abuse, which is being experienced by black children in the North West Province – Moretele District.
- Attempts must be made to reduce the rate of these types of abuse, which may be achieved by e.g. social work service delivery through different intervention methods and approaches, e.g. research, community work, group

work, individual attention or an integration of these methods.

- Community involvement is also recommended.

7.4 THEORETICAL ORIENTATION ON THE CAUSES AND IMPACT OF CHILD ABUSE

7.4.1 Summary

Chapter three focuses on the causes and impact of child abuse. The following factors were indicated by the majority of the parents/caregivers as the main causes of child abuse:

- Lack of mothering imprints;
- excessive expectations towards the child;
- parental role reversal;
- scapegoating;
- immature parents;
- mental illness;
- lack of child rearing skills;
- poverty;
- poor education;
- occupational stress;
- alcohol abuse; and
- drug abuse.

The following factors were indicated by the minority of the parents/caregivers as the contributory causes of child abuse:

- Lack of mothering imprints;
- excessive expectations towards the child;
- parental role reversal;
- scapegoating;
- immature parents;
- mental illness;
- lack of child rearing skills;
- poverty;
- poor education;
- occupational stress;
- alcohol abuse; and

- drug abuse.

The following factors were indicated by the majority of parents/caregivers as not being the causes of child abuse:

- Lack of social skills;
- inferior health status; and
- overcrowding.

The impact of child abuse on the abused child.

- The majority of the parents/caregivers indicated that child abuse had both behavioural and psychological impacts on the abused children.
- The minority of the parents/caregivers indicated that child abuse had cognitive and personality impacts on the abused children.

Child abuse therefore has the following impacts on the abused children:

- Behavioural, psychological, personality and cognitive.

7.4.2 Conclusions

Child abuse is caused by a variety of factors, which can be classified under different models, namely: the psychodynamic, learning and environmental models:

- Under the psychodynamic model the following factors were indicated as the main and contributory causes:
 - Lack of mothering imprints;
 - excessive expectations toward the child;
 - parental role reversal;
 - scapegoating;
 - immature parents; and
 - mental illness.

Child abuse is therefore caused by the parents/caregivers inadequate functioning and understanding of parental roles.

- Under the learning model, the lack of child rearing skills was indicated as the main and contributory cause.

Child abuse is therefore caused by the lack of learning certain skills to employ when interacting with children.

- Under the environmental model the following factors were indicated as the main and contributory causes:
 - Occupational stress;
 - poor education;
 - poverty;
 - alcohol abuse; and
 - drug abuse.

7.4.3. Recommendations

- Community projects for parents/caregivers should be established and focus on the causal factors of child abuse with the aim of reducing its occurrence and reoccurrence.
- The following strategies should be implemented:
 - Groups should be formed which will help parents to develop the following:
 - Knowledge of parenting;
 - their roles as parents;
 - child development
 - the needs of children at different stages;
 - disciplining a child;
 - problem solving;
 - the rights of children;
 - violence against children;
 - conflict management; and
 - the availability of numerous community resources which can be used in times of need, e.g. hospitals, psychologists, social workers, police members and priests.

This chapter fulfilled part of the aim of the study: to formulate guidelines for social workers rendering services concerning child abuse. The chapter also fulfilled part of objective 1: to gather information about the types, causes, symptoms and impact of child abuse.

7.5 SOCIAL WORK SERVICE RENDERING CONCERNING CHILD ABUSE

7.5.1 Summary

Chapter four focused on social work service rendering concerning child abuse and fulfilled the aim of the study: to formulate guidelines for social workers rendering services concerning child abuse and the following objectives:

- Objective 2: to gather information about the nature of services rendered by the social workers concerning child abuse.
- Objective 3: to gather information about the methods employed by social workers rendering services concerning child abuse.
- Objective 4: to gather information about the approaches employed by social workers rendering services concerning child abuse.
- Objective 5: to formulate guidelines for social workers rendering services concerning child abuse based on the gathered information.

- The majority of social workers indicated that they perform the following social work functions:
 - Identification;
 - investigation;
 - intervention; and
 - prevention.

- The majority of social workers indicated that they always employ the following social work methods in their service delivery:
 - Social work with the individual;
 - social work with the family; and
 - social work research.

- The majority of social workers indicated that they never employ the following methods in their service delivery:
 - Social work with the group;
 - social work with the community; and
 - an integrated application of the methods.

- The majority of social workers indicated that they always employ the following approaches in their service delivery:
 - Problem solving; and
 - Ego psychology.

- The majority of social workers indicated that they never employ behaviour modification and crisis intervention in their service delivery.

- The majority of social workers indicated that they do employ cognitive restructuring some of the time in their service delivery.

- All the social workers are offering primary prevention services. The majority of social workers indicated that they do consider the following factors in the primary prevention of child abuse:
 - Children of adolescent parents;
 - children of mentally retarded parents;
 - children of substance abusers; and
 - children of parents who were abused as children.

- The majority of social workers indicated that they do not consider the following factors in the primary prevention of child abuse:
 - Low birth weight;
 - children with special needs; and
 - children of few support systems.

- All the social workers are offering secondary prevention of child abuse in terms of the identification of potential child abusers.

- The majority of social workers indicated that they focus on the following aspects:
 - Nurturing;
 - good parenting skills;
 - family planning;
 - stress management; and
 - health.

- The majority of social workers indicated that they do not focus on the following factors:

- The needs of children at different stages; and
- child development.

- The majority of social workers indicated that they focus on the following goals after child abuse has occurred.
 - Stopping the abuse;
 - improving parental functioning;
 - reducing stress;
 - development of conflict management skills; and
 - improvement of self-esteem.

- The majority of social workers indicated that they do not focus on the improvement of intimacy in their prevention services after child abuse has occurred.

7.5.2 Conclusions

- The following four functions of social work are being performed by social workers in their service rendering concerning child abuse:
 - Identification;
 - investigation;
 - intervention; and
 - prevention.

- The following social work methods are always employed by the social workers in their service rendering concerning child abuse:
 - Social work with the individual;
 - social work with the family; and
 - social work research.

- The following methods are never employed by the social workers in their service rendering concerning child abuse:
 - Social work with the group;
 - social work with the community; and
 - an integrated application of the methods.

- The following approaches are always employed by social workers in service rendering concerning child abuse:
 - Problem solving; and
 - ego psychology.

- Cognitive restructuring is being employed by social workers some of the time in their service rendering concerning child abuse.

- The following approaches are never employed by social workers in their service rendering concerning child abuse:
 - behaviour modification; and
 - crisis intervention.

- Prevention of child abuse is offered on three levels namely: primary -, secondary- and tertiary prevention.
- Primary prevention is being offered by all the social workers in their service delivery.

- The following factors are being considered by social workers in the primary prevention of child abuse:
 - Children of mentally retarded parents;
 - children of adolescent parents;
 - children of substance abusers; and
 - children of parents who were abused as children.

- The following factors are not being considered by social workers in their primary prevention of child abuse:
 - Low birth weight;
 - children with special needs; and
 - children of few support systems.

- Secondary prevention of child abuse is being offered by social workers. Focus is on the following aspects:
 - Nurturing;
 - good parenting skills;
 - family planning;
 - stress management; and

- health.
- Social workers do not focus on the following aspects in their secondary prevention of child abuse:
 - The needs of children at different stages; and
 - child development.
- Tertiary prevention is being offered by social workers in their service delivery. Focus is on the following goals:
 - Stopping the abuse;
 - improving parental functioning;
 - reducing stress;
 - development of conflict management skills; and
 - improvement of self-esteem.
- Social workers do not focus on the improvement of intimacy in the tertiary prevention of child abuse.

7.5.3 Recommendations

- Social work service delivery in child abuse should be rendered in terms of all the methods of social work namely:
 - Social work with the individual;
 - social work with the family;
 - social work with the group;
 - social work with the community;
 - social work research; and
 - an integrated application of these methods.

This will lead to effective intervention.

- A variety of approaches in social work should be employed for effective intervention in child abuse, e.g.
 - Problem solving;
 - ego psychology;
 - behaviour modification;
 - crisis intervention; or

- cognitive restructuring.
- Prevention should be given on all the three levels: namely: primary, secondary and tertiary.
- In primary prevention all the factors which may be preventive to child abuse should be considered, e.g.
 - Children of adolescent parents;
 - children of substance abusers;
 - children of mentally retarded parents;
 - children of parents who were abused as children;
 - low birth weight children;
 - children with special needs; and/or
 - children of few support systems.
- In secondary prevention focus should be on potential factors which may cause child abuse, e.g.
 - Nurturing;
 - good parenting skills;
 - family planning;
 - stress management; and
 - health.
- In tertiary prevention focus should be on goals to be achieved after child abuse has occurred, e.g.:
 - Stopping the abuse;
 - improving parental functioning;
 - reducing stress;
 - development of conflict management skills; and
 - improvement of self-esteem.

7.6.GUIDELINES FOR SOCIAL WORKERS RENDERING SERVICES CONCERNING CHILD ABUSE CASES

8.6.1 Summary

Chapter six focuses on the formulation of guidelines for social workers rendering services concerning child abuse cases. This chapter fulfilled the aim of the study which is to formulate guidelines for social workers rendering services concerning child abuse.

Guidelines, which were formulated, focused on the following aspects:

- The nature of child abuse;
- the functions to be performed by social workers;
- the methods to be employed by social workers; and
- the approaches to be employed by social workers.

7.6.2 Conclusions

- Social workers need to have knowledge of the nature of child abuse before they can render their services. This knowledge should entail the following aspects:
 - The types, causes, symptoms and impact of child abuse; and
 - the nature of social work services to employ in child abuse cases, in terms of the following aspects:
 - Their functioning in service delivery;
 - the methods to employ; and
 - the approaches to employ.
- Taking these guidelines into consideration can enhance the social workers' service rendering concerning child abuse.

7.7 THE AIMS, OBJECTIVES AND QUESTIONS OF THE STUDY

The following discussion focuses on the following aspects:

- The achievement of the aim of the study;
- the achievement of the objectives of the study;
- the answering of the questions of the study; and
- the formulation of the hypothesis for future research.

7.7.1 The achievement of the aim of the study

- The aim of the study, which is to formulate guidelines for social workers rendering services concerning child abuse, has been achieved.
- This aim was achieved through the following:
 - The theory on child abuse in chapter two and three;
 - the theory on social work service rendering concerning child abuse in chapter four;
 - the empirical research in chapter five; and
 - the practical experience of the researcher in chapter five.
- The researcher strongly feels that these guidelines are essential in enhancing social workers' service delivery and that they should be adapted to suit individual client's situations.

7.7.2 Objectives of the study

- The following objectives of the study were achieved:
 - Objective 1: to gather information about the types, causes, symptoms and impact of child abuse among black children in the North West Province – Moretele District.

This objective was achieved as discussed in chapter five of this thesis. Information on the types, causes, symptoms and impact of child abuse was gathered.

- Objective 2: to gather information about the nature of services rendered by social workers concerning child abuse.

This objective was achieved as discussed in chapter five of this thesis. Information on the nature of services rendered by social workers concerning child abuse was gathered.

- Objective 3: to gather information about the methods employed by social workers rendering services concerning child abuse.

This objective was achieved as discussed in chapter five of this thesis. Information on the methods employed by social workers in child abuse cases was gathered.

- Objective 4: to gather information about the approaches employed by social workers' rendering services concerning child abuse.

This objective was achieved as discussed in chapter five of this thesis. Information on the approaches employed by social workers rendering services concerning child abuse was gathered.

- Objective 5: to formulate guidelines for social workers rendering services concerning child abuse.

This objective was achieved as discussed in chapter two to seven. Guidelines were formulated as discussed in chapter seven, on the basis of information in chapter two to six.

7.7.3 The questions of the study

All the questions of the study were satisfactorily answered as discussed below:

- Question 1: What are the types of child abuse that occur in the North West Province?

This question was answered by the empirical research as discussed in chapter five of this thesis. Four types of child abuse has been determined namely: neglect, physical, sexual and emotional abuse.

- Question 2: What are the causes of child abuse in the North West Province?

This question was answered by the empirical research as discussed in chapter five of this thesis. Various causes of child abuse were determined.

- Question 3: Which are the symptoms of child abuse that are enough to identify an abused child?

This question was answered by the empirical research as discussed in chapter five of this thesis. Various symptoms of child abuse were determined.

- Question 4: What is the impact of child abuse on the abused child?

This question was answered by the empirical research as discussed in chapter five of this thesis. Child abuse is found to be having the following impact on the abused child namely: behavioural, psychological, personality and cognitive impacts.

- Question 5: What is the nature of social work services rendered by social workers concerning child abuse?

This question was answered by the empirical research as discussed in chapter five of this thesis. The nature of social work services rendered was determined.

- Question 6: Which methods are being employed by social workers in their service rendering concerning child abuse?

This question was answered by the empirical research as discussed in chapter five of this thesis. The different social work methods employed by social workers were determined.

- Question 7: Which approaches are being employed by social workers in their service rendering concerning child abuse?

This question was answered by the empirical research as discussed in chapter six of this thesis. The different social work approaches employed by social workers were determined.

Guidelines for social workers rendering social work services concerning child abuse were therefore formulated.

7.8 FUTURE RESEARCH

As this research was an exploratory one, with the main reasons of formulating specific hypothesis for future research, such hypothesis has been formulated as discussed below:

- Future research focusing on child abuse, e.g. on the abused child as a victim, on the abuser or on the parents of the abused children should be conducted.
- As this study focused only on the parents/caregivers whose children have been abused and on the formulation of guidelines for social workers in this area, the following hypothesis are formulated:

* Hypothesis 1:

If parents are able to identify the symptoms of child abuse then the rate of child abuse will drop.

* Hypothesis 2:

If parents are involved in social work service rendering concerning child abuse, then child abuse can be prevented.

* Hypothesis 3:

If guidelines for service rendering concerning child abuse are formulated for social workers and are being used properly, then their service rendering can improve.

7.9 CLOSING STATEMENT

Child abuse is a serious problem area, which occur world wide, and its rate is rising on a daily basis. This phenomenon of child abuse attracts the helping professionals such as social workers with the aim of reducing its rate. Various types of child abuse occur with various causes, symptoms and impacts, which requires those who are involved, e.g. social workers to be knowledgeable about these aspects.

Social workers who render services concerning child abuse need to have guidelines, which will enhance their service rendering in this area.

This study provides social workers with guidelines concerning service rendering in child abuse, which can enrich their service rendering, and be of benefit to social workers, their profession and their clients.

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Appendix 1: Application letter

43 Magodiello Street
Atteridgeville
0008
22/07/1998

The Chief Director
Dept.of Health and developmental Welfare
Private Bag X2068
Mmabatho
2735

Dear Sir/Madam

APPLICATION TO CONDUCT RESEARCH ON CHILD ABUSE IN THE NORTH WEST PROVINCE-MORETELE DISTRICT: MS SITUMISE JOYCE NKUNA:STUDENT NUMBER 9283269,UNIVERSITY OF PRETORIA.

I am hereby making an application to conduct research in your institution. I am registered for D Phil(social work) with the University of Pretoria.

The topic of my research is: Guidelines for social workers rendering services concerning child abuse.

The aim of this study is to develop guidelines for social workers rendering services concerning child abuse. Information will be gathered from parents/caregivers whose children were abused during 1995 to 1999,who are receiving social work services, and the social workers who are rendering services concerning child abuse.

Focus will be on the following aspects:

- The types, causes, symptoms and impact of child abuse, and
- The nature of social work services rendered by social workers concerning child abuse.

This research can benefit the parents/caregivers, the abused children, social workers and the profession of social work.

I hope that my application will be positively considered.

Faithfully

SJ NKUNA

Appendix 2: Letter of permission



Republic of South Africa



Office of the Chief Director for Developmental Social Welfare
20 July 1999 NORTH WEST PROVINCE

43 Magodiello Street
ATTERIDGEVILLE
0008

Private Bag X2068
Mmabatho
2735

Tel.: (0140) 87-5282/3
Fax: (0140) 87-5273

E-Mail: Ashley _ Theron @ nwp.org.za

ATTENTION: MS S J. NKUNA

re: APPLICATION TO CONDUCT RESEARCH: YOURSELF

Your letter dated 07 May 1999 bears reference. We apologise for responding late to your letter as we are in a process of integrating the two departments which are Social Services and Arts, Culture and Sports into one Department.

Kindly note that this office grants you permission to conduct research in this Province at the Moretele area. It will be appreciated if a copy of your research could be made available to this office soon as you complete the research.

We would like to wish you all the best in your research and hope it will benefit the people of this Province.

May all the blessing of the Lord be with you when conducting your research.

A S. MOCHE
SECRETARY TO THE CHIEF DIRECTOR
SOCIAL SERVICES

Appendix 3: Letter of information

43 Magodiello Street
Atteridgeville
0008
01/07/2000

The Assistant Director
Dept. of Health and developmental Welfare
Moretele District
HAMMASKRAAL
0400
Dear Sir/Madam

RESEARCH ON CHILD ABUSE

Kindly be informed that a study on child abuse in the North West Province-Moretele District has been planned. Focus will be on parents/caregivers whose children were abuse during 1995-1999 and the social workers rendering services concerning child abuse.

The aim of the study is to formulate guidelines for social workers rendering services concerning child abuse.

On this note, it is requested that a list of parents/caregivers and of social workers together with their addresses be compiled for the researcher's assistance. These names will be treated with strict confidentiality.

The researcher will be visiting your District on dates that will be sent to you at a later stage.

Your co-operation in this regard will be appreciated.

Faithfully

MS.SJ NKUNA

Appendix 4: Programme of study

43 Magodiello Street
Atteridgeville
0008
01/08/2000

The Assistant Director
Dept.of Health and developmental Welfare
Moretele District
HAMMASKRAAL
0400

Dear Sir/Madam

RESEARCH ON CHILD ABUSE

As previously informed that I am studying child abuse in your District, I will be interviewing parents/caregivers and social workers from 8h00 to 16h30 on the following dates:

- Social workers from 01/10/2000 to 06/10/2000.
- Parents/caregivers from 07/10/2000 to 30/11/2000.

Your co-operation in this regard will be appreciated.

Faithfully

SJ NKUNA

Appendix 5: Confirmation of programme

43 Magodiello Street
Atteridgeville
0008
01/08/2000

The Assistant Director
Dept. of Health and developmental Welfare
Moretele District
HAMMASKRAAL
0400

Dear Sir/Madam

RESEARCH ON CHILD ABUSE

In follow-up to the programme sent to you, dated 01/08/2000, I would like to confirm my visits as scheduled in that programme.

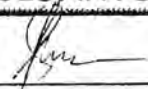


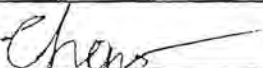
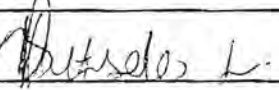

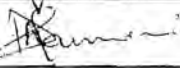


Your co-operation in this regard will be appreciated.

Faithfully

SJ NKUNA

Appendix 6: Signatures for voluntary participation

I am hereby confirming that my participation as a parent/caregiver in the study concerning child abuse is on a voluntary basis.

NR	SURNAME AND NAME	SIGNATURE
1	Baloyi, Annah	
2	Baloyi, Dudu	D. Baloyi
3	Baloyi, Edward	
4	Baloyi, Elizabeth	Baloyi Baloyi E
5	Baloyi, Rose	R. Baloyi
6	Bontsi, Edwin	
7	Chabalala, Amos	Amose
8	Chabalala, William	Chabalala W
9	Chauke, Johannes	J. Chauke
10	Chauke, Patricia	
11	Chauke, Queen	Chauke Q
12	Chauke, Reuben	.chauke R.
13	Chauke, Ruth	RUTH SHARLE
14	Chocho, Bethuel	Bethuel B.
15	Ditsele, Lawrence	
16	Ditshego, Poppy	POPPY DITSHOGO
17	Diphare, Saphirah	
18	Dlamini, Adolphinah	
19	Hobyane, Christina	
20	Hoftman, Patrick	
21	Jele, Isaac	JELE I.
22	Kekana, Anita	A. KEKANA
23	Kekana, Emily	KEKANA E
24	Kekana, Florence	FLORENCE
25	Kekana, Lena	Lena



NR	SURNAME AND NAME	SIGNATURE
26	Kekana, Violet	Kekana Violet
27	Khoza, Christina	Khoza C.
28	Kgomo, Caroline	Kgomo
29	Kgotha, Cecilia	Kgotha
30	Kodise, Lazarus	L. Kodise
31	Komane, Makia	M. Komane
32	Lebese, Johannah	Lebese Johannah
33	Lebese, Martin	Lebese Martin
34	Lebedi, Mirriam	Lebedi m.
35	Lebethe, Matilda	Lebethe Matilda
36	Lefaladi, Koketso	Lefaladi K.
37	Letswalo, Andrew	Letswalo
38	Llale, Florah	Llale Florah
39	Maaga, Maria	Maaga Maria
40	Mabunda, Elizabeth	Mabunda Elizabeth
41	Mabunda, Francinah	Mabunda Francinah
42	Mabusela, Johannah	Mabusela Johannah
43	Macheke, Annah	Macheke Annah
44	Macheke, Elizabeth	Macheke Elizabeth
45	Madikologa, Mmapula	Madikologa Mmapula
46	Madikologa, Stevens	Madikologa Stevens
47	Mahlangu, Linah	Mahlangu Linah
48	Makwaeba, Johannes	Makwaeba Johannes
49	Makwela, Annah	Makwela Annah
50	Makwela, Brenda	Makwela Brenda
51	Makwela, Isaac	Makwela Isaac
52	Makwela, Michael	Makwela Michael



NR	SURNAME AND NAME	SIGNATURE
53	Malema, Lena	Lena Madema
54	Malema, Maria	M Malema
55	Maluleka, Ananias	An
56	Maluleka, Bethuel	B Maluleka
57	Maluleka, Maria	M Maria
58	Maluleka, Moses	M M
59	Maluleka, Naomi	N. Maluleka
60	Maluleka, Nathaniel	N Maluleka
61	Maluleka, Piet	PIET MALULEKA
62	Manamela, Martha	M Manamela
63	Manganye, Elizabeth	E Manganye
64	Manyasha, David	D Manyasha
65	Marema, Beauty	BEAUTY
66	Mashaba, France	F Mashaba
67	Mashaba, Marius	M Mashaba
68	Mashaba, Rebeccah	M Mashaba
69	Mashabathakga, J	J Mashabathakga
70	Mashabathakga, Steve	S Mashabathakga
71	Mashabathakga, Tshepiso	T Mashabathakga
72	Mashika, France	F Mashika
73	Mashishi, Lizzy	L Mashishi
74	Mashishi, Loraine	Loraine
75	Masombuka, Johannah	J Masombuka
76	Masuku, Rachel	Rachel
77	Mathibe, Christinah	C Mathibe
78	Mathensi, Thomas	T Mathensi
79	Matlou, Joyce	J Matlou



NR	SURNAME AND NAME	SIGNATURE
80	Matjila, Henry	Henry Matjila
81	Matseke, Rebeccah	REBECCA
82	Matseke, Lucas	Lucas
83	Moeng, Merriam	Merriam
84	Mogale, Naomi	Naomi
85	Mogale, Zacharia	Zacharia
86	Mogaswa, Elizabeth	Mogaswa
87	Mohale, Merriam	Merriam
88	Mohlala, Florah	Florah
89	Mohlala, Grace	Grace
90	Mohlala, Nkele	NKELE Mohlala
91	Mahlamonyane, Steve	STEVE
92	Moima, Emmah	Emmah
93	Mojela, Johannes	Johannes
94	Mokau, Maggy	Maggy
95	Molebale, James	James
96	Molefe, Joyce	Joyce
97	Molefe, Salome	Salome
98	Molefe, Thomas	Thomas
99	Molefe, Vinolia	Vinolia
100	Molekwa, Jacob	Jacob
101	Molobi, Portia	Portia
102	Moloisane, Dorris	Dorris
103	Molomo, Lettie	Lettie
104	Molokomme, Maria	Molokomme
105	Moloto, William	William
106	Moremi, Andries	Andries



NR	SURNAME AND NAME	SIGNATURE
107	Motau, Ephenia	Ephenia Motau
108	Mothele, Divid	Divid
109	Motileng, Marriam	Marriam
110	Motsamai, William	William
111	Motshabi, Fridda	Fridda
112	Motshabi, Jack	Jack
113	Motshabi, Josinah	Josinah
114	Mpedi, Regina	Regina
115	Mpete, Johannah	J. Mpete
116	Mputle, Lorraine	L. MPUTLE
117	Mpyane, Sarah	Sarah
118	Nohe, Johannah	Nohe Johannah
119	Ngobeni, Maria	Maria
120	Nkuna, Johannah	Johannah
121	Nkuna, Sarah	Sarah
122	Nkuna, Virginia	Virginia
123	Ntudgela, Dinah	Dinah
124	Ntuli, Elizabeth	Elizabeth
125	Phala, Loisa	Loisa Phalaloo
126	Phala, Maria	Maria
127	Phalema, Paulina	Paulina
128	Phanyane, Elizabeth	Elizabeth
129	Phokobye, Pricilla	Pricilla
130	Phuti, Rosina	R. Phuti.
131	Pukwano, Ellah	Ellah
132	Ratapha, Daniel	Daniel
133	Seakamela, Lefty	Lefty

I am hereby confirming that my participation as a social worker in the study concerning child abuse is on a voluntary basis.

NAME		SIGNATURE
Ledingwane	Migal	
Madiba	Gertrude	
Mahapa	Jane	
Mahlangu	Mapula	
Matlala	Mokgadi	
Mmoledi	Sophy	
Mogomotsi	Seanokeng	
Morulane	Nkele	
Nkuna	Deborah	
Sekokotla	Peter	
Sithole	Sophy	
Songwane	Mokgadi	
Tau	Ditshela	
Toka	Kefilwe	

Appendix 7: Invitation for doctoral seminar



Microsoft
GRAPHICS STUDIO

www.home-greetings.com

Created just for you by me

To: Mr/Ms/Dr/Prof

.....
You are cordially invited to a Doctoral Seminar.
Topic: A social work perspective on child abuse
amongst black children in the North West
Province.

Date: 10 September 2001

Time: 10h30

Place: University of Pretoria

Human Sciences Building, 10-02

RSVP: on or before :

24 August 2001

to: Joyce Nkuna 0829739801

Appendix 8: Programme for seminar

Topic: Guidelines for social workers rendering services concerning child abuse

➤ Presentation Outline:

- Introduction
- Motivation for choice of subject
- Problem formulation
- Aims of the study
- Objectives of the study
- Hypothesis
- Research methodology
- Theoretical framework – child abuse
- Research findings
- Conclusions

Appendix 9: Questionnaire for parents/caregivers

QUESTIONNAIRE 1: FOR PARENTS / CAREGIVERS

INTRODUCTION

The aim of this study is to determine the following aspects:

- The types and causes of child abuse experienced by your child.
- The symptoms of child abuse shown by your child, and
- The impact of child abuse on your abused child.

I thus request you to help me by answering the following questions from your experience as a caregiver.

I assure you that your particulars and answers will be presented in such a way that no one will be able to associate you with the answers given.

I really appreciate the time that you have given me and your assistance.

Completing Instructions

Small block : To be marked with an X

Long block : For completion in words

Further instructions : Indicated per question

Respondent Number

V1

--	--	--

 1-3

Card Number

V2

--

 4

I SECTION 1 : PERSONAL DETAILS OF RESPONDENT

1. Sex

Male	
Female	

V3

--

 5

2. What is your age presently?

		Years
--	--	-------

V4

--	--

 6-7

3. What is your marital status?

Never married	
Married	
Divorced	
Widowed	

V5

--

 8

II SECTION 2 : CARE GIVING HISTORY

1. How many children do you have under your care?

		Years
--	--	-------

V6

--	--

 9-10

2. Under age category list the ages of children under your care.

0 - 5	
6 - 10	
11 - 15	
16 - 21	

V7

--

 11

V8

--

 12

V9

--

 13

V10

--

 14

3. Who abused your child?

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

V11		15
V12		16
V13		17
V14		18
V15		19

4. How old was your child during the abuse?

0 - 5	
6 - 10	
11 - 15	
16 - 21	

V16		20
V17		21
V18		22
V19		23

5. In which year was your child abused?

1995	
1996	
1997	
1998	
1999	

V20		24
V21		25
V22		26
V23		27
V24		28



III **SECTION 3 : CHILD ABUSE**

1. Which type of child abuse did your child experience?

Physical	
Sexual	
Emotional	
Neglect	

V25	<input type="checkbox"/>	29
V26	<input type="checkbox"/>	30
V27	<input type="checkbox"/>	31
V28	<input type="checkbox"/>	32

2. If your child experienced physical abuse, indicate its nature.

Injuries	
Burns	
Poisoning	
Suffocation	
Other (Specify)	

V29	<input type="checkbox"/>	33
V30	<input type="checkbox"/>	34
V31	<input type="checkbox"/>	35
V32	<input type="checkbox"/>	36
V33	<input type="checkbox"/>	37
V34	<input type="checkbox"/>	38-39

3. If your child experienced injuries, please indicate the location.

Head	
Face	
Thoracic	
Abdominal	
Bone	
Other (Specify)	

V35	<input type="checkbox"/>	40
V36	<input type="checkbox"/>	41
V37	<input type="checkbox"/>	42
V38	<input type="checkbox"/>	43
V39	<input type="checkbox"/>	44
V40	<input type="checkbox"/>	45-46

4. If your child experiences burns, indicate the location.

Face	
Hands	
Buttocks	
Other (Specify)	

V41	<input type="checkbox"/>	47
V42	<input type="checkbox"/>	48
V43	<input type="checkbox"/>	49
V44	<input type="checkbox"/>	50-51

5. What was used to burn your child?

1. _____

2. _____

3. _____

4. _____

5. _____

V45		52
V46		53
V47		54
V48		55
V48		56

6. If your child experienced poisoning, indicate the substance used.

Drugs	
Household substances	
Other (Specify)	

V50		57
V51		58
V52		59-60

7. If your child experienced suffocation, indicate the item used.

Pillow	
Clothing	
Hands	
Other (Specify)	

V53		61
V54		62
V55		63
V56		64-65



V SEXUAL ABUSE

8. Indicate the nature of sexual abuse which your child experienced.

Sexual contact of intimate parts		V57		66
Fondling		V58		67
Oral contact		V59		68
Sexual intercourse		V60		69
Anal intercourse		V61		70
Interfemural		V62		71
Sexual assault		V63		72
Incest		V64		73
Other (Specify)		V65		74-75

9. Who abused your child sexually?

1. _____
2. _____
3. _____
4. _____
5. _____

V66		76
V67		77
V68		78
V69		79
V70		80



VI EMOTIONAL ABUSE

10. Indicate the nature of emotional abuse which your child experienced.

Rejection		V71		81
Ignorance		V72		82
Terrorising		V73		83
Corruption		V74		84
Isolation		V75		85
Deprivation		V76		86
Accusations		V77		87
Insults		V78		88
Other (Specify)		V79		89-90

Neglect

11. Indicate the nature of neglect as experienced by your child : Lack of :

Education		V80		91
Nutrition		V81		92
Love		V82		93
Protection		V83		94
Supervision		V84		95
Shelter		V85		96
Clothing		V86		97
Medication		V87		98
Other (Specify)		V88		99-100

SYMPTOMS OF PHYSICAL ABUSE
PHYSICAL SYMPTOMS

12. Which physical symptoms did you notice showing that your child has been physically abused.

Bruises		V89		101
Burns		V90		102
Lacerations		V91		103
Fractures		V92		104
Other (Specify)		V93		105-106

BEHAVIOURAL SYMPTOMS

13. Which behavioural symptoms did you notice showing that your child has been physically abused?

Fear physical contact		V94		107
Temper tantrums		V95		108
Craving for attention		V96		109
Wearing long sleeves clothing		V97		110
Fearful of parents/caregivers		V98		111
Over aggressive		V99		112
Withdrawn		V100		113
Sleepy in class		V101		114
Arriving early at school		V102		115
Staying late at school		V103		116
Excessive school absence		V104		117
Lack and curiosity		V105		118
Other (Specify)		V106		119-120

SEXUAL ABUSE
Physical symptoms

14. Which physical symptoms did you notice showing that your child has been sexually abused?

	Noticed	Not Noticed		
Pregnancy at an early age			V107	<input type="checkbox"/> 121
Bruises of external genitalia			V108	<input type="checkbox"/> 122
Bleeding from external genitalia			V109	<input type="checkbox"/> 123
Surstlen cervix			V110	<input type="checkbox"/> 124
Red vagina			V111	<input type="checkbox"/> 125
Presence of semen			V112	<input type="checkbox"/> 126
Torn bloody undergarments			V113	<input type="checkbox"/> 127
Presence of sexually transmitted deceases			V114	<input type="checkbox"/> 128
Vaginal discharge			V115	<input type="checkbox"/> 129
Complains of difficulty in urinating			V116	<input type="checkbox"/> 130
Other (Specify)			V117	<input type="checkbox"/> <input type="checkbox"/> 131-132

15. Which behavioural symptoms did you notice showing that your child has been sexually abused?

	Noticed	Not Noticed		
Poor peer relationships			V118	<input type="checkbox"/> 133
Pro			V119	<input type="checkbox"/> 134
			V120	<input type="checkbox"/> 135
			V121	<input type="checkbox"/> 136
			V122	<input type="checkbox"/> 137
			V123	<input type="checkbox"/> 138



	Noticed	Not Noticed
Torn bloody undergarments		
Presence of sexually transmitted disease		
Vaginal discharge		
Complains of difficulty in urinating		^a
Other (Specify)		

V113		127
V114		128
V115		129
V116		130
V117		131-132

15. Which behavioural symptoms did you notice showing that your child has been sexually abused?

	Noticed	Not Noticed
Poor peer relationships		
Prostitution		
Comments that he/she was assaulted		
Substance abuse		
Irregular school attendance		
Engaging in delinquent acts		
Sleep disturbance		
Suicide attempts		
Other (Specify)		

V118		133
V119		134
V120		135
V121		136
V122		137
V123		138
V124		139
V125		140
V126		141-142

NEGLECT

Physical symptoms if neglect

16. Which physical symptoms did you notice showing that your child was neglected?

	Noticed	Not Noticed
Abandonment		
Poor personal hygiene		
Inadequate clothing		
Absence of needed medical care		
Inadequate supervision for long periods		
Tiredness		
Being hungry		
Inadequate physical environment		
Other (Specify)		

V127		143
V128		144
V129		145
V130		146
V131		147
V132		148
V133		149
V134		150
V135		151-152

17. Which behavioural symptoms did you notice showing that your child has been neglected?

	Noticed	Not Noticed
Falling asleep at school		
Begging for food		
Irregular school attendance		
Use of drugs		
Engaging in delinquent acts		
Failing to as an infant		
Poor academic performance		
Other (Specify)		

V136		153
V137		154
V138		155
V139		156
V140		157
V141		158
V142		159
V143		160-161



CAUSES OF CHILD ABUSE

18. Indicate the extent of the following factors as the cause of child abuse.

	Main cause	Contributory cause	No cause			
Lack of mothering imprints				V144	<input type="checkbox"/>	162
Excessive expectations towards the child				V145	<input type="checkbox"/>	163
Parental role reversal				V146	<input type="checkbox"/>	164
Scapegoating				V147	<input type="checkbox"/>	165
Immature parents				V148	<input type="checkbox"/>	166
Mental illness				V149	<input type="checkbox"/>	167
Lack of social skills				V150	<input type="checkbox"/>	168
Lack of child rearing skills				V151	<input type="checkbox"/>	169
Poverty				V152	<input type="checkbox"/>	170
Poor education				V153	<input type="checkbox"/>	171
Occupational stress				V154	<input type="checkbox"/>	172
Interior health status of the child				V155	<input type="checkbox"/>	173
Handicapped child				V156	<input type="checkbox"/>	174
Overcrowding				V157	<input type="checkbox"/>	175
Alcohol abuse				V158	<input type="checkbox"/>	176
Drug abuse				V159	<input type="checkbox"/>	177
Other (Specify)				V160	<input type="checkbox"/>	178

19. Indicate the impact which child abuse had on your child.

Psychological		V161		179
Behavioural		V162		180
Personality		V163		181
Cognitive		V164		182
Other (Specify)		V165		183

20. Which suggestions can you make to other caregivers regarding child abuse?

1.		V166		184
2.		V167		185
3.		V168		186
4.		V169		187
5.		V170		188

Thank you for your co-operation

Appendix 10: Questionnaire for social workers

QUESTIONNAIRE 2 : FOR SOCIAL WORKERS

INTRODUCTION

The aim of this study is to determine the nature of services rendered by social workers in child abuse cases.

I thus request you to help me by answering the following questions from your experience as a social worker.

I assure you that your particulars and answers will be presented in such a way that no one will be able to associate you with the answers given.

I really appreciate the time that you have given me and your assistance.

Completing Instructions

Small block : To be marked with an X

Long block : For completion in words

Further instructions : Indicated per question

Respondent Number

V1	<input type="text"/>	<input type="text"/>	<input type="text"/>	1-3
V2	<input type="text" value="1"/>	<input type="text" value="4"/>		

Card Number

I SECTION 1 : PERSONAL DETAILS OF RESPONDENT

1. Sex

Male	<input type="text"/>
Female	<input type="text"/>

V3 5

II SECTION 2 : DETAILS ON SERVICE DELIVERY

2. At which area are you rendering social work services?

V4 6

3. For how long have you been rendering such services in that area?

<input type="text"/>	<input type="text"/>	years
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V5 7-8

4. How many cases of child abuse are you handling presently?

1 - 5	<input type="text"/>
6 - 10	<input type="text"/>
11 - 15	<input type="text"/>
16 - 20	<input type="text"/>
21 and more	<input type="text"/>

V6 9
V7 10
V8 11
V9 12
V10 13

5. Which social work function do you perform in your service delivery in child abuse?

Identification	<input type="text"/>
Investigation	<input type="text"/>
Intervention	<input type="text"/>
Prevention	<input type="text"/>
Other (specify) <input type="text"/>	

V11 14
V12 15
V13 16
V14 17
V15 18

6. Which social work method delivery in child abuse?



Social work with the individual	
Social work with the family	
Social work with the group	
Social work with the community	
Social work research	
An integrated application of these methods	
Other (Specify)	

V16	<input type="checkbox"/>	19
V17	<input type="checkbox"/>	20
V18	<input type="checkbox"/>	21
V19	<input type="checkbox"/>	22
V20	<input type="checkbox"/>	23
V21	<input type="checkbox"/>	24
V22	<input type="checkbox"/>	25

7. If you do employ social work with the individual, which approaches do you employ?

Problem solving	
Behaviour modification	
Cognitive restructuring	
Ego psychology	
Crisis intervention	
Other (Specify)	

V23	<input type="checkbox"/>	26
V24	<input type="checkbox"/>	27
V25	<input type="checkbox"/>	28
V26	<input type="checkbox"/>	29
V27	<input type="checkbox"/>	30
V28	<input type="checkbox"/>	31
V29	<input type="checkbox"/>	32
V30	<input type="checkbox"/>	33
V31	<input type="checkbox"/>	34
V32	<input type="checkbox"/>	35

8. Indicate the level at which you are offering prevention services.

Reducing the incidence of new cases of child abuse before it starts	
Identifying of potential child abusers and treating them	
Rendering services after child abuse has occurred	
Other (Specify)	

V33	<input type="checkbox"/>	36
V34	<input type="checkbox"/>	37
V35	<input type="checkbox"/>	38
V36	<input type="checkbox"/>	37



9. If you do reduce the incident before it starts, indicate the factors you are taking into consideration

Low birth weight pre term infants	
Children of adolescent parents	
Children with special needs	
Children of mentally retarded parents	
Children of substance abusers	
Children of parents who were abused as children	
Children of few support systems	
Other (Specify)	

V37	<input type="checkbox"/>	38
V38	<input type="checkbox"/>	39
V39	<input type="checkbox"/>	40
V40	<input type="checkbox"/>	41
V41	<input type="checkbox"/>	42
V42	<input type="checkbox"/>	43
V43	<input type="checkbox"/>	44
V44	<input type="checkbox"/>	45

10. If you do identify potential child abusers and treat them, indicate the aspects on which you focus your services.

Nurturing	
The needs of children at different stages	
Good parenting skills	
Family planning	
Stress management	
Conflict management	
Child development	
Health	
Other (Specify)	

V45	<input type="checkbox"/>	46
V46	<input type="checkbox"/>	47
V47	<input type="checkbox"/>	48
V48	<input type="checkbox"/>	49
V49	<input type="checkbox"/>	50
V50	<input type="checkbox"/>	51
V51	<input type="checkbox"/>	52
V52	<input type="checkbox"/>	53
V53	<input type="checkbox"/>	54



11. If you do offer prevention services, indicate treatment areas you are focussing on.

Stopping the abuse	
Improving parental functioning	
Reducing stress	
Developing conflict management skills	
Improvement of self-esteem	
Improvement of intimacy	
Other (Specify)	

V54	<input type="checkbox"/>	55
V55	<input type="checkbox"/>	56
V56	<input type="checkbox"/>	57
V57	<input type="checkbox"/>	58
V58	<input type="checkbox"/>	59
V59	<input type="checkbox"/>	60
V60	<input type="checkbox"/>	61

12. Which suggestions can you make regarding social work service delivery in child abuse cases?

1. _____
2. _____
3. _____
4. _____
5. _____

V61	<input type="checkbox"/>	62
V62	<input type="checkbox"/>	63
V63	<input type="checkbox"/>	64
V64	<input type="checkbox"/>	65
V65	<input type="checkbox"/>	66

Thank you for your co-operation