

The influence of a lifeskills programme on adolescents' knowledge of child sexual abuse: A gender analysis

Francois Steyn

Department of Social Work & Criminology, University of Pretoria

E-mail: francois.steyn@up.ac.za

Reema Nunlall

Department of Social Work & Criminology, University of Pretoria

E-mail: reema.nunlall@up.ac.za

At primary prevention level, appropriate knowledge and awareness remain the first line of defence against child sexual abuse. This article provides a gendered analysis of the influence of a lifeskills programme on the sexual abuse knowledge of adolescents who live in impoverished and marginalised settings. A pre/post-test design was used to gather data from 348 adolescents by means of group-administered surveys prior to and after the weeklong residential programme. The pre-intervention results showed lower levels of knowledge among male respondents regarding statements on what child sexual abuse is and statistically significant improvements in this regard were recorded at post-intervention. However, their knowledge still remained lower compared to that of female respondents. Respondents' knowledge regarding the nature of child sexual abuse suggests the continuation of gender stereotypes which may hamper effective identification and reporting of sexual abuse. Nevertheless, the lifeskills programme demonstrated value in strengthening adolescents' knowledge of child sexual abuse. It is recommended that future programmes be sensitive to the gendered pre-knowledge of adolescents when providing training on sexual abuse. Research is needed to determine why the programme failed to impact positively on some adolescents' knowledge about child sexual abuse.

Keywords: child sexual abuse; lifeskills programme; gender; adolescence; pre-post survey

INTRODUCTION

Child sexual abuse (CSA) is a global reality with debilitating consequences for victims, their families and society. The World Health Organization (WHO) defines CSA as “[t]he involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violate the laws or social taboos of society” (WHO, 2017a: vii; 1999: 15). The Children’s Act (38 of 2005) states that CSA involves many types of sexually abusive acts towards children, including molestation, assault, forcing a child to be used for the sexual gratification of another person, exposing a child to sexual activities or pornography, or the commercial sexual exploitation of children (Republic of South Africa, 2005: 17-18).

The WHO (2017b: 2) estimates that 18% of girls and 8% of boys are sexually abused worldwide. In South Africa, a nationally representative study among 5 631 adolescents between the ages of 15 and 17 years found that 14.6% of girls and 9.9% of boys experienced some form of sexual victimisation in their lifetime (Ward, Artz, Leoschut, Kassanjee & Burton, 2018: 460). The Birth to Twenty Plus (BT20+) study – which tracks more than 200 children in Soweto, South Africa, from childhood to young adults – found that 10% of primary school-aged children and 30% of adolescents reported having experienced CSA (Richter, Mathews, Kagura & Nonterah, 2018: 185).

CSA has lifelong consequences for children effecting early child brain development which could result in deficits in affective and cognitive abilities (Lim, Radua & Rubia, 2014: 8). In turn, these constraints could increase the likelihood of psychological disorders (depression and suicide), health risks (substance dependency, obesity and related health consequences) and reduced life expectancy (Almuneef, 2019: 4; Felitti & Anda, 2009: 4-11). Research has also acknowledged a direct path from sexual victimisation to sexual abusive behaviour (Leversee, 2015: 2). CSA has shown to increase adult re-victimisation (Heusser & Elkonin, 2014: 83), high-risk behaviours which increase the odds of adolescent pregnancy (Honig, 2012: 185; Noll, Shenk & Putnam, 2009: 366), and HIV infection (Jewkes, Dunkle, Nduna, Jama & Puren, 2010: 838).

The Optimus Study on child abuse, violence and neglect in South Africa identified multiple risk factors for CSA (Burton, Ward, Artz & Leoschut, 2015: 10). Increased vulnerability at the individual level include the child’s gender, age and disability status. CSA is further associated with low family support, low socioeconomic status, low parental education, absent or single parenting, parent substance dependency

and domestic violence. At the societal level children living in poverty and dangerous communities with the lack of resources and adequate protection are at higher risk of CSA. Child protection services are often understaffed and overburdened which have pushed academics, civil society and government towards preventive measures (Sewpaul, 2006: 134).

The WHO (2016: 70) has developed seven strategies for ending violence against children, including educating children about sexual abuse and how to protect themselves. Research in El Salvador found that knowledge of CSA improved after children were exposed to a prevention exhibition at a children's museum (Hurtado, Katz, Ciro, Gutfreund & Nosike, 2014: 103). Children who participated in the board game of the Hands Off Our Children campaign in the Western Cape, South Africa, similarly showed increased awareness of CSA (Dunn, 2008: 44). In addition, media campaigns for parents proved positive to enhance knowledge of CSA and retention of knowledge over time (Rheingold, Campbell, Self-Brown, De Arellano, Resnick & Kilpatrick, 2007: 360). At primary prevention level, appropriate knowledge and awareness remain the first line of defence against CSA.

AIM AND METHODS

The aim of the study was to determine and compare adolescents' knowledge of CSA following their participation in a lifeskills training programme. The results originate from a strategic partnership – with an evaluation component – between the Department of Social Work and Criminology, University of Pretoria, and a Gauteng-based non-governmental organisation which focuses on youth development through, amongst others, lifeskills training. The beneficiaries of the lifeskills programme are from impoverished and severely marginalised backgrounds (amongst others, informal settlements in Meadowlands, Poortjie and Orange Farm) and some participants are on lifelong chronic medication. Adolescents are identified for participation in the programme by means of referrals from schools and community based organisations that care for orphaned and vulnerable children. The weeklong programme is implemented during school holidays and takes place at a residential facility in a rural setting. Structured lifeskills training is offered in classroom-type facilities, while the venue also caters for outdoor activities such as swimming and adventure courses.

A pre/post-test survey design was used to gather data about respondents' knowledge of CSA. Pre-test data was obtained shortly after participants arrived at the venue and post-test data was obtained following completion of the lifeskills training programme. No sampling strategy was followed as it was aimed to gather data from as many participants as possible. The pre- and post-test questionnaires of 348 adolescents who attended the September and December 2018, and March 2019 training sessions were successfully matched. The two scales on adolescents' knowledge of CSA were developed from the lifeskills curriculum of the service provider. The first scale had three response categories (“Yes”, “No” and “Don't know”), while the second scale had four response categories (ranging from “Strongly agree” to “Strongly disagree”). The questionnaire was translated to SeSotho and isiZulu should respondents preferred to answer the questions in one of these two local languages. Data was gathered by group-administered means where respondents were present in one venue and they completed the questionnaire individually.

The Statistical Package for the Social Sciences (IBM, 2019) was used to analyse the data. The data was not normally distributed hence non-parametric procedures (Wilcoxon signed rank test) was opted for to determine significant differences between pre- and post-intervention measurements (Field, 2018: 297). Effect sizes were calculated for statistically significant shifts in respondents' knowledge of CSA. The results of the two scales are presented in table-format showing the pre- and post-intervention results for male and female respondents separately, as well as the results for the entire group.

Data gathering took place under the auspices of the service provider who also obtained informed consent from respondents and ascent from their parents/guardians to participate in the research. In addition, the service provider had to ensure that the ethical considerations of voluntary participation and no harm were adhered to throughout data collection. Social workers in the employ of the service provider were available to debrief respondents in case any respondent were negatively affected during or following completion of the questionnaire. No negative incidents during or after completion of the questionnaires were reported.

RESULTS

The average age of respondents was 14.18 years (standard deviation 1.44 years). Slightly more than half of respondents were female and most respondents lived in households consisting of between four and six household members (Table 1).

Table 1: Background characteristics

	n	%
Sex		
Male	189	55.8
Female	149	44.0
Schooling		
≤ Grade 7	100	29.7
Grade 8	68	20.2
Grade 9	88	26.1
Grade 10	55	16.3
Grade 11	23	6.8
Grade 12	3	0.9
Household size		
1-3 members	77	23.1
4-6 members	177	53.1
7-9 members	57	17.1
≥ 10 members	22	6.6

Table 2 depicts the percentages of “Yes” responses, as well as the mean of responses on the three-point scale. Of the six statements of what constitutes CSA, five showed significant positive shifts in respondents’ knowledge with the remainder statement nearing significance.

Table 3 represents the percentages of the combined total of the “Strongly agree” and “Agree” responses, as well as the mean of responses on the four-point scale. Some positive shifts in knowledge featured regarding respondents’ knowledge of the nature of CSA, although only three of the thirteen proved to be significant.

Table 2: Respondents’ pre- and post-test knowledge of what child sexual abuse is

It is sexual abuse when ...	Male			Female			Total		
	Pre	Post	p (r)	Pre	Post	p (r)	Pre	Post	p (r)
An adult touches the private parts of a child	57.1 (1.57)	67.6 (1.43)	0.026* (-0.19)	69.2 (1.40)	73.0 (1.32)	0.117 (-)	63.6 (1.48)	69.9 (1.38)	0.011* (-0.14)
An adult kisses a child in a sexual way	53.1 (1.53)	63.6 (1.43)	0.035* (-0.17)	70.3 (1.35)	72.6 (1.35)	0.664 (-)	61.9 (1.44)	68.2 (1.39)	0.073 (-)
An adult hugs a child in a friendly manner	38.2 (1.69)	27.3 (1.82)	0.036* (-0.17)	26.9 (1.79)	25.4 (1.84)	0.334 (-)	33.2 (1.73)	27.1 (1.82)	0.026* (-0.12)
An adult asks a child to touch his/her private parts	54.2 (1.55)	69.2 (1.35)	0.000** (-0.29)	67.0 (1.42)	69.6 (1.36)	0.183 (-)	61.1 (1.48)	69.0 (1.36)	0.001** (-0.17)
An adult shows his private parts to a child	53.5 (1.56)	61.1 (1.51)	0.612 (-)	62.5 (1.51)	76.9 (1.27)	0.000** (-0.31)	58.6 (1.53)	69.5 (1.38)	0.001** (-0.17)
An adult has sexual intercourse with a child	49.0 (1.73)	58.6 (1.52)	0.004** (-0.24)	64.3 (1.51)	69.0 (1.44)	0.178 (-)	56.8 (1.61)	65.0 (1.47)	0.001** (-0.17)

* p < 0.05

** p < 0.01

Table 3: Respondents’ pre- and post-test knowledge about the nature of child sexual abuse

	Male			Female			Total		
	Pre	Post	p (r)	Pre	Post	p (r)	Pre	Post	p (r)
Most sexual abusers are mentally ill	66.0 (2.15)	73.5 (2.06)	0.556 (-)	59.3 (2.23)	65.8 (2.13)	0.157 (-)	61.9 (2.21)	69.6 (2.09)	0.094 (-)
Child sex abuse only happens in poor communities	39.5 (2.68)	38.0 (2.64)	0.741 (-)	33.4 (2.80)	28.8 (2.86)	0.501 (-)	36.1 (2.75)	33.1 (2.75)	0.861 (-)
Very few children are victims of sex abuse	51.1 (2.45)	50.0 (2.49)	0.631 (-)	53.0 (2.45)	47.3 (2.53)	0.719 (-)	51.1 (2.47)	48.5 (2.51)	0.900 (-)
Only girls are victims of sex abuse	31.5 (2.90)	25.9 (2.95)	0.335 (-)	39.7 (2.67)	26.7 (2.96)	0.002** (-0.22)	35.8 (2.78)	26.1 (2.97)	0.003** (-0.16)
Child sex abuse happens mostly outside the home	47.2 (2.49)	59.1 (2.30)	0.068 (-)	57.7 (2.25)	23.5 (2.52)	0.001** (-0.24)	52.5 (2.37)	52.2 (2.44)	0.245 (-)
Children who have been sexually abused end up sexually abusing other children	60.5 (2.28)	58.4 (2.30)	0.601 (-)	59.5 (2.25)	61.3 (2.25)	0.806 (-)	59.7 (2.28)	59.7 (2.28)	0.918 (-)
Most sex abusers are a family member of the abused child	76.9 (2.01)	79.6 (1.86)	0.073 (-)	75.6 (2.04)	85.7 (1.81)	0.003** (-0.21)	75.2 (2.05)	82.2 (1.85)	0.001** (-0.18)
In sex abuse cases the child is never responsible	52.7 (2.43)	64.2 (2.19)	0.013* (-0.20)	58.3 (2.25)	64.2 (2.16)	0.168 (-)	55.4 (2.34)	64.1 (2.17)	0.005** (-0.15)

continued/

	Male			Female			Total		
	Pre	Post	<i>p</i> (<i>r</i>)	Pre	Post	<i>p</i> (<i>r</i>)	Pre	Post	<i>p</i> (<i>r</i>)
Children who have been sexually abused will one day abuse their own children	42.8 (2.60)	38.4 (2.66)	0.468 (-)	39.8 (2.65)	40.1 (2.63)	0.975 (-)	41.1 (2.62)	39.0 (2.65)	0.523 (-)
A child who has been sexually abused will become gay	23.1 (3.08)	26.4 (3.03)	0.545 (-)	22.7 (3.05)	19.3 (3.16)	0.128 (-)	24.1 (3.04)	22.8 (3.10)	0.339 (-)
Children who have been sexually abused develop mental health problems	69.2 (2.14)	64.0 (2.31)	0.119 (-)	68.9 (2.12)	69.8 (2.12)	0.830 (-)	68.2 (2.15)	66.3 (2.22)	0.244 (-)
Child sexual abuse happens only at night	30.4 (2.88)	30.8 (2.81)	0.619 (-)	22.7 (3.07)	21.0 (3.08)	0.862 (-)	25.8 (2.99)	25.6 (2.96)	0.684 (-)
By law only children under the age of 12 can be sexually abused	29.8 (3.09)	33.6 (3.00)	0.487 (-)	21.2 (3.28)	24.6 (3.13)	0.084 (-)	25.9 (3.18)	28.1 (3.08)	0.164 (-)

* $p < 0.05$ ** $p < 0.01$

DISCUSSION

Regardless of contexts and settings, children are vulnerable to CSA and any effort to curb victimisation should be welcomed. The present study found promising but equally worrying results about marginalised adolescents' knowledge of CSA. Roughly two-thirds of respondents were in Grade 8 or higher and, given their average age (14 years), one would expect them to have relevant information regarding CSA. However, the pre-intervention results paint a bleak picture. For example, 43.2% of respondents answered either "No" or "Don't know" to the statement "It is sexual abuse when an adult has sexual intercourse with a child". In this regard, the impoverished backgrounds of respondents could possibly have influenced their knowledge as evidence shows that children who are from low socioeconomic contexts have lower prior knowledge of CSA (Hurtado et al, 2014: 106). Furthermore, only one in four respondents lived in households that resemble the average South African household size of 3.3 members per household (Statistics South Africa, 2016: 96). The majority (76.8%) of respondents lived in larger than average households possibly due to the high prevalence (62%) of children living in extended family households in South Africa (Hall & Makomane, 2018: 34). The matter is a cause for concern since sharing a bedroom with numerous household members has been identified as a potential risk factor for CSA (Ward et al, 2018: 464).

Seen broadly, approximately a third of respondents at pre-intervention did not consider the statements depicted in Table 2 as CSA. However, the post-intervention results suggest that the lifeskills programme has increased respondents' knowledge of what CSA is. Despite positive shifts in knowledge, the effect sizes appear small. Upon closer inspection, the results show gendered differences with regard to adolescents' awareness about CSA. Of the six items on knowledge about CSA, female respondents presented only one statistically significant shift. However, they presented higher levels of CSA knowledge at pre-intervention compared to male respondents which suggest that girls are exposed to CSA information at an earlier age. The results of female respondents can be seen as a positive indicator of CSA knowledge given that girls are more likely than boys to be victims of CSA (Ward et al, 2018: 460; WHO, 2017b: 2). It is noteworthy that the significant shifts in CSA knowledge originate largely from male respondents, yet they still presented lower levels of knowledge at post-intervention compared to their female counterparts. Though promising, the results are of concern in terms of not only boys' vulnerability to CSA, but also their possible perpetration of CSA.

With regard to respondents' knowledge about the nature of CSA (Table 3), the results again show some gender differences. Female respondents presented a significant shift in knowledge regarding the statement that only girls are victims of sexual abuse. The finding suggests that stereotypical notions of masculinity and femininity, as noted by Geister and Pardiwalla (2010: 81), are still active in society which could place females in submissive roles and later victimisation, and boys at risk of later perpetration of sexual or physical violence (Jamieson, Mathews & Röhrs, 2018: 90). Despite the positive shift in responses to the statement, one in four female and male respondents at post-intervention still indicated that males cannot be victims of sex abuse. Therefore, it appears that the misconception that men and boys cannot be raped is still present in society (Walfield, 2018: 5). The failure to acknowledge boys as victims of sexual abuse have several consequences, including the failure to disclose abuse because of the fear of stigmatisation (Banyard, Williams & Siegel, 2004: 225). Also, boys might not know that the abuse can be reported or they might fear that no one would believe them that the abuse took place (McDonald & Tijerino, 2013: 16-17).

Another positive shift featured in female respondents having demonstrated increased knowledge that CSA does not just happen outside the home and that most child sex abusers are a family member of the abused child. Respondents acknowledging that a family member can be a perpetrator has potential to decrease the myth that only strangers are perpetrators of sexual abuse which could in turn lead to disclosure and preventive measures. In addition, boys showed increased awareness that the child is never responsible for acts of CSA. It is, however, worrying that only two-thirds of respondents agreed that children are not responsible for sexual abuse considering that CSA is regarded as a risk factor for later suicide and non-suicidal self-injury (Maniglio, 2011: 39).

In conclusion, the study shows that marginalised adolescents' knowledge about CSA is a major cause of concern because, without appropriate information, CSA might go unnoticed and unreported. The surveys also point to gender differences in CSA knowledge, including gender stereotypes and myths around CSA. Gendered analyses alert us to deeper sociocultural dynamics of CSA which requires attention. The lifeskills programme appears to hold value in strengthening adolescents' knowledge about CSA, although there seems to be barriers in this regard since a meaningful proportion of adolescents failed to demonstrate increases in CSA knowledge. It is recommended that the lifeskills programme be targeted at younger adolescents from all socioeconomic backgrounds in order to equip them with relevant information on how to prevent and report CSA.

LIMITATIONS AND FUTURE RESEARCH

The study relied on non-random sampling procedures and generalisations across populations and geographic contexts should be made with caution. The researchers acknowledge that, despite the questionnaire having been available in local languages, some respondents might have had difficulties to fully understanding the items and response categories. We also acknowledge that the coercive nature of group-administered surveys – even more so in given the ages of respondents and the unfamiliarity of the setting in which the surveys took place – might have compromised voluntary participation in the surveys. Longitudinal research is suggested to track the influence of the intervention over time and to determine why the programme failed to impact positively on some adolescents' knowledge about CSA. It is further acknowledged that research and life-skills programmes should not only focus on adolescents from marginalised backgrounds but also adolescents from higher socioeconomic backgrounds.

LIST OF REFERENCES

- Almuneef, M. 2019. Long term consequences of child sexual abuse in Saudi Arabia: A report from a national study. *Child Abuse & Neglect*, accepted 4 March 2019, in press.
- Banyard, V.L., Williams, L.M. & Siegel, J.A. 2004. Childhood sexual abuse: A gendered perspective on contexts and consequences. *Child Maltreatment*, 9(3): 223-238.
- Burton, P., Ward C.L., Artz, L. & Leoschut, L. 2015. *Optimus study on child abuse, violence and neglect in South Africa*. Cape Town: Centre for Justice and Crime Prevention, University of Cape Town (Gender Health & Justice Research Unit).
- Dunn, M. 2008. The HOOC board game as prevention measure against child sexual abuse within the South African context. *Child Abuse Research a South African Journal*, 9(2): 37-48.
- Felitti, V.J. & Anda, R.F. 2009. The relationship of adverse childhood experiences to adult medical disease, psychiatric disorders, and sexual behavior: Implications for healthcare. In Lanius, R & Vermetten, E (Eds.). *The hidden epidemic: The impact of early life trauma on health and disease*. Cambridge University Press: Cambridge.
- Field, A. 2018. *Discovering statistics using IBM SPSS statistics*. Los Angeles: SAGE.
- Geister, G. & Pardiwalla, M. 2010. Socialization patterns and boy's underperformance in Seychellois School. *Journal Statistique Africain*, 11: 62-84.
- Hall, K. & Makomane, Z. 2018. The shape of children's families and households: A demographic overview. In Hall, K., Richter, L., Mokomane, Z. & Lake, L. (Eds.). *Children, families and the state: Collaboration and contestation*. Cape Town: University of Cape Town (The Children's Institute).
- Heusser, S. & Elkonin, D. 2014. Childhood sexual abuse and HIV sexual-risk behavior among men who have sex with men in South Africa. *South African Journal of Psychology*, 44(1): 83-96.

- Honig, A.S. 2012. Teen pregnancy. *International Journal of Adolescence and Youth*, 17(4): 181-187.
- Hurtado, A., Katz, C.L., Ciro, D., Gutfreund, D. & Nosike, D. 2014. Children's knowledge of sexual abuse prevention in El Salvador. *Annals of Global Health*, 80(2): 103-107.
- IBM Corp. 2019. *IBM SPSS Statistics for Windows*. Version 25.0. Armonk, NY: IBM Corp.
- Jamieson, L., Mathews, S. & Röhrs, S. 2018. Stopping family violence: integrated approaches to address violence against women and children. In K. Hall, L. Richter, Z. Mokomane, & L. Lake (eds), *Children, families and the state: Collaboration and contestation*. Cape Town: Children's Institute, University of Cape Town.
- Jewkes, R.K., Dunkle, K., Nduna, M., Jama, P.N. & Puren, A. 2010. Associations between childhood adversity and depression, substance abuse and HIV & HSV2 incident infections in rural South African youth. *Child Abuse & Neglect*, 34(11): 833-841.
- Leversee, T. 2015. *Etiology and typologies of juveniles who have committed sexual offenses*. Washington: United States Department of Justice (Office of Sex Offender Sentencing, Monitoring, Apprehending, Registering, and Tracking).
- Lim, L., Rubia, K. & Radua, J. 2014. Gray matter abnormalities in childhood maltreatment: A Voxel-Wise Meta-Analysis. *American Journal of Psychiatry*, 171(8): 1-10.
- Maniglio, R. 2011. The role of child sexual abuse in the etiology of suicide and non-suicidal self-injury. *Acta Psychiatrica Scandinavica*, 124(1): 30-41.
- McDonald, S. & Tijerino, A. 2013. *Male survivors of sexual abuse and assault: Their experiences*. Ottawa: Department of Justice Canada (Research and Statistics Division).
- Noll, J., Shenk, C.E. & Putnam, K.T. 2009. Childhood sexual abuse and adolescent pregnancy: A meta-analytic update. *Journal of Pediatric Psychology*, 34(4): 366-378.
- Republic of South Africa. 2005. *Children's Act 38 of 2005*. Government Printer: Pretoria.
- Rheingold, A.A., Campbell, C., Self-Brown, S., De Arellano, M., Resnick, H. & Kilpatrick, D. 2007. Prevention of child sexual abuse: Evaluation of a community media campaign. *Child Maltreatment*, 2(4): 352-363.
- Richter, L.M., Mathews, S., Kagura, J. & Nonterah, E. 2018. A longitudinal perspective on violence in the lives of South African children from the Birth to Twenty Plus cohort study in Johannesburg-Soweto. *South African Medical Journal*, 108(3): 181-186.
- Sewpaul, V. 2006. The african union plan of action on the family in Africa. *International Social Work*, 49(1): 129-136.
- Statistics South Africa. 2016. *Community Survey 2016 in Brief*. Pretoria: Statistics South Africa.
- Walfield, SM. 2018. Men cannot be raped: Correlates of male rape myth acceptance. *Journal of Interpersonal Violence*, published online 17 December. Available at: <https://journals.sagepub.com/doi/10.1177/0886260518817777>.
- Ward, C.L., Artz, L., Leoschut, L., Kassanje, R. & Burton, P. 2018. Sexual violence against children in South Africa: A nationally representative cross-sectional study of prevalence and correlates. *Lancet Global Health*, 6(4): 460-468.
- World Health Organization. 2017a. *Responding to children and adolescents who have been sexually abused*. Geneva: World Health Organization.
- World Health Organization. 2017b. *Child maltreatment: The health sector responds (Infographic)*. Geneva: World Health Organization.
- World Health Organization. 2016. *Inspire: Seven strategies for ending violence against children*. Geneva: World Health Organization.
- World Health Organization. 1999. *Consultation on child abuse prevention. Violence and injury prevention team & global forum for health research. report of the consultation on child abuse prevention*. Geneva: World Health Organization.