Social Workers' Views on Pre-trial Therapy in Cases of Child Sexual Abuse in South Africa

Ansie Fouché,*

Social Work Subject Group, Optentia, North-West University, Vanderbijlpark Campus

Liana (M.P.) Le Roux,

Department of Social Work and Criminology, University of Pretoria, South Africa

*Corresponding Author:

Ansie Fouché, Social Work Subject Group, Optentia, North-West University, Private Bag x1174. Vanderbijlpark, South Africa

Email: ansie.fouche@nwu.ac.za

Abstract

This study sought to explore anecdotal reports that social workers in South Africa are often advised to postpone therapy with child complainants of sexual abuse until after the child's testimony, based on concerns of legal professionals that therapeutic interventions could influence the child's testimony. Applying purposive sampling and a qualitative research study, individual and focus group interviews were conducted with 18 social workers and one psychologist that provide therapeutic services to child complainants of sexual abuse in the Gauteng province. Interviews were audio-recorded, transcribed and independently analyzed by both researchers, performing thematic analysis. Emerging themes include a lack of directives in terms of the provision of pre-trial therapy for child victims of sexual abuse, current practices and challenges in this regard. Recommendations for the way forward are presented. Limitations and future research will be discussed.

1. Introduction

Globally, researchers argue that it is difficult to determine an accurate figure of child sexual abuse (CSA) since this social problem is an underreported phenomenon. The worldwide prevalence of CSA among boys is estimated to be between 3% and 17%, and for girls between 8% and 31% (Barth, Bermetz, Heim, Trelle, & Tonia, 2012). A recent systematic review of meta-analyses on the incidence of child maltreatment indicated a global prevalence in self-reports of CSA of 18% in girls and 7.6% in boys (Stoltenborgh, Bakermans-Kranenburg, Alink, & van Ijzendoorn, 2015). The first national representative survey on the incidence of CSA in South Africa found that self-reports among a sample of 9730 adolescents between the ages of 15 and 17 years, stratified between households and schools, indicated that one in three young people reported a sexually abusive experience in their lifetime (Artz et al., 2016).

In South Africa, it is mandatory to report knowledge or suspicion of CSA to the relevant authorities (RSA, Sexual Offences and Related Matters Amendment Act 32 of 2007). Once a case has been reported to the South African Police Services (SAPS) an investigative process follows, which includes taking statements from the child complainant and other witnesses as well as a medical examination. A state prosecutor will ultimately decide whether sufficient evidence exists to enrol the case, and must prove his/her case beyond reasonable doubt (Fouché & Fouché, 2015). Child complainants, including victims of sexual abuse, are expected to testify in person in criminal trials, and are consequently subjected to cross-examination of which the main aim is to test the credibility of the witness' evidence. In 1996, the South African Criminal Justice System adopted special measures to protect child witnesses, namely the intermediary system (Matthias & Zaal, 2011). This system entails that children may testify, when deemed necessary, by means of close circuit television and assisted by a professional who would relay the general purport of the questions to the child witness. However, the child witness still has to

testify regarding the traumatic ordeal and may face harsh cross-examination (Fouché & Le Roux, 2014; Matthias & Zaal, 2011).

CSA typically occurs in secrecy without any eye witnesses, and the child is therefore often the only witness. In South Africa, trial courts approach the testimony of children and single witnesses with caution due to cautionary rules that apply in such cases (Bellengére et al., 2013). These cautionary rules are applied due to the fact that in the past child witnesses and single witnesses were perceived to be less reliable; consequently, their evidence is approached with caution (Bellengére et al., 2013). The purpose of this judicial practice is to assist presiding officers, when evaluating evidence, in upholding the principle that guilt should be proven beyond reasonable doubt (Van der Merwe, 2009). Maintaining the credibility of the child's testimony is thus of vital importance for the court to deliver a fair verdict (Meintjies, 2000). Any possible tainting or contamination of the child's version of events prior to testimony should therefore be avoided at all costs. One source of contamination is perceived to be the rendering of pre-trial therapy, a term commonly referred to when therapy is provided to a child victim of sexual abuse while the criminal justice process is ongoing and there is a possibility that the child has to testify in court (Branaman & Gottlieb, 2013; Fouché & Le Roux, 2014; Jenkins, Muccio, & Paris, 2015; Maxwell, 2003). For this study, the authors will use the terms *therapy* and *pre-trial therapy* interchangeably.

In South Africa, several authoritative documents exist that prescribe how cases of CSA should be dealt with, including the provision of support to victims. In one such document, The National Policy Framework on the Management of Sexual Offences Matters (Department of Justice and Constitutional Development, 2012), it is described that child complainants of sexual abuse should be referred for psycho-social services to the relevant helping professionals such as social workers, directly after the case has been reported. Although not explicitly specified, these psycho-social services would typically include therapeutic services. However, ,

anecdotal reports from practice indicate that parents, social workers and other mental health professionals are often advised to postpone any therapeutic intervention until after the child has testified in court. This practice, aimed at preventing contamination of the child's testimony, poses the ethical dilemma that the child is being deprived of healing to take place, since the legal process can take up to two or more years to be concluded (Fouché & Le Roux, 2014). In addition, Artz et al. (2016) reported that many of such criminal cases in South Africa are withdrawn or other actions taken (e.g. mediation or diversion) during the ongoing criminal proceedings. As such, children may be deprived of therapy pending the ongoing criminal proceedings, with the potential of the case not even being prosecuted.

The practice of delaying therapy until the child has given evidence in court is not unique to South Africa (Fouché & Le Roux, 2014). The occurrence hereof has been reported and debated in literature for more than a decade among researchers in the United States of America (USA), Australia, and the United Kingdom (UK) (Brannaman & Gottlieb, 2013; Crawford & Bull, 2006; Jenkins et al., 2015; Maxwell, 2003). In South Africa, little has been done to address this practice problem. In 2001, Müller called for directives in this regard. Hereafter there was a paucity of literature until recently when Fouché and Le Roux (2014) investigated anecdotal reports about this practice by exploring the views of 15 legal professionals with experience in working with cases of CSA in a legal context in the Gauteng Province. In this study, it was reported that the participants did not object to therapeutic intervention with child complainants of sexual abuse. However, the timing thereof was a contentious issue due to a perception that therapy could contaminate the child's recollection and version of the events and consequently negatively impact on the credibility of the child's evidence. The participants however highlighted that the existence of such perceived practice rule would not be in the best interests of children.

The Constitution of the Republic of South Africa clearly states in Section 28, that the best interests of the child is paramount in all matters concerning the child (Bellengére et al., 2013). Subsequently social workers are mandated by the *Children's Act 38 of 2005* (RSA) to advance the constitutional rights of the most vulnerable in society, namely children in need of care and protection. Due to the findings in the study by Fouché and Le Roux (2014) and continuous anecdotal reports from social work practice that point to the tendency of postponing therapy until after the child complainant's testimony, the aim of this study was to conduct a qualitative study of perceptions of providers of pre-trial therapy. Social workers confronted with the dilemma on a daily basis should be granted the opportunity of voicing their views and experiences on this contentious issue whereby the healing process of sexually abused children who are potential witnesses in criminal trials are often curtailed. By giving social workers a collective voice, policy makers and legislatures responsible for respecting and protecting the constitutional rights of, amongst others, child victims of sexual abuse, can be alerted to such unfounded prevailing culture in South Africa.

In doing so, we will firstly contextualize pre-trial therapy for child complainants of sexual abuse. Hereafter, the research methodology will be discussed, followed by the findings of the study and a discussion of implications for practice.

1.1. Contextualizing Pre-trial Therapy for Child Complainants of Sexual Abuse

Internationally no consensus has been reached regarding the definition of CSA (Artz et al., 2016). In South Africa, the *Children's Act 38 of 2005* (RSA) defines sexual abuse in relation to a child as follows: "(a) sexually molesting or assaulting a child or allowing a child to be sexually molested or assaulted; (b) encouraging, inducing, or forcing a child to be used for the sexual gratification of another person; (c) using a child or deliberately exposing a child to sexual activities or pornography; or (d) procuring or allowing a child to be procured for commercial sexual exploitation or in any way participating or assisting in the commercial sexual exploitation of a child." However, according to *Sexual Offences and Related Matters Amendment Act 32 of 2007(* RSA) a person in South Africa cannot be criminally charged with "child sexual abuse" but with amongst others, rape, sexual assault, sexual exploitation and child pornography.

1.2. Impact of Sexual Abuse on Children

The harmful impact of CSA on the social and emotional wellbeing of children is well documented in literature. Earlier studies indicate that between 21% and 36% of victims of CSA present with no detectable symptoms during childhood (Conte & Schuerman, 1987; Kendall-Tackett, Williams, & Finkelhor, 1993; Mannarino & Cohen, 1986; Tong, Oates & McDowell, 1987). A more recent study found that between 10% and 53% of children with a history of CSA have normal levels of functioning (Domhardt, Munzer, Fegert, & Goldbeck, 2014). Kendall-Tacket et al. (1993) found that the percentages of child victims of sexual abuse with symptoms were between 20% and 30%; with 32% presenting with symptoms of post-traumatic stress disorder (PTSD), 35% with poor self-esteem, 38% with promiscuity, and 57% with general behavioural problems. A recent South African study found that 43.3% of victims of

CSA met the criteria for full diagnosis of PSTD and a further 30% met with the criteria for partial diagnosis of PTSD (Mathews, Abrahams, & Jewkes, 2013). The impact of sexual abuse on the child can be influenced by factors such as the extent and severity of the abuse, the age of the child, the relationship with the perpetrator, and resilience processes.

Children who experienced sexual abuse may present with difficulties such as fear, anxiety, PTSD, and various externalizing and internalizing behaviour problems such as depression, low self-esteem, anger and hostility, sleep difficulties and sexual reactive behaviour (Berk, 2013; Macdonald et al., 2012; Mathews et al., 2013). In addition, adult survivors of CSA are at risk of developing a wide range of long-term negative outcomes such as sexual difficulties, adverse mental health outcomes, and inter- and intra-personal problems (Hodges & Myers, 2010; Maniglio, 2012; 2013; Singh, Parsekar, & Nair, 2014). The adverse effects of CSA suggest a need for timeous therapeutic intervention for child victims of sexual abuse.

Although Branaman and Gottlieb (2013, p. 302) state that "Currently, no empirical data suggest that delay of treatment would have either adverse short- or long-term consequences" a large body of literature concur that children should receive counseling as soon as possible after the traumatic event to reduce the risk for developing mental health- and other psychosocial problems (Macdonald et al., 2012; Swiecicki & Hollingsworth, 2015).

In addition to the adverse effects of the CSA *per se*, many victims may need assistance to cope with the effects of the emotional distress related to the legal process (Kuehnle & Connell, 2011; Müller, 2001). Similar to adult complainants, child complainants are exposed to the formal legal system, whereby it is expected of them to give a statement of what had happened in chronological order, and to provide specific details about a sensitive and personal experience of a sexual nature that is regarded as taboo in society (Bellengére et al., 2013). When children have to testify in court, they have to repeat the details, are challenged about whether

they are telling the truth, and can even be accused of lying when they forget specific information (Bellengére et al., 2013; Müller, 2001). Despite protective measures such as the intermediary system, the child may still come into direct contact with the accused, for example in the corridors of the court building (Matthias & Zaal, 2011). As a result, participation of children in criminal trials could be experienced as stressful and lead to emotional distress, fears and frustration, although some children may find it beneficial to participate in the legal process (Hayes, Bunting, Lazenbatt, Carr, & Duffy, 2011). Hence, delaying the healing process could be regarded as disservice to this vulnerable population and not consistent with the ethical principles of the mental health professions (Swiecicki & Hollingsworth, 2015).

1.3. The Child Witness

In recent decades researchers reported that children may be vulnerable to suggestion, which may taint their testimony in court (Bond & Sandhu, 2005; Ceci & Bruck, 1995; Principe & Schindewolf, 2012). An overview of children's suggestibility research, highlights that all people are susceptible to suggestions by interviewers and that factors other than age play a role in determining suggestibility, including race and economic status, language differences, gender, cognitive factors, mental state, culture, strength of the original memory trace, delay between the event and the interviews, and confirmatory bias (Hritz et al., 2015). Research indicates that, when interviewed properly, children as young as three years old can recall recent events accurately (Berk, 2013). Fivush, Peterson, and Schwarzmueller (2002) highlight that the response accuracy rate to wh- questions, for example what, where and when, can be up to 90% for young children. Against this background, the perception exists that the provision of pre-trial therapy might pose a risk to the credibility of the child's evidence as it is perceived to have

the potential of contaminating the child's recollection of events (Fouché & Le Roux, 2014; Meintjies, 2000; Van der Merwe, 2009).

1.4. Issues Concerning Contamination

Any professional person working with child complainants who are witnesses in a criminal trial need to be aware of the possible impact their practice may have on the child's evidence (Bond & Sandhu, 2005; Branaman & Gottlieb, 2013). A number of factors that can lead to contamination of the child's evidence have been identified in literature. It is commonly found in South Africa that during the investigation phase, child complainants have to give numerous accounts of the abusive event, e.g. during investigative interviews conducted by a member of SAPS, the medical practitioner who performs the medical examination, and a forensic social worker who conducts forensic social work assessment interviews (Fouché & Le Roux, 2015). Repeated interviewing and suggestive questioning may have an influence on whether the child will remain consistent with his/her initial statement about the sexual abuse ordeal (Berk, 2013; Faller, 2015; Principe & Schindewolf, 2012). Moreover, the child who is afforded the opportunity of telling his/her story in a safe environment over a period of time, may become aware of gaps in his/her version of events and attempt to fill these gaps, leading to additional details of the alleged event/s (Bond & Sandhu, 2005).

Researchers from Australia, the UK and South Africa reported that the legal professionals in their studies strongly argue that a suspicion reigns that therapists may coach children on what to say (Fouché & Le Roux, 2013; Jensen et al., 2015; Maxwell, 2003). Furthermore, opportunities for rumination may lower the child's distress and therefore the visible signs of the trauma. Globally, researchers reported that the outward appearance of the child witness may influence the judgment in CSA cases (Fouché & Le Roux, 2014; Golding,

Dunlap, & Hoddell, 2009). A general trend that was reported was that a child showing more visible signs of distress was perceived to be more credible (Fouché & Le Roux, 2014; Lyon & Saywitz, 2006). Given the fact that therapeutic intervention is inherently based on a safe therapeutic relationship and environment, and on a process of interpersonal dialogue, the above-mentioned factors are relevant in the consideration of pre-trial therapy.

1.5. Pre-trial Therapy

In Social Work, therapy is defined as "social work assistance which focuses on the emotional and psychological needs of the client" (New Dictionary of Social Work, 1995). Social work assistance or social work intervention is "a process whereby a social worker, within a professional relationship, uses specific methods and techniques, performs functions and tasks, and utilizes resources to prevent, alleviate or eliminate social problems to promote the social functioning of a client system" (New Dictionary of Social Work, 1995).

In the context of this study, pre-trial therapy entails therapy to meet the emotional and psychological needs (e.g. anxiety, nightmares) of the child complainant of sexual abuse who is a potential witness in the criminal justice system. Therapy for children in general refers to a therapeutic process, using counselling skills, entailing communication and engagement through which the child is supported to gain insight, and change or tolerate certain aspects of themselves or their environment to promote their social functioning (Geldard, Geldard, & Yin Foo, 2013; New Dictionary of Social Work, 1995).

In the United Kingdom, The Crown Prosecuting Service (CPS) launched practice guidelines for professionals who deal with cases of CSA (Hutton, Cranston, & Clarke, 2017). The Practice Guidance was developed due to a concern that the provision of pre-trial therapy could taint the evidence of the child witness and influence the outcome of the case. The primary

aim of the Practice Guidance is to provide guidance on, amongst others, when therapy should take place, for example after a child's statement to the police; that factual records of the therapy should be kept and made available to the CPS when requested; that the focus of the therapy should be on the child's current coping rather than on the original abuse; and on the roles of the different role players (Hutton et al., 2017).

Due to the diverse effects of CSA, different therapeutic approaches could be relevant in the treatment thereof (Maxwell, 2003). A recent scoping review by Allnock and Hynes (2012) found that the types of therapy commonly provided for victims of CSA fall within two broad categories, namely talking therapies (e.g. psychodynamic therapy, cognitive behavioral therapy, solution-focused therapy), and creative therapies (e.g. non-directive play therapy). The authors reported considerable evidence for the effectiveness of cognitive behavioural therapy (CBT) as an intervention for child victims of sexual abuse; however they state the following: "It would be wrong to conclude that other types of therapy do not work, but the evidence is lacking to prove that they do. New research is needed" (Allnock & Hynes, 2012, p.6).

Cognitive behavioral approaches inherently focus on the present conditions in the person's life and identify cognitive distortions and misconceptions that may contribute to problematic behaviors in the sexually abused child. Through restructuring a child's perception of his/her world and of the self in relation to the trauma, symptoms can be reduced or eliminated and future behaviors changed – a process known as cognitive restructuring (Cummins, Sevel, & Pedrick, 2012). CBT thus attempts to alter and process the feelings and cognitions associated with the abuse in order to change the behavior associated with the abuse and integrate it with the self (Wilen, Little, & Salanti, 2012). A strong argument is made by Maxwell (2003) that to effectively help a child victim of sexual abuse to overcome the traumatic ordeal some discussion about the traumatic event is inevitable. In support, Allnock and Hynes (2012) argue

that therapeutic intervention that is trauma-focused is found to have a more positive impact than a non-directive approach.

A systematic review that aimed to assess the efficacy of cognitive-behavioural approaches in treating the immediate and long-term effects of child sexual abuse suggests that CBT could have a positive impact on reducing symptoms of CSA (Macdonald et al., 2012, p. 9). A number of randomised control studies point to trauma-focused cognitive behavioural therapy (TF-CBT) as an established evidence-based practice for the treatment of victims of CSA. These include studies conducted by Cohen and Mannarino (1996), Deblinger, Lippman, and Steer (1006), Cohen and Mannarino (1998), King et al. (2000), Deblinger, Stauffer, and Steer (2001), Cohen, Deblinger, Mannarino, and Steer (2004), Cohen, Mannarino, and Knudsen (2005), Cohen, Mannarino, Perel, and Staron (2007), and Deblinger, Mannarino, Cohen, Runyon, and Steer (2011) (Jensen et al., 2014). As such, Cohen, Deblinger, and Mannarino (2016) conclude that strong evidence exists that TF-CBT is an effective treatment for addressing childhood trauma.

Another treatment showing strong evidence for its efficacy in treating traumatized children, is Eye Movement and Desensitizaton and Reprocessing (EMDR) (Edmund, Lawrence, and Schrag, 2016). EMDR is a standardized procedure that is aimed at processing memories that have negative associations (Fleming, 2012).

Given the nature of therapy and the factors that could contribute to contamination, it can be postulated that pre-trial therapy could pose a threat to the child's credibility as a witness. Bond and Sandhu (2005) classify therapeutic intervention and its potential threat to evidence of the child on a spectrum from lower risk of undermining evidence, to medium and higher levels of risk. Therapeutic interventions aimed at improving self-esteem and self-confidence as well as court preparation lies on the lower-risk spectrum, whereas treatment of the emotional

and psychological needs of the child without discussing the sexual abuse incident are regarded as medium risk. Exposure to or reliving the event, hypnotherapy and unstructured groups are regarded as a higher risk for contamination of the child's version of events. However, there is paucity in literature on evidence confirming that pre-trial could potentially contaminate a child's version of event. Despite this lack of evidence and sufficient support for the need for therapeutic intervention for child complainants of sexual abuse who are potential witnesses in trials, social workers and other helping professionals are confronted with the dilemma of being accused of tainting the child's evidence (Fouché & Le Roux, 2014; Jenkins et al., 2015; Maxwell, 2003).

In the South African context, the notion of not providing pre-trial therapy is apparently based on anecdotal reports. This perceived practice rule was confirmed in a small-scale qualitative exploration of the views of legal professionals on the provision of pre-trial therapy (Fouché & Le Roux, 2014). Given the nature of the social work profession, namely to enhance the social functioning of those in need, and the obligation placed on them by the *Children's Act 38 of 2005* (RSA) to support children in the child protection practice setting, the mentioned perceived practice rule presents social workers with a dilemma. The focus of this study was therefore to explore the views and experiences of South African social workers faced with this dilemma.

2. Methodology

We conducted a qualitative research study to explore the perceptions and experiences of social workers who provide services to victims of CSA in Gauteng; a province in South Africa (Creswell, 2014). We were mindful that due to the small number of participants, the conclusions from the study cannot be generalized to the total South African context.

Through purposive sampling participants were recruited from a population of social workers working with child complainants of CSA who are potential witnesses in criminal trials in the Gauteng province (Maschi & Youdin, 2012). The following sampling criteria were applied: to be a registered social worker, with a minimum of two years' experience of working with child victims of sexual abuse.

Data were collected by means of two focus group interviews (focus group 1: n=9; focus group 2: n=6) as well as individual semi-structured interviews with four participants who did not form part of either of the focus groups. Interviews were conducted to collect rich information that could shed more light on the topic (Creswell, 2014). A semi-structured interview schedule was compiled, comprising of open-ended questions as a guideline to explore the perceptions of social workers regarding pre-trial therapy. The following questions guided the interviews and probing and prompts were used to gain a deeper understanding of the topic: What is your view on the role and desirability of pre-trial therapy with child victims of sexual abuse?; What is the current practice in terms of the provision of pre-trial therapy in South Africa?; What is the origin of these practices? How is the current practice in the best interests of the child?; Are you aware of any risks involved in providing pre-trial therapy? What advantages/disadvantages are involved in providing or withholding pre-trial therapy? What is your exposure to legal professionals' requests in terms of pre-trial therapy?; and What recommendations do you have for practice?

A total of 18 social workers participated. One clinical psychologist voluntarily joined one of the focus groups, and her views were subsequently incorporated with the findings. The average age of the participants was 38 years; participants had between two to 25 years' experience in working with child victims of sexual abuse (average of 8.5 years); and the sample included 15 females and four males; 12 white, six black and one Indian. The participants

worked at trauma clinics, non-governmental organizations, and in private practice. Ethical clearance for the study was obtained from the Optentia ethics committee (Institutional Ethics Board), North-West University, Vanderbijlpark Campus, South Africa. All the participants gave consent to participate in the study, based on informed consent letters that contained comprehensive information on the study and the nature of participation. Ethical principles such as avoidance of harm, confidentiality and privacy, informed consent, and debriefing were adhered to (Creswell, 2014). Both researchers are registered with the South African Council for Social Service Professions (SACSSP) as professional social workers and are required to comply with the Code of Ethics as set out by the SACSSP.

Interviews were conducted independently by the two authors in either Afrikaans or English, audio-recorded with the permission of the participants, and transcribed. Where applicable, direct quotes utilized in this manuscript were translated from Afrikaans into English and checked for accuracy by an independent reviewer.

To enhance trustworthiness, both authors independently analyzed the data inductively, by manually performing thematic analysis, and engaged in a consensus discussion to finalize themes and subthemes (Creswell, 2014).

3. Findings

A golden thread throughout the research findings was that some social workers might refrain from providing pre-trial therapy to victims of CSA due to a perceived practice rule, based on anecdotal reports, that therapy prior to the child's testimony would contaminate the child's evidence. Five main themes were identified in the data. Firstly, we outline a lack of guidelines or structure that directs practice in the case of the provision of pre-trial therapy for child complainants of sexual abuse who are witnesses in a criminal trial. Next, the issue of

contamination is addressed. Following, the themes "our hands are tied" and "we can't do nothing" indicate social workers' dilemma in not providing pre-trial therapy in light of the duty to uphold the best interests of the child in all matters. Finally, the participants made recommendations for practice.

3.1. Theme 1: Lack of Guidelines or Structure for Practice

The participants highlighted the challenges they encountered due to a lack of guidelines or structure when dealing with child complainants of sexual abuse who are potential witnesses in criminal trials. As a result, it appears that providing therapy in such cases is mainly guided by anecdotal or "they say" reports; in the participants' view mostly originating from the legal profession. The participants described the dilemma they face in this situation, as well as the potential consequences for providing social work services.

"This is an untenable situation". The participants reported that no specific standards of practice exist for dealing with child complainants of sexual abuse who are potential witnesses in criminal trials. Participant 16 pointed out that no guidelines exist that are provided by legislation, policy frameworks or the professional council for social workers:

> *There's in general a lack of knowing what you may and what you may not do. … I don't think the Council gives us guidelines… there is not a book that we can pick up, there is not a … children's act that is telling us specifically what we can do.*

As a consequence of this lack of guidelines, social workers are unsure of what the expectations are, as depicted by Participant 10: *You don't know really what the expectations are. … It's a mess … I think really we are lost in this. We have to work in an untenable situation.* Participant 3 formulated this situation as a grey area, which she explained as follows: *I think*

there's one school of thought that one shouldn't [provide pre-trial therapy] and another school of thought that believes one should. So there's only grey areas here, there's nothing in writing.

The excerpts show that the absence of clear guidelines and structure places social workers in an untenable situation, as explained by Participant 10. The resulting uncertainty may explain why social workers seem to delay the provision of therapy for child complainants due to an unfounded school of thought that believes in no pre-trial therapy; commonly based on "they say" reports.

"They say, no pre-trial therapy". All the participants were aware of anecdotal reports that "they say" that pre-trial therapy should not be provided to child victims of sexual abuse due to fears of affecting the credibility of the child's evidence and ultimately losing the case. Participants 3 and 19 identified different role-players that could be responsible for the school of thought that believes in no pre-trial therapy:

> *I think it's definitely coming from the prosecutors … (also) from the defense. [They say] that we contaminate and influence the child because the child was in therapy* (P3); ... *the prosecutors,… the police ... They say 'not now, leave her [the child], let the case run its course ... the child has to testify'* (P19).

Participant 10 shed some light on why a perceived practice rule could be perpetuated by stating the following: *They say … who 'they' are, we still don't know … but I was taught that they say that you do not do therapy with children prior to a criminal trial. But who 'they' are and whether it is a rule or a myth, I can't say.*

Participant 5 gave an example of how this perceived rule could play out in practice: *In one of our cases … where there were six or seven children involved, we had strict instructions not to do therapy. … still these children haven't been in therapy and it's already two years plus.* Participant 2 confirmed that some parents are also aware of the "they say" reports: *So you*

would find the parents saying 'no. no, no, I'm not taking my child for therapy, they've said so … we need to win the case'.

The participants put forward different reasons underlying the arguments against the provision of pre-trial therapy. Participants 16 and 11 explained that one of these reasons pertain to the lowering of visible signs of trauma in the child witness, which could affect the credibility of the child's evidence: *...a child [who was not empowered through therapy] … that regresses and cries when they see the perpetrator … could obviously make the whole process credible"* (P16). *A child can be in a much better place [due to therapy] so it looks like they're not as affected as when they didn't have therapy* (P11). Participant 19 added another reason, namely that the child might prefer not to continue with the case as a result of working through the trauma during therapy: *… the child can withdraw and say 'I have worked through this … I have put it behind me, I am now OK and would rather leave this and move on with life'.*

The participants perceived the main reason for withholding therapy prior to the child complainant's testimony as perceptions that therapy could contaminate the child's evidence.

3.2. Theme 2: The Issue of Contamination

The participants were of opinion that legal professionals often claim that pre-trial therapy is a major source of contamination of the evidence of a child witness, which could affect the credibility of the child witness and the outcome of the case. Some participants indicated that there is a lack of clarity on how therapeutic practices could lead to contamination, while others were of opinion that there could be many other sources of contamination of the evidence of a child witness, other than pre-trial therapy.

In which way can we contaminate? Participant 16 described the uncertainty around what would constitute contamination within a therapeutic process as follows: *You don't want*

to contaminate anything. So what do you do to not contaminate? Social workers themselves do not always know how they can approach it [therapy] without contaminating.

In addition, Participant 11 questioned whether therapists would be able to contaminate a child's version of events: *I think it raises the question: in which way can we possibly contaminate information? Maybe with very young children ... surely, after a certain age a child knows what happened to them. The therapist is not going to be able to tell the child something happened to you that did not happen.* Participant 10 provided a thought-provoking opinion regarding generalized claims that pre-trial therapy would inevitably lead to contamination, without any evidence in this regard: *This … alleged contamination ... should it not be the other way around? Should they not prove that there was contamination, rather than assuming that it was?*

Participants were well aware of the claims of contamination through therapy. However, they opened a debate that contamination should be proven, rather than assumed. They provided practice examples of other possible sources of contamination of a child's version of events.

Alternative sources of contamination. From their prior experience, the participants provided examples of how opportunities could arise where children spontaneously talk about the alleged abuse in their interaction with others in their daily life. Participants raised concern that the child's version of events might be influenced by others, either on a verbal or non-verbal level.

> *A child cannot stay in isolation ... anyone can influence a child. It could be a newspaper article or family member or friend ... friends at school ... anyone. And then it [contamination] was not because of therapy, but merely exposure within the school setting, the peers, the teachers, the community that are inquisitive ... they all could influence the child's testimony.* (P 18)

Participant 10 confirmed that opportunities for contamination could present in various systems in which children normally function: *It could happen that the child sits at the [dinner] table and gets a flashback. How are you going to stop that child when she starts talking about it?* Participant 19 mentioned that similar situations could also apply to children who have been removed from parental care and placed in a child and youth care center:

> *I observe it in our setting ... you take away cell phones, you say 'No telephone contact ... contact under supervision of a social worker.' And still, it happens under our noses ... You don't have any control. A mother that gives a child a look [during visits], or says half a word ... Or a mother that influences the child and say 'withdraw the case, don't tell'.*

In further reflection, Participant 19 explained:

> *[The children] are talking about it to different people who are not qualified to talk about it. But when we do it in a structured, healthy manner, we're [accused of] contaminating. I think most children naturally experience some form of contamination before they get to court anyway. ... these guys want to keep children from therapy, but therapy is not the only problem.*

The nature of the legal process was also identified as a possible source of contamination, as indicated by Participant 4: ... *the child has to make a statement, [and] then go for the forensic assessment, then they are with the therapist, and ...they tell the story to their parents. ... The more individuals the child is exposed to, the more the truth will be contaminated.*

The arguments above, denoting multiple possible sources of contamination, in fact contest the school of thought that places emphasis on therapy as a major source of contamination. Fears related to possible contamination as well as the lack of guidelines of

practice, as discussed in Themes 1 and 2, had practice implications for participants dealing with child witnesses in therapy.

3.3. Theme 3: "Our hands are tied"

The participants shared practice implications in terms of adhering to the perceived practice rule of "no therapy" before the child's testimony in court.

"How do I deal with the elephant in the room?". Participant 16 highlighted how the lack of guidelines in terms of the provision of pre-trial therapy could place social workers in a predicament. She stated: *So they ask you to help ... 'Please see this child. He is very difficult but you may say nothing about anything.' I'm not sure how you are supposed to do therapy and avoid the elephant in the room* (P16). Participant 13 indicated how this situation hampers the role of the social worker: *It is difficult, but it is our reality that as social workers ... we have to know exactly what we may or may not do, but we cannot do nothing*.

In practice, this confusion resulted in a number of "what if" questions: What if I do therapy? What if I don't? What if new information comes up during therapy?

"What if I do therapy?" Participant 12 highlighted a possible ripple effect of a social worker providing pre-trial therapy to a child complainant of sexual abuse:

> *There is a risk that it [therapy] could lead to problems with the legal process ... or confusion ... and no one will be prosecuted because the correct procedures were not followed by the helping professional. ... if a guilty person goes free, he can do it to ten other children, and then society suffers as well.*

On the other hand, two participants reported on instances where prosecutors were in support of pre-trial therapy despite concerns over contamination. These participants explained

that the prosecutors were experienced in working with children and knowledgeable about the effects of CSA. Participant 7 mentioned:

> *... the prosecutors ... they were the ones pushing for therapy ... they knew they might never win the case if the kid was not given therapy ... but I think it is because of such close interaction [between the prosecutor and the child] that they could clearly see that there is a problem and that if they were not realistic [about allowing therapy] they will not win [the case]*.

In agreement, Participant 9 stated: *If a prosecutor has enough experience working with children and understand the effects [of CSA] ... they will probably be supporting the provision of therapy to children.*

Some participants were hesitant to provide therapy as it could result in them having to testify in court, which they perceived to be a hostile environment. Participant 17 mentioned: ... *because then I have to testify in court, which I don't want to,* whereas Participant 13 stated the following: *After having been battered in court for so many times when I was a young social worker, I said to myself: 'No more. You won't get me in court again'*.

The perception of the court as being a hostile environment may not be unfounded, although it appears that such court appearance had not happened often. Only one participant indicated that she had to answer twice to the court about providing therapy to a child complainant of sexual abuse: *[Once] I had to respond to that [a query by the court] in writing, justifying and motivating why therapy was provided and the benefits thereof. ... [Another] time I was subpoenaed and actually had to talk to that* (P3).

New information about the alleged abuse that could surface during therapy could pose a problem as its occurrence could be interpreted as a result of contamination. Participants

expressed uncertainty about what should be regarded as new information and, then, what should be done with new information.

> *Now the child says something … and [the social worker wonders] 'what must I do with this information?' … The child expects you to do something with that [information] … my hands are tied because you don't really know … you are not allowed to intervene* (P13). *And there is another way that our hands are tied. We don't have access initially to the original statement of the child. So we don't know what is known, what is not known. … in therapy you might get more information … is it relevant, should it be reported?* (P10).

The above quotes indicate that the participants were wary of the possible consequence of providing pre-trial therapy. However, they were faced with a dichotomy, in that withholding therapy would not be in the best interests of the child.

"What if I don't do therapy?". Participants were concerned about cases where pretrial therapy is postponed and the case is eventually withdrawn, as stated by Participant 11:

> *What if we're not going to give them therapy and there's not going to be a court date. … maybe in a year's time … sometimes six years [the case is withdrawn] … this child has been waiting for everything to be finalized and then it just fizzles away . … It takes years and in the meantime this child must try and live with his trauma.*

In this light, one of the participants asked whether it was worth postponing therapy to let the child testify in court, given the low conviction rates in cases of CSA: *Should we really further victimize the child [by not giving therapy] when there is a small chance of a conviction? Should our focus not rather be on helping the child to get better?* (P19).

The participants accurately pointed out dilemmas often experienced in practice, namely charges being withdrawn and low conviction rates. Despite uncertainties and challenges, the participants took a firm stance in favor of pre-trial therapy.

3.4. Theme 4: "We can't do nothing"

The participants supported the importance of a sound legal process, and acknowledged that therapeutic intervention could have adverse consequences for the quality of the child's evidence and the outcome of the criminal case. In their views, the best interests of the child however remains paramount, especially because of the unique impact of CSA on the victim and the stressful nature of being a witness in a criminal trial.

The best interests of the child is paramount. From the participants' point of view, not providing pre-trial therapy to victims of CSA would constitute failure to perform their duties, as illustrated by the following quote: *We [social workers] are regulated by the Children's Act where the focus is on the best interests of the child. And that is our guiding principle ... Failure to do that would constitute secondary trauma to the child"*(P3). Participant 16 was concerned about how to explain to a child that he/she could not go for therapy: *How do you explain to a child…the policeman, the lawyer, everyone wants to help you and we want to make sure that you're safe, but for two years you can't talk about this?*(P16). The participants acknowledged that the legal process needs to take its course. However, seen from a social work perspective they were of opinion that it would be wrong not to support a child in crisis. Their perceptions were mostly motivated by their acute awareness of the unique trauma context of the child exposed to CSA.

The unique trauma context of CSA. Based on their experience in practice, the participants provided some insight into the unique trauma context of CSA which underlies their

stance towards pre-trial therapy. They argued that, once this unique trauma context is understood, a strong argument could be made in support of pre-trial therapy. Participants 17, 14 and 18 highlighted how disclosure of CSA could create chaotic circumstances for the child complainant: *In my experience, when this type of allegation is made, it is fairly chaotic. The mother does not know what to do … there is a big uproar that the child will inevitably see and experience* (P17); *It [reporting sexual abuse] causes division in the family. So the whole family becomes dysfunctional* (P14); *The siblings blame her [the victim of CSA] for the fact that all of them were removed and placed in alternative care* (P18).

Participant 18 shared information on a case that was covered in the media and the distressing consequences it had for the child victim:

> *Everybody [close to the child victim] asks her about the sexual abuse. It is very exposing ... she feels ashamed. Although it is a good thing that there is media coverage, as it shows something is being done about the case, it is bad for the victim as she has to go back to school. You can't keep her out of school for two years [the expected duration of the trial]. She has to deal with the mockery* (P18).

Participant 16 spoke on behalf of a victim of CSA:

> '*I've lost my school, my friends, I am deprived of my whole world where I was and placed somewhere else …' He [the child] is now in a children's home, he has no mother to talk to, she visits him every second weekend and is actually cross with him, because since he spoke this 'nonsense' dad left and there is no money. 'My brothers are cross with me, but I did tell the truth' … and now he starts recanting* (P16).

One participant emphasized the importance of timeous therapeutic intervention as the negative impact of CSA can last into adulthood: *It becomes a cycle … I have often experienced in practice that, once you start exploring, you find that the mother [of the sexually abused*

child] was a victim...it becomes a theme. And later it affects their relationship with their children (P19).

The participants highlighted the upheaval that allegations of CSA could cause for the child complainant as well as for the broader family. Participants further noted the consequences of lengthy legal processes for the victim of CSA as a reason for not postponing pre-trial therapy.

Lengthy legal processes. Participants expressed concern about the well-being of victims of CSA who are denied pre-trial therapy in a context where lengthy legal processes are common. In this regard, Participant 18 stated:

> *It is a pity that the court role is so full and the time period from the case being reported until finalization is so lengthy. It's a long time for a child to have to deal with something that's happened … It manifests in behavior problems and you don't know how to address it as you are not allowed to deal with the cause of this behavior, namely the incident [sexual abuse]. You are not allowed to do anything … it becomes bigger and bigger. … the victim [child] remains a victim.*

Participants 19 and 10 cautioned that the children are often the forgotten ones in the whole process: *These children are in limbo. It's like a wound that is there the whole time, but we do not do anything for these children* (P19); *Unless you do therapy, you do not really help this child. So you leave this child in limbo* (P10). Participant 16 placed herself in the child's shoes and described the internal world of the child who finds him or herself in this situation:

> *'And I've told my teacher everything, now I've told my mother everything, now I've told this policeman everything …Then I really want to tell that lady [therapist] that I see every week, and I'm not allowed to talk to her about it [sexual abuse]. … And then, two years later when I'm trying my best to bury it, I have to go and tell some strange lady*

[in court] things that happened, after you have been telling me for two years that we're not allowed to talk about it.' *I just think there is a lot of conflicting messages* (P16).

The lengthy court processes was not the only concern raised by the participants. They viewed the nature of the court proceedings in itself as traumatizing for the child.

The nature of the court proceedings. The participants highlighted testimony and cross examination as factors that could lead to traumatization of the child witness, as it would require the child to relive the traumatic event(s), while he/she is expected to describe the ordeal in graphic detail. Participant 12 described these experiences from a child's viewpoint: *'I had to go to court [where] I had to experience it again, had to recall all these things that happened to me.' It feels as if the children battle, they are being re-victimized. The court can be very intimidating* (P12). Participant 18 emphasized that testimony about an ordeal such as CSA could be traumatic for a child witness irrespective of whether they testify in an open court or in a separate room by means of closed-circuit television (CCTV): *It is intimidating. Even if the child sits in a separate [intermediary] room, the questions being asked are so personal and so graphic. I think it can be a very traumatic experience for the child* (P18).

Lastly, the participants provided recommendations for the provision of pre-trial therapy for child witnesses in cases of CSA.

3.5. Theme 5: Recommendations

The recommendations made by the participants focused on revisiting current practices related to pre-trial therapy, guidelines and training, multidisciplinary collaboration, and reforming legal processes related to CSA. Participants were of opinion that professionals should stand back and re-evaluate the situation on whether current practices serve the best interests of the child. They highlighted the need for guidelines and training regarding pretrial

therapy to prevent re-traumatization of the child witness. One participant recommended that research be conducted to hear the child witness's view on the provision of pre-trial therapy. Furthermore, emphasis was placed on the need for all role players working with CSA to collaborate as part of a multi-disciplinary team. Suggestions relating to the legal processes included a shorter period to complete criminal trials where child witnesses are involved and a call for directives from the legislator to provide structure to services rendered concerning complaints related to CSA. In conclusion, it was suggested that social workers be the profession that advocates for the best interest of the child in criminal cases, especially those involving CSA.

4. Discussion

The findings from our study indicate that some social workers are hesitant to provide therapy to child complainants of CSA due to anecdotal reports claiming that therapy might contaminate the child's evidence (Fouché & Le Roux, 2014). The source of these claims is unclear; however, most of the social workers in our study claimed that it originated from legal professionals. Consequently, it appears that fear of being held accountable for the ripple effect therapy could have for the child witness, the outcome of the legal process; and for themselves in their professional role, forces social workers to adhere to the perceived practice rule of delaying therapy until after the child testified. In addition, it appears that the said practice has been carried over from one generation of social workers to the next.

Our findings suggest that a lack of practice guidelines in South Africa with regard to the provision of pre-trial therapy for child complainants of sexual abuse pose significant challenges for social workers. In this sense, social workers are confronted with a dichotomy: that healing needs to commence as soon as possible in order to ameliorate the adverse effects

of CSA (Kuehnle & Connell, 2011; Mathews et al., 2013) whereas, on the other hand, therapeutic interventions holds the potential of contaminating the child's version of events (Branaman & Gottlieb, 2013; Crawford & Bull, 2006; Maxwell, 2003). This dichotomy creates an untenable situation for social workers, whose day-to-day confrontation with the harmful consequences of CSA and the complexities related to the unique trauma context of CSA in South Africa urge them not to ignore the crucial role of timeous therapy for these children. A lack of practice guidelines leaves child complainants of sexual abuse in limbo, and creates an untenable situation for professionals who experience that they are not advancing the ethical principles of their profession and in addition, they are not promoting the best interests of the child.

In this study, the participants raised a significant point to be noted, namely that there are numerous possible sources of contamination of a child's evidence, besides therapy (Principe & Schindewolf, 2012). Possible sources could include the statement to the police, forensic assessments, engagement in discussions with family and other significant people, and even interrogation during the court proceedings. In addition, there appear to be no evidence that pre-trial therapy will indeed lead to contamination of the child's evidence. Thus, the claim that pre-trial therapy is a main source of contamination appears to be another moot point that could be contested and needs to be researched.

Our study has found that social workers in South Africa seem to be placed in a compromising position, as they lack direction from legislation or policy frameworks as well as specific training on pre-trial therapy for victims of CSA that will place them in a position to address this aspect. Amidst these uncertainties, the participants were acutely aware of their professional duty to protect children and help them heal after trauma, and therefore supported therapy as soon as possible, as failure to do so constitutes secondary trauma. A serendipitous

finding was the emphatic nature of the responses of some participants who spoke 'as the child' or from the child's perspective. Also, they showed insight into the fact that legal professionals, due to their roles, place strong emphasis on the sound legal outcome of a case.

The overall view of the participants was that the best interests of the child should be central in decision-making regarding the provision of pre-trial therapy; overriding fears of contamination of the child witness. Social work as a profession should take the lead in advocating for the rights of victims of alleged CSA for pre-trial therapy and for developing practice guidelines for dealing with cases of CSA. Practice guidelines need to be informed by research studies on determining the functions of different role players, protocols involved, evidence-based therapeutic interventions, whether a therapeutic approach such as CBT could potentially contaminate a child's version of events, and the prevention of potential of contaminating evidence. In addition, practice guidelines could for example stipulate the timing and context of aspects such as reporting to the police, forensic assessment, court preparation and the provision of therapy; ensuring that children involved in allegations of CSA do not remain the forgotten victims. However, such guidelines need to be enforced by policy and legislation. Training of legal professionals, social workers and other mental health professionals on aspects such as the harmful effects of CSA, different sources of contamination of the child's evidence and the timeous therapeutic interventions for victims of CSA is imperative.

Policy makers and legislatures urgently need to address this contentious issue, bearing in mind aspects such as the cautionary rule, prevailing perceptions among legal professionals, legal principle that guilt should be proven beyond reasonable doubt, and that there appear to be no evidence supporting anecdotes that appropriate therapeutic intervention could potentially contaminate children's testimony (Bellengére et al., 2013). Furthermore, legal processes

involving child victims of sexual abuse should be prioritized to prevent lengthy legal processes, in which the duration and outcome, for example withdrawal of cases, seem to create unnecessary confusion and trauma for the child and the systems in which he/she is involved. The findings of this small-scale exploratory study cannot be generalized. However, we believe that our findings can contribute to national and international debates by "experienced practitioners already grappling with the complexity of providing pre-trial therapy, while the system itself is clearly under growing pressure to change" (Jenkins et al., 2015).

Funding

This research did not receive any specific grant from funding agencies.

References

Allnock, D., & Hynes, P. (2012). *Therapeutic services for sexually abused children and young people. Scoping the evidence base***.** Summary report**.** London: NSPCC**.** Retrieved from www.nspcc.org.uk .

Artz, L., Burton, P., Ward, C. L., Leoschut, L., Phyfer, J., Lloyd, S. … Le Mottee, C. (2016). *Sexual victimisation of children in South Africa. Final report of the Optimus Foundation Study: South Africa.* Cape Town, South Africa: UBS Optimus Foundation. Retrieved from www.optimusstudy.org.

Barth, J., Bermetz, L., Heim, E., Trelle, S., & Tonia, T. (2012). The current prevalence of childhood sexual abuse worldwide: A systematic review and meta-analysis. *International Journal of Public Health*, *58*, 469-483. doi:10.1007/s00038-012-0426-1.

Bellengére, A., Palmer, R., Theophilopoulos, C., Whitcher, B., Roberts, L., Melvilles, N., ... Reddy, S. (2013). *The law of evidence in South Africa: Basic principles*. Cape Town,

South Africa: Oxford Press.

Berk, L.E. (2013). *Child development.* (9th ed.). Boston: Pearson.

Bond, T., & Sandhu, A. (2005). *Therapists in court: Providing evidence and supporting witnesses*. London, UK: SAGE Publications

Branaman, T.F., & Gottlieb, M.C. (2013). When does it become witness tampering? Ethical and legal considerations for treatment of alleged victims. *Professional Psychology: Research and Practice, 14*, 299–306. doi: 10.1037/a0033020.

Ceci, S.J., & Bruck, M. (1995). *Jeopardy in the courtroom: a scientific analysis of children's testimony.* Washington, US: American Psychological Association.

Children's Act 38 of 2005. (RSA). http://www.justice.gov.za/legislation/acts/2005-038%20 childrensact.pdf

Cohen, J. A. & Mannarino, A. P. (1996). A treatment outcome study for sexually abused preschool children: Initial findings. *Journal of the American Academy of Child & Adolescent Psychiatry, 35,* 42-10. http://dx.doi.org/10.1097/00004583-199601000-00011.

Cohen, J. A. & Mannarino, A.P. (1998). Interventions for sexually abused children: Initial treatment outcome findings. *Child Maltreatment, 3,* 17-26. http://dx.doi.org/10.1177/1077559598003001002.

Cohen, J. A., Mannarino, A. P., & Knudsen, K. (2005). Treating sexually abused children: 1 year follow-up of a randomized control trial. *Child Abuse & Neglect, 29,* 135-145. http://dx.doi.org/10.1016/j.chiabu.2004.12.005.

Cohen, J. A., Deblinger, E., Mannarino, A. P. & Steer, R. A. (2004). A multisite, randomized controlled trial for children with sexual abuse-related PTSD symptoms. *Journal of the*

American Acadamy of Child & Adolescent Psychiatry, 43, 393-402. http://dx.doi.org/10.1097./00004583-200404000-00005.

Cohen, J. A., Mannarino, A. P., Perel, J. M., & Staron, V. (2007). A pilot randomized controlled trial of combined trauma-focused CBT and sertraline for childhood PTSD symptoms. *Journal of the American Academy of Child & Adolescent Psychiatry, 46,* 811-819. http://dx.doi.org/10.1097/chi.0b013e3180547105.

Cohen, J. A., Deblinger, E., & Mannarino, A. P. (2016) Trauma-focused cognitive behavioural therapy for children and families. *Psychotherapy Research,* 1-11. doi:10.1080/10503307.2016.1208375.

Conte, J., & Schuerman, J. (1987). The effects of sexual abuse on children: A multidimensional view. *Journal of Interpersonal Violence, 2,* 380–390. http://dx.doi.org/ 10.1177/088626058700200404.

Crawford, E., & Bull, R. (2006). Child witness support and preparation: are parents/caregivers ignored? *Child Abuse Review, 15,* 243–256. http://dx.doi.org/10.1002/car.946.

Creswell, J.W. (2014). *Research design. Qualitative, quantitative and mixed methods approaches*. London, UK: SAGE Publications.

Cummins, L.K., Sevel, J. A., & Pedrick, L. (2012). *Social work skills for beginning direct practice.* Upper Saddle River, NJ: Pearsons.

Deblinger, E., Lippman, J., & Steer, R. (1996). Sexually abused children suffering posttraumatic stress symptoms: Initial treatment outcome findings. *Child Maltreatment, 1,* 310-321. http://dx.doi.org/10.1177/1077559596001004003.

Deblinger, E., Stauffer, L. & Steer, R. (2001). Comparative efficacies of supportive and cognitive behavioural group therapies for young children who have been sexually

abused and their nonoffending mothers. *Child Maltreatment, 6,* 332-343. http://dx.doi.org/10.1177.1077559501006004006.

Deblinger, E., Mannarino, A., Cohen, J. A., Runyon, M. K. & Steer, R. A. (2011). Trauma-focused cognitive behaviour therapy for children: Impact of the trauma-narrative and treatment length. *Depression and Anxiety, 28,* 67-75. http://dx.doi.org/ 10.1002.da.20744.

Department of Justice and Constitutional Development. (2012). *National Policy Framework: Management of Sexual Offence Matters*. Retrieved from www.justice.gov.za.

Domhardt, M., Munzer, A., Fegert, J. M., & Goldbeck, L. (2014). Resilience in survivors of child sexual abuse: a systemic review of the literature. *Trauma, Violence, & Abuse, 16,* 476-493. http://dx.doi.org/10.1177/1524838014557288.

Edmond, T., Lawrence, K. A., & Schrag, R. V. (2016). Perceptions and use of EMDR therapy in rape crisis centers. *Journal of EMDR Practice and Research, 10(1),* 23-32. http://dx.doi.org/10.1891/1933-3196.10.1.23.

Faller, K.C. (2015). Forty years of forensic interviewing of children suspected of sexual abuse, 1974–2014: Historical benchmarks. *Social Sciences*, *4(*1), 34-65.

Fivush, R., Peterson, C., & Schwarzmueller, A. (2002). Questions and answers: the credibility of child witnesses in the context of specific questioning techniques. In M.L. Eisen, J.A. Quass, & G.S. Goodman (Eds.). *Memory and suggestibility in the forensic interview.* Mahwah, NJ: Lawrence Erlbaum Associates, Publishers.

Fleming, J. (2012). The effectiveness of Eye Movement Desensitization and Reprocessing in the treatment of traumatized children and youth. *Journal of EMDR Practice and Research. 6*(1), 16-26. http://dx.doi.org/10.1891/1933-3196/6/1/16.

Fouché, A., & Fouché, D. F. (2015). Requirements for evidence by a forensic social worker as set by the Supreme Court of Appeal. *Child Abuse Research in South Africa, 16,* 105-155.

Fouché, A., & Le Roux, M. P. (2014). Legal professionals' views on pre-trial therapy in cases of child sexual abuse in South Africa. *Journal of Psychology in Africa, 24,* 207-214. http://dx.doi.org/10.1080/14330237.4014.903071.

Geldard, K., Geldard, D., & Yin Foo, R. (2013). *Counselling children. A practical introduction.* London, UK: Sage.

Golding, J. M., Dunlap, E. E., & Hodell, E. C. (2009). Jurors' perceptions of children's eyewitness testimony. In B. L. Bottoms, G. S. Goodman, & C. J. Najdowski (Eds.). *Children as victims, witnesses, and offenders: Psychological science and the law* (pp. 189–208). New York, NY: Guilford Press.

Hayes, D., Bunting, L., Lazenbatt, A., Carr, N., & Duffy, J. (2011). *The experiences of young witnesses in criminal proceedings in Northern Ireland. A report for the Department of Justice*. NSPCC. Retrieved from www.nspcc.org.uk/inform/reportdepartment justice.

Hodges, E., & Myers, J. (2010). Counseling adult women survivors of childhood sexual abuse: benefits of a wellness approach. *Journal of Mental Health Counseling, 32*, 139–153. http://dx.doi.org/10.17744/mehc.32.2.t537j335522kx62q.

Hritz, A.C, Royer, D.E., Helm, R.K., Burd, K.A., Ojeda, K., & Ceci, S.J. (2015). Children's suggestibility research. Things to know before interviewing a child. *Anuario de Psicología Jurídica, 2,* 3–12. http://dx.doi.org/10.1016/j.apj.2014.09.002.

Hutton, J., Cranston, R., & Clarke, C. (2014). *Provision of therapy for child witnesses prior to a criminal trial: Practice guidance.* The Crown Prosecution Service. Retrieved from www.cps.gov.uk.

Jenkins, P., Muccio, J., & Paris, N. (2015). Pre-trial Therapy: Avoiding the pitfalls. *Healthcare Counselling & Psychotherapy Journal, 15*(2). Retrieved from www.ebschohost.com.

Jensen, T. K., Holt, T., Ormhaug, S. M., Egeland, K., Granly, L., Hoaas, L. C., … Wentzel-Larsen, T. (2014). A randomized effectiveness study comparing trauma-focused cognitive behavioural therapy with therapy as usual for youth. *Journal of Clinical child & Adolescent Psychology, 43,* 356-369. www://dx.doi.org/10.1080/15374416. 2013.822307.

Kendall-Tackett, K. A., Williams, L. M., & Finkelhor, D. (1993). Impact of sexual abuse on children: A review and synthesis of recent empirical studies. *Psychological Bulletin, 113,* 164-180. www://dx.doi.org/10.1037/0033-2909.133.1.64.

King, N. J., Tonge, B. J., Mullen, P., Myerson, N., Heyne, D., Rollings, S., … Ollendick, T. H. (2000). Treating sexually abused children with posttraumatic stress symptoms: A randomized clinical trial. *Journal of the American Academy of Child & Adolescdent Psychiatry, 39,* 1347-1355. http://dx.doi.org/10.1097/00004583-200011000-00008.

Kuehnle, K., & Connell, M. (2011). Managing children's emotional and clinical needs. In M.E. Lamb, D.J. La Rooy, L.C.Y. Malloy, & C. Katz (Eds.). *Children's testimony: A handbook of psychological research and forensic practice* (pp. 179–198). Oxford, London: Wiley-Blackwell.

Lyon, T. D., & Saywitz, K.J. (2006) .From post-mortem to preventive medicine: next steps for research on child witnesses. *Journal of Social Issues, 62,* 833–861. http://dx.doi.org/ 10.1111/j.1540-4560.2006.00489.x.

Macdonald, G., Higgins, J. P., Ramchandani, P., Valentine, J. C., Bronger, L. P., Klein, P., … Taylor, M. (2012). Cognitive-behavioural interventions for children who have been

sexually abused. *Cochrane Database of Systematic Reviews.* http://dx.doi.org/10.1002/14651858.cd001930.pub3.

Maniglio, R. (2012). Child sexual abuse in the etiology of anxiety disorders: a systematic review of reviews. *Trauma, Violence, & Abuse, 14*, 96–112. http://dx.doi.org/10.1177/1524838012470032.

Maniglio, R. (2013). The impact of child sexual abuse on the course of bipolar disorder: a systematic review. *Bipolar Disord*, *15*, 341–358. http://dx.doi.org/10.1111/bdi.12050.

Mannarino, A. P. & Cohen, J. A. (1986). A clinical-demographic study of sexually abused children. *Child Abuse & Neglect, 10*(1), 17-23. http://dx.doi.org/10.1016/0145-2134(86)90027-x.

Maschi, T., & Youdin, R. (2012). *Social worker as researcher. Integrating research with advocacy.* Boston, United States: Pearson.

Mathews, S., Abrahams, N., & Jewkes, R. (2013). Exploring mental health adjustment of children post sexual assault in South Africa. *Journal of Child Sexual Abuse, 22*, 639–657. http://dx.doi.org/10.1080/10538712.2013.811137.

Matthias, C.R., & Zaal, F.N. (2011). Intermediaries for child witnesses: old problems, new solutions and judicial differences in South Africa. *The International Journal of Children's Rights, 19*, 251–69. http://dx.doi.org/10.1163/157181810x527987.

Maxwell, A. (2003). Pre-trial therapy for child complainants of sexual abuse in the criminal justice system: Forensic implications. Paper presented at the child sexual abuse: justice response or alternative resolution conference convened by the Australian Institute of Criminology and held in Adelaide, 1–2 May 2003. Retrieved from www.aic.gov.au/media_library/conferences/2003-abuse/maxwell.pdf.

Meintjies, R. (2000). A call for a cautionary approach to common sense. *Child Abuse Research in South Africa, 1*(1), 40–44. Retrieved from http://reference.sabinet.co.za/search_sa_epublication/carsa.

Müller, K. (2001). Clinical and forensic interviews and the child witness. *Child Abuse Research in South Africa, 2*(2), 8–14. Retrieved from http://reference.sabinet.co.za/sa_epublication/carsa.

New Dictionary of Social Work, (1995). Cape Town, South Africa: CTP Book Printers.

Principe, G.F., & Schindewolf, E. (2012). Natural conversations as a source of false memories in children: implications for the testimony, *Developmental Review, 32,* 205–223. http://dx.doi.org/10.1016/j.dr.2012.06.003.

Sexual Offences and Related Matters Amendment Act 32 of 2007. (RSA). Retrieved from http://www.justice.gov.za/legislation/acts/32/2007.

Singh, M., Parsekar, S., & Nair, S. (2014). An epidemiological overview of child sexual abuse. *Journal of Family Medicine and Primary Care*, *3,* 430–435. http://dx.doi.org/10.4103/2249-4863.148139.

Stoltenborgh, M., Bakermans-Kranenburg, M.J., Alink, L.R.A., & van Ijzendoorn, M.H. (2015). The prevalence of child maltreatment across the globe: review of a series of meta-analyses. *Child Abuse Review, 24*(1), 37-50. http://dx.doi.org/10.1002/car.2353.

Swiecicki, C.C., & Hollingsworth, J. (2015). A response to Branaman and Gottlieb's "Ethical and Legal Considerations for Treatment of Alleged Victims: When Does It Become Witness Tampering?" *Professional Psychology*: *Research and Practice, 46,* 197–201. http://dx.doi.org/10.1037/pro0000012.

Tong, L., Oates, K., & McDowell, M. (1987). Personality development following sexual abuse. *Child Abuse & Neglect, 11,* 371-383. http://dx.doi.org/10.1016/0145-2134(87)90011-1.

Van Der Merwe, A. (2009). Children as victims and witnesses**.** In T. Boezaart (Ed.). *Child law in South Africa* (pp. 563– 586). Cape Town, South Africa: Juta.

Wilen, J.S., Littell, J.H., & Salanti, G. (2012). Psychosocial interventions for adults who were sexually abused as children (Protocol). *Cochrane Database of Systematic Reviews, 2012*(9), http://dx.doi.org/10.1002/14651858.CD010099.