

The copyright of this thesis vests in the author. No quotation from it or information derived from it is to be published without full acknowledgement of the source. The thesis is to be used for private study or non-commercial research purposes only.

Published by the University of Cape Town (UCT) in terms of the non-exclusive license granted to UCT by the author.

**Developing a Psychosocial Understanding of Child Sexual Abuse Disclosure
among a Group of Child and Adolescent Females in
Cape Town, South Africa**

By

Natasha Hendricks

HNDNAT004

Submitted to the University of Cape Town
In partial fulfillment of the requirement for the degree

**Masters in Public Health
Faculty of Health Sciences**

August 2012

Supervisors:

Phyllis Orner (Women's Health Research Unit, UCT)

Dr. Shanaaz Mathews (Gender and Health Research Unit, MRC)

Developing a Psychosocial Understanding of Child Sexual Abuse Disclosure among a Group of Child and Adolescent Females in Cape Town, South Africa

¹Natasha Hendricks, ¹Shanaaz Mathews and ²Phyllis Orner

¹Gender and Health Research Unit, Medical Research Council

²Women's Health Research Unit, University of Cape Town

ABSTRACT

Aim:

To develop an understanding of the factors that promotes and inhibits child sexual abuse (CSA) disclosure and its impact on the child and caregiver.

Methods:

Young girls and adolescents between the ages of 8-17 years who experienced penetrative sexual abuse were recruited from two sexual assault centres in the Western Cape, South Africa. On arrival at the centre, caregivers were approached and informed about the study and informed consent was obtained from those who agreed to participate in the study. Thirty-one children and their caregivers were enrolled into the study. Semi-structured interviews were conducted with children and their caregivers and analyzed using thematic analysis.

Findings:

This study has shown that factors promoting CSA disclosure include circumstances around the incident, caregiver concerns around the child's behavior, which made caregivers suspicious and allowed them to create an enabling environment to facilitate disclosure for the child as well as coercion by caregivers to talk. Factors inhibiting CSA disclosure include fear of caregiver reactions where children were more inclined to disclose to a friend or relative, dysfunctional family environments, threats from perpetrators and caregiver expectations on children to be responsible for their own safety. CSA disclosure impacts the caregiver psychologically, leading to self-blame, changes in parenting, fear of stigmatization from family and community. The negative impact on children includes caregiver-blame leading to self-blame and lack of support post-disclosure.

Conclusion:

The children and their caregivers presented disclosure of CSA as fraught with anxiety which has a negative psychological and emotional impact on the child, family and community. This study provides a good understanding of factors promoting and inhibiting CSA disclosure and how this influences post-sexual abuse adjustment for the child and family.

Keywords: *Child sexual abuse, disclosure, psychosocial, girls and adolescents, Western Cape*

CONTENTS

PART A: PROTOCOL.....	P7
1. INTRODUCTION.....	P7
2. BACKGROUND.....	P8
2.1 Defining Child Sexual Abuse.....	P8
2.2 Defining Disclosure.....	P8
3. PURPOSE OF STUDY.....	P9
4. RESEARCH QUESTION.....	P10
5. AIM.....	P10
6. OBJECTIVES.....	P10
7. METHODS.....	P10
7.1 Study Design.....	P10
7.2 Study Setting.....	P11
7.3 Study Sample.....	P11
7.4 Exclusion Criteria.....	P11
7.5 Recruitment.....	P12
7.6 Data Collection.....	P12
7.7 Interviews with Children.....	P13
7.8 Interviews with Caregivers.....	P14
7.9 Data Analysis.....	P14
8. ETHICAL CONSIDERATIONS.....	P15
8.1 Risks to Children.....	P15
8.2 Risks to Adults.....	P16
8.3 Benefits and Compensation.....	P16
8.4 Confidentiality.....	P17
8.5 Informed Consent.....	P17
8.6 Voluntary Participation.....	P17
9. REFERENCES.....	P18

CONTENTS

PART B: LITERATURE REVIEW.....	P21
1. INTRODUCTION.....	P21
2. THE SOCIAL CONTEXT OF CHILD SEXUAL ABUSE IN SOUTH AFRICA.....	P22
3. DEFINING CHILD SEXUAL ABUSE (CSA).....	P23
4. DEFINING CSA DISCLOSURE.....	P24
4.1 Patterns of CSA Disclosure.....	P25
4.2 Processes of CSA Disclosure.....	P27
5. FACTORS IMPACTING CSA DISCLOSURE.....	P28
5.1 Age of Child.....	P29
5.2 Gender of Child.....	P30
5.3 Relationship to Perpetrator.....	P30
5.4 Perpetrator Selection and Grooming.....	P30
5.5 Caregiver/Familial Reactions.....	P31
5.6 Culture.....	P33
5.7 Crime Reporting Barriers.....	P33
6. CONCLUSION.....	P34
7. REFERENCES.....	P36

CONTENTS

PART C: MANUSCRIPT.....	P46
ABSTRACT.....	P46
INTRODUCTION.....	P47
Defining Child Sexual Abuse (CSA).....	P47
Conceptualizing CSA Disclosure.....	P48
Types of CSA Disclosure.....	P49
METHODS.....	P51
Study Design.....	P51
Study Sample.....	P52
Data Collection.....	P52
Data Analysis.....	P53
Ethical Considerations.....	P53
FINDINGS.....	P54
Participant Socio-demographics.....	P54
Factors Promoting Disclosure.....	P55
<i>Circumstances around the incident.....</i>	<i>P55</i>
<i>Caregiver concerns around child's behaviour.....</i>	<i>P55</i>
<i>Coercion by caregivers.....</i>	<i>P56</i>
Factors Inhibiting Disclosure.....	P57
<i>Fear of caregiver reactions.....</i>	<i>P57</i>
<i>Dysfunctional family environments.....</i>	<i>P58</i>
<i>Perpetrator threats.....</i>	<i>P59</i>
<i>Caregiver expectations.....</i>	<i>P59</i>
Impact of Disclosure on Caregiver.....	P60

<i>Psychological Impacts</i>	P60
<i>Self-blame</i>	P61
<i>Changes in parenting</i>	P62
<i>Fear of stigmatization</i>	P63
Impact of Disclosure on Child	P64
<i>Caregiver-blame leading to self-blame</i>	P64
<i>Lack of support post-disclosure</i>	P65
DISCUSSION	P66
LIMITATIONS	P72
CONCLUSION	P72
REFERENCES	P74
APPENDIX: Guide for Authors - Journal of Child Abuse and Neglect	

University of Cape Town

PART A: PROTOCOL

Developing a Psychosocial Understanding of Child Sexual Abuse Disclosure among a Group of Child and Adolescent Females in Cape Town, South Africa

1. INTRODUCTION

Child¹ Sexual Abuse (CSA) is considered to be an enormous problem in South Africa.

Nearly half of all sexual assaults reported to the South African police are children under 18 years (Crime Statistics, SAPS, 2009). In 2009 a total of 27 417 sexual offences against children were reported to the police in South Africa (Crime Statistics, SAPS, 2009).

Although a huge amount of cases are being reported, child sexual abuse often goes unreported as well as undisclosed making the true magnitude of the problem in this country unknown. Responses of the child to sexual abuse are complex as the perpetrator is often known to the child, and the abuse may thus manifest in a relationship of trust and affection (Mathews, 2007). Other factors such as family dysfunction also play an important role in how the child responds to sexual abuse, as this directly affects the support the child receives post-sexual assault (Mathews, 2007).

There is a clear and urgent need to understand the dynamics of child sexual abuse disclosure, which can be used as a basis for the development of a more evidence-based approach to practice by helping professionals who deal with these issues (Collings, 2006). In an attempt to fill this gap, this study aims to develop an understanding of the process of disclosure of child sexual abuse and its impact on the child and the child's caregiver. The purpose of the present study, therefore, is to explore the process of disclosure and what factors promote or inhibit disclosure of child sexual abuse in South Africa.

¹ Child refers to ages 0 to 17 years based on the United Nations definition of childhood.

2. BACKGROUND

Fears of retribution and abandonment, and feelings of complicity, embarrassment, guilt and shame all conspire to silence children and inhibit their disclosures of abuse (Sauzier, 1989; Summit, 1983). Due to the fact that there is often little or no physical evidence of sexual abuse, interventions and programmes largely depend on children's disclosure. Non-disclosure however, may not only allow abuse to continue and prevent receiving treatment, but it may also exacerbate an already existing level of stress (Chin & Kroesen, 1999). Non-disclosure may also increase vulnerability for negative mental health outcomes, as often an undesirable consequence of non-disclosure includes the lack of accessibility to mental health resources (McNulty & Wardle, 1994; Collings, Griffiths & Kumalo, 2005). By not disclosing, children may be subjected to longer and repeated abuse and may not receive the necessary treatment for psychologically damaging sequelae (Goodman-Brown, Edelstein, Goodman, Jones & Gordon, 2003).

2.1 Defining Child Sexual Abuse

Although there are often limitations and variations to many definitions of CSA around the world, the World Health Organization (2002), defines CSA as encompassing a range of acts including: physically forced or coerced penetration of the vagina or anus with a penis or other body part or object; Coerced sexual activity through a spectrum of degrees of force; Sexual harassment including sexual humiliation, unwanted sexual contact; Prostitution of children; Virginit testing; Female genital mutilation; Participation in pornographic performances or production of materials or exposure to pornography.

2.2 Defining Disclosure

It has been argued that the concept of disclosure is fundamentally inadequate because of its general lack of specificity and the variation in the way the term is used (Jones, 2000). It is

often not clear whether the term refers to the act of simply telling someone or if it is a more official act of reporting the event to an authoritative body. The word disclosure is more commonly used in reference to a child's reporting of abuse, while telling is more often used when adults share their abuse experiences (Alaggia, 2004). However, within the current study disclosure will be defined as the act of a child telling someone about the sexual abuse regardless of whether they are an authoritative figure or not. Many factors influence CSA disclosure and will be discussed in more detail within the literature review.

3. PURPOSE OF STUDY

A broader study was conducted by the Medical Research Council's (MRC) Gender and Health Research Unit in 2008, exploring the psychosocial needs of young and adolescent female children and their caregiver post-sexual abuse. The study was conducted at two established rape centres in the Western Cape, one partially run by both NGOs and the government while the other is fully supported by the government. Even though sexual abuse occurs among boys, most reported cases at the centre are among girls and it was decided to focus on this vulnerable group. The study provided valuable data on the disclosure of all forms of sexual abuse. However, this was not an objective of the broader study and the opportunity to explore disclosure emerged. The qualitative interviews carried out with the child and child's caregiver also showed that disclosure of the sexual abuse by the child is often fraught with anxiety which has a negative psychological and emotional impact on the whole family. These influences affect how the child is managed within the family and community. This provides us with an opportunity to develop an understanding of disclosure and how this influences post-sexual abuse adjustment.

4. RESEARCH QUESTION

How, to whom and under which circumstances do young and adolescent females who have been sexually abused disclose?

5. AIM

This study aims to develop an understanding of the psychosocial factors that impact on disclosure of child sexual abuse by the child and the impact of the disclosure on both the child and the child's main caregiver.

6. OBJECTIVES

1. To explore the psychosocial factors that promote or inhibit disclosure of child sexual abuse by the child
2. To explore whether disclosure impacts on the child's psychosocial adjustment post-sexual abuse
3. To explore whether disclosure impacts on the caregiver's psychosocial adjustment post-sexual abuse
4. To explore responses to disclosure of sexual abuse of the child

7. METHODS

7.1 Study Design

The broader study was designed as a longitudinal follow-up study using both quantitative and qualitative methods. However, only the qualitative data from the first interviews with the child and caregiver were analyzed for this paper. The choice of qualitative methodology is crucial in allowing the research to focus on participant experiences and the meaning(s) they ascribe to them while also allowing for a variety of data collection methods. Similar to the methodology used by Cluver and colleagues (2007), semi-structured qualitative interviews

were used with adult caregivers and children to assess psychological symptomatology (Kovacs 1992; Reynolds & Richmond, 1978). CSA survivors and their caregivers were followed-up from point of contact for a six-month follow-up period. Repeated interviews to a maximum of three interviews per child/caregiver were conducted over this period. This methodology allowed the researcher to assess the psychosocial factors which manifested in the post-sexual abuse period.

7.2 Study Setting

Study participants were recruited from Simelela which is run by both NGOs and the government while Karl Bremer's Unit M5 is supported by the government, which are both dedicated sexual assault services within the public health system in the Western Cape.

7.3 Study Sample

A purposive sample of girl children who experienced penetrative sexual abuse and presented to Karl Bremmer and Simelela sexual assault centres in the Western Cape, with their caregivers were recruited into the study. Thirty-one respondents (including children and their caregivers) were selected and interviewed. Children ranged between the ages of 8-17 years.

7.4 Exclusion Criteria

Children and parents who were exceptionally traumatised were excluded as the follow-up interviews may have led to further trauma. In cases where the caregiver was the perpetrator, these were excluded from the study. Traumatization was assessed through a consultation with the parent/carer prior to enrolment into the study. A set of questions were developed based on the literature review and in consultation with other experts in the field of CSA. The questions were open-ended in order to assess how the child adjusted within weeks after presentation at the sexual assault centre. Where children were mentally challenged, such cases were also

excluded as these children were not able to meaningfully participate in the study. Cases were also excluded where parents laid a charge of statutory rape and there was evidence that the child was in a consensual intimate relationship with the perpetrator, usually a male. Where a case of statutory rape was not opened such cases were reported and referred to the social worker for further investigation and legal intervention. Cases were also excluded where the child was removed from the parent or guardian's care and placed at a place of safety due to an incestuous relationship or the perpetrator living in the home.

7.5 Recruitment

Potential study participants were identified and recruited by trained fieldworkers as they presented to the sexual assault centre. At recruitment, the parent or care giver was approached and provided with information about the study and permission was obtained to be contacted by the researchers. Enrolment into the study followed when informed consent with the carer and assent from the children was obtained. This happened a week after presenting to the sexual assault centre, before the first interview. Interviews with care-giver and child were set-up as they were enrolled into the study.

7.6 Data Collection

Separate, repeated interviews were conducted with respondents (children and care giver). A maximum of three child interviews and three care-giver interviews per child/carer were conducted. Initially one care-giver interview and one child interview was held, and then follow-up interviews were conducted at two monthly intervals over a six-month period. The repeated interviews allowed for an assessment of social and psychological adjustment over a period of time. The repeated interviews enabled the researchers to document emotions and behaviours displayed at particular points and to assess the trajectories for healing.

7.7 Interviews with Children

Interviews with children were worksheet-based structured interviews, a format that children had some familiarity with from school. These worksheets were adapted from standardised scales used in other studies in the Western Cape (Cluver et al., 2007). These instruments have been extensively used in other studies and validated for use in South Africa. These tools were used in combination with exercises where the child was asked to depict their experiences by drawing and scenarios in the worksheet were used as a discussion point. The instructions were read out to the child by the field worker who assisted the child with the completion of the worksheet when they needed help. Although the tools measured coping, the whole interview was tape recorded to capture discussion about items presenting in the different sections. The child's explanation of the drawings and probing of their experiences was an important aspect of data collection, therefore all interviews were transcribed. The questionnaires were translated into both isiXhosa and Afrikaans, as interviews were held in the participant's language of choice. Each interview ended off with the field worker doing a fun age appropriate activity, such as playing a game with the younger child and listening to music for the older children. The sections of the questionnaire can be seen below:

Section One	Collection of Demographic data	This section will only be used in the first interview
Section Two	“What I have experienced” Through drawing allowing the child to debrief about their experience.	This section will be used in the first interview to allow for some discussion the sexual assault
Section Three	“What I think and feel” The child depression Inventory (Kovacs 1992)	This section will be used in all the interviews to assess adjustment over time
Section Four	“Slam the Box” This is the revised children's manifest anxiety scale (Reynolds & Richmond 1978)	This section will be used in all the interviews to assess adjustment over time

Section Five	“My road of Life” Will document care over time and attempt to elicit whether abuse has happened in the past	This section will only be used in the second interview
Section Six	“People looking after people” Will explore support systems and who support systems exists	This section will only be used only in the second interview
Section Seven	“How do you feel about” This is the child PTSD checklist (Amaya-Jackson 1995)	This section will be used in all the interviews to assess adjustment over time
Section Eight	“Stuff I do in an ordinary week” This section will assess current level of involvement in activities.	This section will be used in all the interviews to assess adjustment over time

7.8 Interviews with Caregivers

In-depth interviews with carers were conducted through the use of semi-structured interviews using the following scope of inquiry. The first adult interview focused on the circumstances of the assault, care seeking, responses from the police and how the adult felt. The second one asked about the child, and was much shorter. Each follow up interview asked about progress with the cases; changes in adult and child feelings and social circumstances as a result of rape; and use of and perceptions of responses from services. All interviews were audio taped. The interviews were conducted in the preferred language, i.e., isiXhosa, English or Afrikaans. The researchers were fluent in all three main languages of the region. All interviews were transcribed and translated into English where required.

7.9 Data Analysis

The present study will entail a secondary analysis of the qualitative data from the broader study. Thematic analysis of interviews will be used. Transcripts of the first interviews will be analysed inductively, a standard analytic technique characterised by a process of iteratively coding and sub-coding and interpretation of the findings through the development of mini-

hypotheses and testing (and modification) of these hypotheses with reference to the data (Silverman 2001). Initial codes will broadly correspond to questions as grouped in the scope of enquiry. Once broad coding has been established, thematic categories will be refined, with sub-categories being formed and relationships between these elucidated. This method of analysis has been used in a cross cultural ethnographic study on CSA in South Africa and Namibia which has provided us with an important understanding of the social context of CSA (Jewkes et al., 2005).

8. ETHICAL CONSIDERATIONS

The WHO Guidelines for Ethical Research on Violence Against Women, the MRC ethics on research with children as well as experiences of other researchers who have done work with children guided this study. The broader study was ethically approved by the MRC Ethics Committee in February 2008, Protocol ID No: EC07-006. The current study was ethically approved by the University of Cape Town's Ethics Committee in October 2009.

8.1 Risks to Children

Children under the age of 18 years were only recruited into the study if they were accompanied by a guardian/care giver. Interviews with children have to be approached with great sensitivity to avoid re-traumatising the child. Field workers were trained in working with children. When the child showed any signs of undue trauma they were referred for immediate crisis intervention at a centre specialising in managing sexually abused children and their families. Field workers were trained to stop the interview and to step out of their role when the child showed signs of emotional distress and needed to be contained. The field workers had a list of child care services to which the child and carer were referred to. In the case of an acute psychological response, arrangements were made for the child and carer to be seen immediately.

The research team accepted responsibility to make the necessary referrals and assist in setting up of appointments. In addition, researchers involved with vulnerable children should provide assistance if a child is considered to be in need of care. When the research indicated that the child's safety was compromised, the research team were ethically bound to refer the child to a social worker for the home circumstances to be investigated. The information sheet indicated that confidentiality was maintained unless it was clear that the child was at significant risk of harm. All study participants were referred for counselling to a service for children and families, once their interviews were completed, if they were not referred to one by the sexual assault centre. Written consent was taken from the guardian as for adult respondents and informed assent was taken from all children. A process of written assent was taken from all children recruited into the study.

8.2 Risks to Adults

To have a child who has been sexually assaulted is a traumatic experience for a parent or guardian, and they were approached with empathy to prevent secondary trauma. The process of recruiting the child into the study should not further traumatise the parent/guardian and fieldworkers were trained to approach them with sensitivity. Guardians were informed that their participation in the study was voluntary. They were also told that they may exit the study at any time and this would not influence the medical management of the child.

8.3 Benefits and Compensation

All children and their guardians participating in the study benefited as they were provided with a list of support services for children who have been sexually abused and were provided with support and a referral to a social worker when it was deemed necessary by the researchers. Most patients attending the public health services were from lower socio-

economic areas in the Western Cape area. Compensation of R50 for their time and an additional transport allowance of R50 (when transport was used) were given to parents at the end of each interview.

8.4 Confidentiality

This was ensured during the consent taking process and was stressed in the information sheet handed to the respondent. Both the recruitment and interviews with the child and guardian were conducted in private, and strict confidentiality was applied. All efforts were made to ensure that data confidentiality was maintained. Data were stored securely and all data was coded to ensure anonymity. Contact details of families were retained securely during the study and were destroyed after the end of the fieldwork.

8.5 Informed Consent

The study was firstly explained to all potential participants and their guardians in their language of choice and they were given an information sheet. The information sheet was read by the fieldworker to the guardian and they were required to provide written informed consent and competent children were required to provide oral assent. The fieldworkers approached the guardian in a sensitive manner during the consent taking phase to ensure no further trauma. All children were included in the information giving process and separate information sheet and assent process that was age appropriate was followed.

8.6 Voluntary Participation

The potential respondents were informed that their participation in the study was completely voluntary and that they were free to withdraw from the study at any time.

9. REFERENCES

- Alaggia, R. (2010). An ecological analysis of child sexual abuse disclosure: Considerations for child and adolescent mental health. *Journal of the Canadian Academy of Child and Adolescent Psychiatry, 19*, 32-39.
- Alaggia, R. (2004). Many ways of telling: Expanding conceptualizations of child sexual abuse disclosure. *Child Abuse and Neglect, 28*, 1213-1227.
- Alaggia, R. (2001). Cultural and religious influences in maternal response to intrafamilial child sexual abuse: Charting new territory for research and treatment. *Journal of Child Sexual Abuse, 10*, 41-60.
- Chin, D., & Kroesen, K. W. (1999). Disclosure of HIV infection among Asian/Pacific Islander American women: Cultural stigma and support. *Cultural Diversity and Ethnic Minority Psychology, 5*, 222-235.
- Cluver L, Gardner, F., & Operario, D. (2007). Psychological distress amongst Aids-orphaned children in urban South Africa. *Journal of Child Psychology and Psychiatry. 48*, 755-763.
- Cluver, L & Gardner F. (2006). The psychological well-being of children orphaned by AIDS in Cape Town, South Africa. *Annals of General Psychiatry, 5*.
- Collings, S. J. (2006). How do sexually abused children disclose? Towards an evidence-based approach to practice. *Acta Criminologica, 19*, 33-41.

Collings, S. J., Griffiths, S., & Kumalo, M. (2005). Patterns of disclosure in child sexual abuse. *South African Journal of Psychology*, 35, 270-285.

Faller, K. C. (2004). *Disclosure of sexual abuse: Research findings and practice implication*. Paper presented at the 15th Congress of the International Society for the Prevention of Child Abuse and Neglect, Brisbane, Australia.

Goodman-Brown, T. B., Edelstein, R. S., Goodman, G. S., Jones, D. P. H., & Gordon, D. S. (2003). Why children tell: a model of children's disclosure of sexual abuse. *Child Abuse and Neglect*, 27, 525-540.

Jewkes R, Penn-Kekana L, & Rose-Junius H. (2005). "If they rape me, I can't blame them": Reflections on gender in the social context of child rape in South Africa and Namibia. *Social Science and Medicine*, 61, 1809-1820.

Jones, D. P. H. (2000). Editorial: Disclosure of Child Sexual Abuse. *Child Abuse and Neglect*, 24, 269-271.

Kovacs, M. (1992). *Children's Depression Inventory*. Niagra Falls, NY: Multi-health Systems.

Matthews, S. (2007). *Child Sexual Assault: Exploring the needs of the girl child and their caregiver in the period after rape*. Gender and Health Research Unit: Research Protocol. Medical Research Council

McNulty, C., & Wardle, J. (1994). Adult disclosure of sexual abuse: A primary cause of psychological distress? *Child Abuse and Neglect*, 18, 549-555.

Reynolds, C., & Richmond, B. (1978). What I think and feel: A revised measure of children's anxiety. *Journal of Abnormal Child Psychology*, 6, 271-280.

Sauzier, M. (1989). Disclosure of child sexual abuse: For better or for worse. *Psychiatric Clinics of North America*, 12, 455-469.

Silverman, D. (2001). *Interpreting Qualitative Data; Methods in Analysing talk, text and interaction*. Sage Publications. London.

South African Police Services. (2009). *Police Crime Statistics*. Pretoria.

Summit, R. (1983). The child sexual abuse accommodation syndrome. *Child Abuse and Neglect*, 7, 177-193.

World Health Organization, (2002). *World report on violence and health*. Geneva, World Health Organization.

PART B: LITERATURE REVIEW

Developing a Psychosocial Understanding of Child Sexual Abuse Disclosure among a Group of Child and Adolescent Females in Cape Town, South Africa

1. INTRODUCTION

Child² Sexual Abuse (CSA) is considered to be an enormous problem in South Africa and globally it affects the health, social and psychological well-being of many children (Pinheiro, 2006). In 2009, a total of 27 417 sexual offences against children were reported to the police in South Africa (Crime Statistics, SAPS, 2009). Police statistics indicate that even though CSA occurs among boys it is a greater problem among girls (Mathews, 2007). Establishing the true magnitude of CSA in South Africa is extremely difficult due to under-reporting, suggesting that prevalence estimates are grossly underestimated (Jewkes and Abrahams, 2002; Jewkes, Penn-Kekana and Rose-Junius, 2005). Waterhouse (2008) suggests that under-reporting is likely to be much higher in cases involving children due to factors such as: the nature of the relationship with the perpetrator, feeling responsible for the abuse, fear of perpetrator retaliation, feeling protective of family, feelings of shame, complicity of family members concealing the abuse and patriarchal norms making it hard to expose male perpetrators.

Children in South Africa are most at risk of being sexually abused by a person known to them (Mokoae, Warria, Bower, Ward, Loffel and Dawes, 2009; Townsend and Dawes, 2004).

Evidence shows that between April 2007 to March 2008 approximately 16 068 children were raped in South Africa with 29.8% of the perpetrators being known community members, 22.1% school mates, 16% relatives or household members, 9.8% friends or acquaintances,

² Children refer to aged 0-17 years based on the United Nations definitions of childhood.

7% bosses or teachers, 5.5% boyfriends or girlfriends, 4.2% unknown community members, 2.6% other unknown persons, 1.7% gang members, 0.8% other, 0.3% police and 0.2% other authority figures (RAPCAN, 2009). Responses to CSA are complex as the perpetrator is often known to the child, and the abuse thus manifests in a relationship of power, and at times trust and affection (Mathews, 2007). Other factors such as family dysfunction also play an important role in how the child responds to sexual abuse, as this directly affects the support the child receives post-sexual assault (Mathews, 2007).

2. THE SOCIAL CONTEXT OF CHILD SEXUAL ABUSE IN SOUTH AFRICA

Contributing social dynamics driving these high levels of interpersonal violence include factors such as, poverty, patriarchal ideologies of masculinity, poor parenting and dysfunctional childhoods, substance abuse and weakness in the law enforcement system resulting in the persistent nature of CSA (Seedat, Van Niekerk, Jewkes, Suffla and Ratele, 2009). The development of a sociological understanding of CSA requires reflection on aspects of childhood, ideas about sexual desires and activity of children as well as intergenerational perspectives on sexual desires, child rearing and social hierarchies (Jewkes et al., 2005).

A review of the literature on CSA for Sub-Saharan Africa by Lalor (2004), suggests that rapid social change impacts CSA, where socio-economic and cultural change is attributed to a breakdown in traditional values known to be a protective factor against child abuse (Korbin, 1991). The disintegration of families during the migrant labour system in South Africa led to increased isolation of individuals from a sense of community and dissipation of adult supervision and support for children. Furthermore, male domination involves the dominant patriarchal constructions of masculinities in South Africa that legitimate male control over

women and children and promotes male sexual entitlement (Townsend and Dawes, 2004; Seedat et al., 2009).

The high status of men in relation to girls and women leads to vulnerability by reducing their ability to refuse sexual advances and creating expectations in men that they should control women and children by using rape as a punishment (Jewkes et al., 2005). This notion is often exacerbated with children being socialized to respect and obey their elders with harsh methods of discipline used to enforce parental control (Townsend and Dawes, 2004). Findings from ethnographic research in South Africa and Namibia shows that ‘teenage girls’ bodies were constructed as highly sensual and a ‘natural’ object of male desire, indicating a perception that sexual desire was inevitable and experienced by men, but ‘provoked’ by women and girls (Jewkes et al., 2005). Thus, the responsibility of controlling men’s ‘uncontrollable’ sexual desires and preventing acts of sexual violence would be placed on women and girls. These unequal power relations between men, women and girls reflect a deep-rooted system of patriarchy and girls’ vulnerability to CSA is embedded in this ideology.

3. DEFINING CHILD SEXUAL ABUSE (CSA)

Worldwide, definitions of CSA are often limited and varied. The Community Agency for Social Enquiry (CASE) (2005), suggests that definitions of CSA in South Africa may vary and often covers a wide range of acts. The Criminal Law (Sexual Offences and Related Matters) Amendment Act, 2007, is the law under which sexual offences are prosecuted in South Africa and defines rape as, *“Any person (“A”) who unlawfully and intentionally commits an act of sexual penetration with a complainant (“B”), without the consent of B, is guilty of the offence of rape”*. The World Health Organization (2002) outlines a range of acts that encompasses CSA:

- *Rape and attempted rape i.e. physically forced or coerced penetration of the vagina or anus with a penis or other body part or object*
- *Coerced sexual activity through a spectrum of degrees of force*
- *Sexual harassment including sexual humiliation, unwanted sexual contact*
- *Prostitution of children*
- *Virginity testing*
- *Female genital mutilation*
- *Participation in pornographic performances or production of materials or exposure to pornography*

Some of the acts above occur in certain countries and not in others, and may not be considered by many (or most) in these contexts as CSA, such as female genital cutting and forced marriage, which is not common in South Africa. Almost all definitions involve the abuse of power and stipulate that CSA is a sexual violation perpetrated by a person who holds (or is perceived to hold) power over a child (CASE, 2005). Children of different ages may vary in their understanding of sexual activity with older children being more capable of making informed choices. For example, young children below the age of 16 years often cannot refuse to consent to sexual activity because they lack the maturity to understand the consequences of such acts for themselves.

4. DEFINING CSA DISCLOSURE

It has been argued that the concept of disclosure is fundamentally inadequate because of its general lack of specificity and the variation in the way the term is used (Jones, 2000). It is often not clear whether the term refers to the act of simply telling someone or if it is a more official act of reporting the event to an authoritative body. Jones (2000), states that any discussion regarding the nature and extent of CSA disclosure needs to be preceded by a clear understanding of the term. While *Formal disclosure* involves someone making a formal statement to the authorities; *Informal disclosure* occurs when the disclosure content is usually

brief, vague and lacking in detail regarding the incident and where confidants are predominantly family members or friends (Kogan, 2004). The word disclosure is more commonly used in reference to a child's reporting of abuse, while telling is more often used when adults share their abuse experiences (Alaggia, 2004).

4.1 Patterns of CSA Disclosure

A broad range of categories of disclosure can be found within the international literature (Campis, Hebden-Curtis, Demaso, 1993; Sorenson and Snow, 1991; Keary and Fitzpatrick, 1994; Nagel, Putnam, Noll and Trickett, 1997; Alaggia, 2004). For example, according to a study conducted by Alaggia (2004), which involved in-depth interviews with 24 female and male survivors of child sexual abuse, the following types of disclosure were reported:

Purposeful disclosure (survivors intentionally told someone themselves); *Accidental disclosure* (third-party detection through witnessing, physical symptoms leading to suspicion of abuse); *Prompted/Elicited disclosure* (supportive environments where survivors were either encouraged to disclose or disclosed through a precipitating event); *Behavioral/Verbal disclosure* (where the survivor attempts to tell through behavior, non-verbal communication, or indirect hints); *Purposefully withheld* (despite opportunities to disclose, through intervention, survivor chose not to tell) and *Triggered disclosure* (disclosure through recall of repressed memories of abuse).

Although these patterns may describe the multi-dimensional and complex nature of CSA disclosure, few consistent findings have emerged from clinical and research studies (Collings, Griffiths & Kumalo, 2005). Some studies have found that purposeful disclosure is often the predominant mode amongst CSA (Higson-Smith, Lamprecht & Jacklin, 2004; Sauzier, 1989) while others have found that this only occurs in a minority of CSA cases (Berliner & Conte, 1995; Sgori, 1982). The only consistent theme to emerge from the data, is the finding that

children who are abused by a family member are less likely to disclose compared to those abused by strangers (Collings et al., 2005). Similar evidence was found in a study conducted in South Africa by Collings and colleagues (2005), among a forensic sample of 1 737 (1 614 girls and 123 boys) CSA survivors, where only 30% of respondents made *Purposeful disclosures* (spontaneous and unambiguous verbal disclosure of abuse by the child). A further 9% of the cases were facilitated by a second party in the form of *Indirect disclosure* (involving vague comments in the form of a spontaneous but ambiguous verbal comment by the child, which may not be an explicit form of telling but alerted a significant other that something may be wrong); with 18% involving *Eyewitness detection* (occurring when CSA was directly witnessed by a second party who then reports the abuse to a caregiver or to the authorities); and 43% facilitated by *Accidental detection*, (involving observations by a second party through injuries, bruises, behavioral changes, involving changes in emotional and behavioral states, development of avoidance strategies and phobias, usually leading to the child being questioned or referred for a professional opinion.)

In a clinical study of 1 614 South African child rape victims, it was found that 13% of children disclosed to a reporting adult on the day of the abuse, while 22% disclosed after a delay of more than a month (Collings, Wiles & Wiles, 2004). *Delayed disclosure* may occur due to repression and delayed memories (Alaggia, 2004; Flathman, 1999). Delayed memory is determined by a range of mechanisms involved in the loss of traumatic memory through repression, psychological blocking and forgetting (Flathman, 1999). Childhood memories that are difficult to access are often associated with traumatic events where secrecy is an operative dynamic and where the child is powerless compared to the perpetrating adult (Melchert & Lance Parker, 1997). In a study of 218 CSA victims referred to a District Attorney's Office in the United States, it was found that 42% of children disclosed to a

reporting adult within 48 hours of the abuse, while 34% disclosed more than a month later (Goodman-Brown et al, 2003).

Despite the range of international clinical and research literature on CSA disclosure, there appears to be a need for increased knowledge around the circumstances of children's disclosures within the South African context (Collings et al., 2005). The above mentioned forms of disclosures are predominantly accounts provided by children in the United States of America and other western countries who do not experience the same circumstances around CSA disclosures experienced by South African children (Collings et al., 2005). Jewkes and Abrahams (2002) state that cases of CSA which are reported to the police are only the tip of the iceberg due to under-reporting. Moreover, children cannot access the criminal justice system and other appropriate services without the support of adults (Waterhouse, 2008). Perpetrators of CSA are often adults with close ties to the child and his/her family, and adults that the child decides to disclose to may disbelieve the child and minimize the seriousness of the abuse and support the offending adult due to possible emotional and financial dependency on the abuser (Waterhouse, 2008). This poor response by adults leaves the child helpless to access services unless another adult is disclosed to and intervenes, and the abuse may continue until the child is able to seek his/her own help when older (Summit, 1983). These studies suggest that immediate disclosure is not common among CSA survivors and this can be linked to a variety of factors discussed later.

4.2 Processes of CSA Disclosure

Many children, including boys and girls find it difficult to talk about their sexual abuse experiences (De Voe & Faller, 2002; Paine & Hansen, 2002). Understanding the dialogical process of disclosure within families is important and a qualitative study conducted in Norway among 20 families and 22 children (15 girls and 7 boys), who have experienced CSA

found that three phenomena emerged namely; *Opportunity, Purpose and Connection*.

Findings showed that disclosure was promoted when the child perceived an opportunity to talk, a purpose for speaking and a connection to what they were talking about (Jensen, Gulbrandsen, Mossige, Reichelt & Tjersland, 2005). Opportunities arose when a trusted person or caregiver would initiate a dialogue with the child about what was troubling them or where a situation prompted dialogue between the two parties. How the child perceived the consequences of the disclosure and support by significant others played an important role in facilitating their disclosure (Jensen et al., 2005).

These findings are supported by that found by Staller and Nelson-Gardell (2005), who conducted a secondary data analysis from focus groups in which 34 pre-adolescent female survivors of CSA were asked about their experiences. Three phases of disclosure was found namely; *the Self Phase; the Confidant Selection-Reaction Phase and the Consequence Phase*. The study found that the participants experienced a process of disclosure whereby they had to firstly make a decision to disclose by themselves and understand their feelings about the abuse and the perpetrator. Secondly, they had to find a time, place and a person to tell and reflect on that person's possible reaction to the disclosure. Many girls experienced both supportive and hostile reactions after disclosure. Thirdly, they experienced a wide range of consequences both good and bad including gossiping and stigma, changing relationships, institutional responses, as well as insider/outsider communities where the child relates to those girls who have been abused and those who have not (Staller & Nelson-Gardell, 2005). These processes often influence further strategies of disclosing by children.

5. FACTORS IMPACTING CSA DISCLOSURE

It is critical to gain a better understanding of factors that impact on CSA disclosure in order to create environments that are more supportive and encourage disclosure instead of

discouraging it (Tang et al., 2007). Variables such as age of child, gender, severity of abuse, relationship to perpetrator, perceived lack of social support, grooming by the perpetrator, fear of perpetrator, cultural considerations, fear of not being believed and feelings of shame and embarrassment may impact CSA disclosure for the child (Alaggia, 2004; Freyd, 1994; Jonzon & Lindblad, 2004; Kogan, 2004). On the other hand, social and maternal support has shown to encourage CSA disclosure and facilitate recovery for the child (Gries, Goh, Andrews, Gilbert, Praver & Stelzer, 2000; Jonzon & Lindblad, 2004; Lovett, 2004; Kogan, 2004). Fears of retribution and abandonment, and feelings of complicity, guilt and shame all conspire to silence children and inhibit their disclosures of sexual abuse (Sauzier, 1989; Summit, 1983).

5.1 Age of Child

A common factor in the literature impacting CSA disclosure is age of the child. Studies have shown that pre-school age children appear more likely to disclose accidentally and due to a precipitating event (Campis et al., 1993; Mian, Wehrspann, Klajner-Diamond, Labaron & Winder, 1986; Sorenson & Snow, 1991) while older children disclose purposefully (Campis et al., 1993; Sorenson & Snow, 1991). Young children may not have the ability to surmount the barriers to disclosure due to developmental stage and susceptibility to perpetrators manipulations for maintaining secrecy (Kogan, 2004). Adolescents are certainly more self-sufficient than young children and willingness to seek help from trusted adults or professionals are expected (Crisma Bascelli, Paci and Romito, 2004). However, maltreated adolescents seldom seek help when the abuse has been continuing for a long time and disclosure becomes even harder (Bacon and Richardson, 2000). Research findings by Collings and colleagues (2005) are consistent with previous studies which indicate that older children are more likely to disclose purposefully (Campis et al., 1993; Sorenson & Snow,

1991) while younger children tend to disclose in a more incomplete and vague manner (Faller, 1988; Mordock, 1996).

5.2 Gender of Child

Literature shows that boys are significantly less likely than girls to report their abuse (Gries et al., 1996; Keary & Fitzpatrick, 1994; Lamb & Edgar-Smith, 1994). However, research by Collings and colleagues (2005) suggest that while the above notion may be true, when boys do report or disclose their abuse, they employ similar disclosure patterns to girls.

5.3 Relationship to Perpetrator

Wyatt and Newcomb (1990) found that the more closely victims are related to the perpetrator the less likely they are to disclose childhood sexual abuse. Moreover, when the perpetrator is a significant caregiver, then attachment issues, traumatic bonding and the child's need to protect the integrity of the family unit are cited as possible explanations for withholding or delaying disclosure (Alexander, 1992; Hindman, 1989; Paine & Hansen, 2002; Summit, 1983). The perpetrator will often establish a trusting relationship with the family as well as the child, affording greater access to control and power (Elliot, Brown & Kilcoyne, 1995). These factors contribute to the growing body of clinical and research literature which indicate that children are particularly hesitant to disclose abuse by a close family member (Arata, 1998; Berliner & Conte, 1990; Sauzier, 1989; Sorenson & Snow, 1991).

5.4 Perpetrator Selection and Grooming

Many perpetrators of CSA report that they specifically target emotionally vulnerable children with whom they are able to develop a trusting relationship (Paine & Hansen, 2002).

Survivors and perpetrators have identified a gradual process whereby the perpetrator employs inappropriate touches and behaviors so subtle that the abuse is often well under way

before the child realizes what is happening (Berliner & Conte, 1990; Conte, Wolfe & Smith, 1989; Paine & Hansen, 2002). Strategies to gain compliance may include the addition or withdrawal of attention and privileges and giving the perception that the child will be negatively judged, blamed and punished if they disclose (Kaufman, Hilliker & Daleiden, 1996). Threats by perpetrators may also include physical harm to the survivor and/or their loved ones which may decrease the likelihood of self-disclosure (Lyon, 1996; Kaufman et al., 1996; Kelley, Brant & Waterman, 1993).

5.5 Caregiver/Familial Reactions

Literature from developed countries has shown that the role of mothers in the protection of children and in helping them heal after trauma such as sexual abuse, can hardly be overstated (Plummer, 2006). Parents experience that their children often do talk to them about both trivial and significant experiences and failure of children to disclose such personal experiences may constitute a breach in normal expectations (Jensen et al., 2005). Therefore, in cases of CSA, parents either assume that there is nothing to tell, or if the child shows signs of distress, they may become concerned about what is troubling the child (Jensen et al, 2005). A clinical study with 125 non-abusive mothers of sexually abused children showed that before mothers gained concrete evidence of the abuse, almost half had a suspicion that something “wasn’t quite right” and would try to talk to the child, get more information and confront the suspected perpetrator (Plummer, 2006).

In order to reap the full benefits of disclosure and minimize adverse effects, the child must be the recipient of a positive reaction to disclosure (Gries et al., 2000). Parental reactions or anticipated reactions are likely to influence the willingness to disclose the sexual abuse (Distel, 1999). Retrospective analyses of childhood abuse reported in adulthood show that fear of family rejection and disbelief are major factors inhibiting disclosure (Palmer, Brown,

Rae-Grant and Loughlin 1999; Somer and Szwarcberg, 2001). Once CSA is suspected, there is likelihood that enormous pressure is placed on the child to disclose by caregivers, teachers, helping professionals and the law and justice system (Gries et al., 2000). Studies about the role of abuse-specific parental support in relation to disclosure have shown that the child's willingness to disclose in a professional context increased when the mother was supportive and believed in the child's disclosure (Elliot and Briere, 1994; Lawson and Chaffin, 1992). Furthermore, parents' inability to be supportive may reflect their own distress (Heflin, Deblinger and Fisher, 2000). This is usually the case when parents themselves have been sexually abused in their lifetime (Alaggia and Turton, 2005).

Within the South African context, the family unit often consists of single mothers or extended family members who share the responsibility of taking care of children. When CSA occurs within this context, the child often depends on the main caregiver, who could range from an aunt, older sister, uncle, brother, grandmother or grandfather when the parents are not present. Studies have shown that lack of social support is often related to emotional distress among mothers following their child's disclosure and those who have a strong social network are better equipped to deal with the stress from the disclosure (Hiebert-Murphy, 1998; Manion, McIntyre, Firestone, Ligezinska, Ensom & Wells, 1996). Since mothers are usually the main caregivers of children within society, it is not uncommon for them to be blamed for the occurrence of CSA by the fathers, other family members and the community (Carter, 1993).

Blame may also be cast on the child survivor. Collings and Wiles (2005), reported on a study of 856 CSA victims seen at an urban crisis centre in KwaZulu-Natal, South Africa, where 222 victims (26%) experienced non-supportive reactions at the time of disclosure involving non-supportive reactions from friends, family and community members, where ignoring the

child occurred in 16% of the cases and punishing or pressurizing the child to deny the abuse occurred in 10% of the cases. Even though the maternal mother was seen as the main agent of these non-supportive reactions (43%), the majority were attributed to other family members (22%), helping professionals (teacher 8%; doctor 6%; policeman 6%) or community members (adult 10%; child 5%). Non-supportive reactions to informal disclosure of CSA have been associated with a decreased likelihood of cases being reported to the police or other agencies (Elliott & Briere 1994; Lawson & Chaffin, 1992).

5.6 Culture

Differences in cultural beliefs also influence a child's willingness to disclose sexual abuse. Studies have shown that various cultural factors are associated with vulnerability to violence and obstacles to the utilization of social and health services. The factors relevant to CSA disclosure includes language barriers, social isolation, discrimination, lack of knowledge and familiarity with community support systems, absence of culture specific services, racism and cultural insensitivity in mainstream programs (Kazarian & Kazarian, 1998). Moreover, cultural factors influencing an individual's willingness to disclose CSA are directly relevant to the response of their family to the disclosure and the family's willingness to seek legal, social and therapeutic support (Paine & Hansen, 2002).

5.7 Crime Reporting Barriers

In his discussion around non-supportive disclosure in CSA, Collings (2005) reflects on the two-stage model of crime reporting barriers to disclosure by child crime victims formulated by Finklehor, Wolak and Berliner (2001). The *Problem Recognition Stage* involves recognition on the part of survivors, their families and significant others that CSA has occurred, however, Collings (2005) states that there are many barriers to such recognitions since many children do not disclose due to the fact that they are not aware that they have been

abused. Many sexual offenders deliberately disguise their actions by representing the abuse to the child as a special game or secret, as part of a child's education or as normal parental behavior (Faller, 2004). These strategies may become so normal that the child may not realize the need to disclose the event. There is often also a failure on the part of family members and other confidants to conceptualize the incident as CSA, especially in cases where no obvious physical coercion was employed and is viewed as either consensual or promiscuity on the part of the child (Collings, 2005).

The Consideration Stage occurs when the children and their families consider the costs and benefits of reporting the abuse, which may involve issues relating to justice, and social and psychological support from child protection services and safety (Collings, 2005). Many children and their families often fear further victimization within their communities following disclosure. They may often experience secondary victimization by the offender, significant others and/or the justice system. Moreover, generic costs which may be considered include, fears regarding the loss of emotional and/or financial support (in cases where the offender is the confidant's partner) as well as time, expense, stigmatization and secondary victimization which may be relevant to involvement with welfare and other service agencies (Collings, 2005).

6. CONCLUSION

Disclosure of CSA is determined by various factors related to child characteristics, family dynamics, community context as well as larger cultural and societal attitudes (Alaggia, 2010). Disclosure may be inhibited in contexts that hold negative attitudes and taboos about sexuality (Alaggia, 2001). It is evident that CSA is highly influenced by reactions from both caregivers, family and community members and this is important in understanding this phenomenon with regards to development of prevention interventions. A child's decision to

disclose or not is impacted by many factors which makes it a complex process and consideration needs to be given to each child's context and what they bring to their unique situation. Although a wide range of literature exists on CSA disclosure, particularly internationally, caution needs to be taken since most of these findings are established from children in Western countries within clinical settings. The limited work within South Africa is useful in the understanding of CSA disclosure within this context but further research needs to be done within various settings, with boys and girls of various ages, to truly understand this phenomenon.

University of Cape Town

7. REFERENCES

- Alaggia, R., & Turton, J. (2005). Against the odds: The impact of woman abuse on maternal response to disclosure of child sexual abuse. *Journal of Child Sexual Abuse, 14*, 95-113.
- Alaggia, R. (2004). Many ways of telling: Expanding conceptualizations of child sexual abuse disclosure. *Child Abuse & Neglect, 28*, 1213-1227.
- Alaggia, R. (2001). Cultural and religious influences in maternal response to intrafamilial child sexual abuse: Charting new territory for research and treatment. *Journal of Child Sexual Abuse, 10*, 41-60.
- Alexander, P. C. (1992). Application of attachment theory to the study of sexual abuse. *Journal of Consulting and Clinical Psychology, 80*, 185-195.
- Arata, C. M. (1998). To tell or not to tell: Current functioning of child sexual abuse survivors who disclose their victimization. *Child Maltreatment, 3*, 63-71.
- Bacon, H., & Richardson, S. (2000). Child sexual abuse and the continuum of victim disclosure. In C. Itzin (Ed.), *Home truths about child sexual abuse* (pp. 235-276). London: Routledge.
- Berliner, L., & Conte, J. (1995). The effects of disclosure and intervention on sexually abused children. *Child Abuse & Neglect, 19*, 371-384.

Berliner, L. & Conte, J. (1990). The process of victimization: The victim's perspective.

Child Abuse & Neglect, 14, 29-40.

Campis, L. B., Hebden-Curtis, J., & Demaso, D. (1993). Developmental differences detection and disclosure of sexual abuse. *Journal of American Academy of Child Psychiatry, 5.*

Carter, B. (1993). Child sexual abuse: Impact on mothers. *Affilia: Journal of Women and Social Work, 1.*

CASE. (2005). Child Sexual Abuse and Exploitation in South Africa. Researched for Save The Children Sweden. Community Agency for Social Enquiry.

Collings, S. J. (2005). Non-supportive disclosure in child sexual abuse: Some conceptual considerations. *Child Abuse Research in South Africa, 6, 13-17.*

Collings, S. J., Griffiths, S., & Kumalo, M. (2005). Patterns of disclosure in child sexual abuse. *South African Journal of Psychology, 35, 270-285.*

Collings, S. J. & Wiles, W. A. (2005). *Non-supportive disclosure in child rape: The effects of children's disclosure strategies.* Paper presented at the 10th ISPCAN European Regional Conference on Child Abuse and Neglect, Berlin, Germany.

Collings, S. J., Wiles, W. A. & Wiles, E. A. (2004). *Patterns of disclosure in child rape: implications for primary prevention and community education.* Paper presented at the 15th International Congress on Child Abuse and Neglect, Brisbane, Australia.

- Conte, J. R., Wolfe, S., & Smith, T. (1989). What sexual offenders tell us about prevention strategies. *Child Abuse & Neglect, 11*, 293-301.
- Crisma, M., Bascelli, E., Paci, D., & Romito, P. (2004). Adolescents who experienced sexual abuse: fears, needs and impediments to disclosure. *Child Abuse & Neglect, 28*, 1035-1048.
- DeVoe, E. R., & Faller, K. C. (1999). The characteristics of disclosure among children who may have been sexually abused. *Child Maltreatment, 4*, 217-227.
- Distel, N. E. (1999). Disclosure of childhood sexual abuse: Links to emotion expression and adult attachment. *Dissertation Abstracts: Section B: The Sciences and Engineering, 60*, 2938.
- Elliott, A. N. & Carnes, C. N. (2001). Reactions of nonoffending parents to the sexual abuse of their child: A review of the literature. *Child Maltreatment, 6*, 314-331.
- Elliott, M., Browne, K., & Kilcoyne, J. (1995). Child sexual abuse prevention: what offenders tell us. *Child Abuse & Neglect, 19*, 579-594.
- Elliot, D. M., & Briere, J. (1994). Forensic sexual abuse evaluations of older children: Disclosures and symptomatology. *Behavioral Sciences and the Law, 12*, 261-277.
- Faller, K. C. (1988). Criteria for judging the credibility of children's statements about their sexual abuse. *Child Welfare, 68*, 389-401.

- Finkelhor, D., Wolak, J., & Berliner, L. (2001). Police reporting and professional help seeking for child crime victims. *Child Maltreatment*, 6, 17-30.
- Flathman, M. (1999). Trauma and delayed memory: A review of the “repressed memories” literature. *Journal of Child Sexual Abuse*, 8, 1-23.
- Freyd, J. J. (1994). Betrayal-trauma: Traumatic amnesia as an adaptive response to childhood abuse. *Ethics & Behavior*, 4, 307-329.
- Goodman-Brown, T. B., Edelstein, R. S., Goodman, G. S., Jones, D. P. H., & Gordon, D. S. (2003). Why children tell: a model of children’s disclosure of sexual abuse. *Child Abuse and Neglect*, 27, 525-540.
- Gries, L. T., Goh, D. S., Andrews, M. B., Gilbert, J., Praver, F., & Stelzer, D. N. (2000). Positive reaction to disclosure and recovery from child sexual abuse. *Journal of Child Sexual Abuse*, 9, 29-51.
- Heflin, A. H., Deblinger, E., & Fisher, C. D. (2000). Child sexual abuse. In A. Freeman & F. M. Dattilio (Eds.), *Cognitive behavioral strategies in crisis intervention* (2nd ed, pp. 166-195). New York: Guilford Press.
- Hiebert-Murphy, D. (1998). Emotional distress among mothers whose children have been sexually abused: The role of a history of child sexual abuse, social support and coping. *Child Abuse & Neglect*, 55, 423-435.

- Higson-Smith, C., Lamprecht, L., & Jacklin, L. (2004). "Access to specialist services and the criminal justice system. In: Richter, L., Dawes, A. & Higson-Smith, C. (Eds.). *Sexual abuse of young children in Southern Africa*. Cape Town: HSRC Press, 333-354.
- Hindman, J. (1989). *Just before dawn*. Oregon: Alexandrai Associates.
- Jensen, T, K., Gulbrandsen, W., Mossige, S., Reichelt, S., & Tjersland, O. A. (2005). Reporting possible sexual abuse: A qualitative study on children's perspectives and the context for disclosure. *Child Abuse & Neglect*, 29, 1395-1413.
- Jewkes R, Penn-Kekana L, & Rose-Junius H. (2005). "If they rape me, I can't blame them": Reflections on gender in the social context of child rape in South Africa and Namibia. *Social Science and Medicine*, 61, 1809-1820.
- Jewkes, R., & Abrahams, N. (2002). The epidemiology of rape and sexual coercion in South Africa: an overview. *Social Science & Medicine*, 55, 1231-1244.
- Jones, D. (2000). Editorial: Disclosure of child sexual abuse. *Child Abuse & Neglect*, 24.
- Jonzon., E., & Lindblad, A. (2004). Disclosure, reactions, and social support: Findings from a sample of adult victims of child sexual abuse. *Child Maltreatment*, 9, 190-200.
- Kaufman, K. L., Hilliker, D. R., & Daleiden, E. (1996). Subgroup differences in the modus operandi of adolescent sexual offenders. *Child Maltreatment*, 1, 17-24.

- Kazarian, S. S., & Kazarian, L. Z. (1998). Cultural aspects of family violence. In: S.S. Kazarian, & D. R. Evans (Eds.), *Cultural clinical psychology: theory, research and practice* (pp. 316-347), Oxford: Oxford University Press.
- Keary, K. & Fitzpatrick, C. (1994). Children's disclosure of sexual abuse during formal investigation. *Child Abuse & Neglect, 18*, 543-548.
- Kelley, S. J., Brant, R., & Waterman, J. (1993). Sexual abuse of children in day care centers. *Child Abuse & Neglect, 17*, 71-89.
- Kogan, M. S. (2004). Disclosing unwanted sexual experiences: Results from a national sample of adolescent women. *Child Abuse & Neglect, 28*, 147-165.
- Korbin, J. (1991). Cross-cultural perspectives and research directions for the 21st century. *Child Abuse & Neglect, 15*, 67-77.
- Lalor, K. (2004). Child sexual abuse in sub-Saharan Africa: a literature review. *Child Abuse & Neglect, 28*, 439-460.
- Lawson, L., & Chaffin, M. (1992). False negatives in sexual abuse disclosure interviews: Incidence and influence of caretaker's belief in abuse in cases of accidental abuse discovery by diagnosis of PTSD. *Journal of Interpersonal Violence, 7*, 532-542.
- Lovett, B. B. (2004). Child Sexual Abuse Disclosure: Maternal Responses and other Variables Impacting the Victim. *Child and Adolescent Social Work Journal, 21*, 355-371.

Lyon, T. (1996). The effect of threats on children's disclosure of sexual abuse. *The APSAC Advisor*, 9, 9-15.

Manion, I. G., McIntyre, J., Firestone, P., Ligezinska, M., Ensom, R., & Wells, G. (1996). Secondary traumatization in parents following the disclosure of extrafamilial child sexual abuse: Initial effects. *Child Abuse & Neglect*, 11, 1095-1109.

Matthews, S. (2007). *Child Sexual Assault: Exploring the needs of the girl child and their caregiver in the period after rape*. Gender and Health Research Unit: Research Protocol. Medical Research Council

Melchert, T. P., & Lance Parker, R. (1997). Different forms of childhood abuse and memory. *Child Abuse & Neglect*, 21, 125-135.

Mian, M., Wehrspann, W., Klajner-Diamond, H., Labaron, D., & Winder, C. (1986). Review of 125 children 6 years of age or under who were sexually abused. *Child Abuse & Neglect*, 4, 223-229.

Mokoae, M., Warria, A., Bower, C., Ward, C., Loffel, J., & Dawes, A. (2009). *South Africa country report on the situation on prevention of child maltreatment study*. HSRC WHO. Cape Town.

Mordock, J. B. (1996). Treatment of sexually abused children: Interview techniques, disclosure, and progress in therapy. *Journal of Child Sexual Abuse*, 5, 105-121.

- Nagel, D. E., Putnam, F. W., Noll, J. G., & Trickett, P. K. (1997). Disclosure patterns of sexual abuse and psychological functioning at a 1-year follow-up. *Child Abuse & Neglect, 21*, 137-147.
- Paine, M., & Hansen, D. (2002). Factors influencing children to self-disclose sexual abuse. *Clinical Psychology Review, 22*, 271-295.
- Palmer, S. E., Brown, R. A., Rae-Grant, N. I., & Loughlin, M. J. (1999). Responding to children's disclosure of familial abuse: What survivors tell us. *Child Welfare, 78*, 259-282.
- Pinheiro, P. S. (2006). World Report on Violence Against Children: Report of the Independent Expert for the United Nations Study on Violence Against Children. Presented at the sixty-first session, Item 62(a) of the provisional agenda: *Promotion and protection of the rights of children*.
- Plummer, C. A. (2006). The discovery process: What mothers see and do in gaining awareness of the sexual abuse of their children. *Child Abuse & Neglect, 30*, 1227-1237.
- RAPCAN Factsheet: Crimes against Children. (2009). Compiled by Waterhouse, S. Retrieved from the web: 23 March 2010.
http://rapcan.org.za/File_uploads/Resources/Fact%20Sheet%20Violence%20against%20Children%202008.pdf.
- Sauzier, M. (1989). Disclosure of child sexual abuse: For better or for worse. *Psychiatric Clinics of North America, 12*, 455-469.

- Seedat, M., Van Niekerk, A., Jewkes, R., Suffla, S., & Ratele, K. (2009). Violence and injuries in South Africa: prioritizing an agenda for prevention. *The Lancet*, 374, 1011-1022.
- Sgori, S. M. (1982). *Handbook of clinical intervention in child sexual abuse*. Lexington, MA: D.C. Health & Co.
- Somer, E., & Szwarcberg, S. (2001). Variables in delayed disclosure of childhood sexual abuse. *American Journal of Orthopsychiatry*, 71, 332-341.
- Sorensen, T., & Snow, B. (1991). How children tell: The process of disclosure of child sexual abuse. *Child Welfare*, 70, 3-15.
- South African Police Services. (2009). Police Crime Statistics. Pretoria.
- Staller, K. M., & Neslon-Gardell, D. (2005). "A burden in your heart": Lessons of disclosure from female preadolescent and adolescent survivors of sexual abuse. *Child Abuse & Neglect*, 29, 1415-1432.
- Summit, R. C. (1983). The Child Abuse Accommodation Syndrome. *Child Abuse & Neglect*, 7, 186.
- Tang, S. S., Freyd, J. J., & Wang, M. (2007). What Do We Know About Gender in the Disclosure of Child Sexual Abuse? *Journal of Psychological Trauma*, 6, 1-26.
- Townsend L. & Dawes A. (2004). Individual and contextual factors associated with sexual abuse of children under 12: a review of recent literature. In Richter L., Dawes A. &

Higson-Smith C. (Eds). *Sexual abuse of young children in southern Africa*. HSRC Press. Cape Town. South Africa.

Waterhouse, S. (2008). The impact of changing criminal justice responses to child victims of sexual abuse. Good intentions, questionable outcomes. *Criminal Justice Initiative of Open Society Foundation*.

World Health Organization, (2002). *World report on violence and health*. Geneva, World Health Organization.

Wyatt, G. E., & Newcomb, M. (1990). Internal and external mediators of women's sexual abuse in childhood. *Journal of Consulting and Clinical Psychology*, 58, 758-767.

University of Cape Town

PART C: MANUSCRIPT

Developing a Psychosocial Understanding of Child Sexual Abuse Disclosure among a Group of Child and Adolescent Females in Cape Town, South Africa

ABSTRACT

Aim:

To develop an understanding of the factors that promotes and inhibits child sexual abuse (CSA) disclosure and its impact on the child and caregiver.

Methods:

Young girls and adolescents between the ages of 8-17 years who experienced penetrative sexual abuse were recruited from two sexual assault centres in the Western Cape, South Africa. On arrival at the centre, caregivers were approached and informed about the study and informed consent was obtained from those who agreed to participate in the study. Thirty-one children and their caregivers were enrolled into the study. Semi-structured interviews were conducted with children and their caregivers and analyzed using thematic analysis.

Findings:

This study has shown that factors promoting CSA disclosure include circumstances around the incident, caregiver concerns around the child's behavior, which made caregivers suspicious and allowed them to create an enabling environment to facilitate disclosure for the child as well as coercion by caregivers to talk. Factors inhibiting CSA disclosure include fear of caregiver reactions where children were more inclined to disclose to a friend or relative, dysfunctional family environments, threats from perpetrators and caregiver expectations on children to be responsible for their own safety. CSA disclosure impacts the caregiver psychologically, leading to self-blame, changes in parenting, fear of stigmatization from family and community. The negative impact on children includes caregiver-blame leading to self-blame and lack of support post-disclosure.

Conclusion:

The children and their caregivers presented disclosure of CSA as fraught with anxiety which has a negative psychological and emotional impact on the child, family and community. This study provides a good understanding of factors promoting and inhibiting CSA disclosure and how this influences post-sexual abuse adjustment for the child and family.

Keywords: *Child sexual abuse, disclosure, psychosocial, girls and adolescents, Western Cape*

INTRODUCTION

Child³ Sexual Abuse (CSA) is considered to be an enormous problem in South Africa. Based on police reports it is estimated that there were 27 417 sexual offences against children for 2009 (South African Police Service, 2009). Unfortunately, specific statistics for CSA in the Western Cape, the focus of this paper, were not available at time of publication. Nevertheless, establishing the true magnitude of CSA in South Africa is extremely difficult due to under-reporting which is often influenced by the psychological impact of the incident, suggesting that prevalence estimates are grossly underestimated (Jewkes and Abrahams, 2002; Jewkes, Penn-Kekana and Rose-Junius, 2005; Battiss, 2005). High levels of violence in South Africa combined with poverty, patriarchal ideologies of masculinity, poor parenting and dysfunctional childhoods, substance abuse and weakness in the criminal justice system drives the CSA pandemic and increases girl children's vulnerability (Seedat, Van Niekerk, Jewkes, Suffla and Ratele, 2009; Jewkes et al., 2005). Evidence shows that children in South Africa are most at risk of being sexually abused by a person known to them (Mokoae, Warria, Bower, Ward, Loffel & Dawes, 2009) and sometimes the abuse may even manifest within a relationship of trust and affection between the child and perpetrator (Mathews, 2007). These relationship dynamics make it difficult for children to disclose sexual abuse partly because they often are unable to view it as abuse.

Defining Child Sexual Abuse (CSA)

The World Health Organization (WHO) defines CSA as encompassing a range of acts including physically forced or coerced penetration of the vagina or anus with a penis or other body part or object; sexual harassment through sexual humiliation and unwanted sexual contact; prostitution; virginity testing; female genital mutilation; forced participation in pornographic performances or production of materials or exposure (WHO, 2002). The

³ Child refers to ages 0-17 years based on the United Nations definition of childhood.

development of a sociological understanding of CSA requires reflection on aspects of childhood, ideas about sexual desires and activity of children as well as intergenerational perspectives on sexual desires, child rearing and social hierarchies (Jewkes et al., 2005). The high status of men in relation to girls leads to vulnerability in girls by reducing their ability to refuse sexual advances and creating expectations in men that they should have control over women and children. This notion is often exacerbated with children being socialized to respect and obey their elders, especially male caregivers, relatives and other figures (Townsend and Dawes, 2004). Findings from ethnographic research by Jewkes et al (2005) in South Africa and Namibia shows that ‘teenage girls’ bodies were constructed as a ‘natural’ object of male desire, indicating a perception that sexual desire was inevitable and experienced by men, but ‘provoked’ by women and girls. This belief reflects a deep-rooted system of patriarchy in South Africa which often increases girls’ vulnerability to CSA.

Conceptualizing CSA Disclosure

It has been argued that the concept of disclosure is fundamentally inadequate because of its general lack of specificity and the variation in the way the term is used (Jones, 2000). The word disclosure is more commonly used in reference to a child’s reporting of abuse, while telling is more often used when adults share their abuse experiences (Alaggia, 2004). Within the current study disclosure will be defined as the act of a child telling someone about the sexual abuse regardless of whether they are an authoritative figure or not. This seemed to be appropriate to this study since it gave the opportunity to explore the various persons children disclose to and why they choose to do so. McNulty and Wardle (1994), state that non-disclosure may increase the child’s vulnerability to negative mental health outcomes. This is often worsened by the lack of accessibility to mental health resources commonly found in South Africa (Collings, Griffiths & Kumalo, 2005). By not disclosing, children may be subjected to longer and repeated abuse and may not receive the necessary treatment for

psychologically damaging sequelae (Goodman-Brown, Edelstein, Jones & Gordon, 2003). If children are able to disclose, the necessary treatment can be sought which may lead to better mental health outcomes (Alaggia, 2010).

Factors such as age of child, gender, severity of abuse, relationship to perpetrator, perceived lack of social support, grooming by the perpetrator, fear of perpetrator, cultural considerations, fear of not being believed and feelings of shame and embarrassment may impact on disclosure for the child (Alaggia, 2004; Freyd, 1994; Jonzon & Lindblad, 2004; Kogan, 2004). International literature has shown that social support and support by a mother encourages CSA disclosure and facilitate recovery for the child (Gries, Goh, Andrews, Gilbert, Praver & Stelzer, 2000; Jonzon & Lindblad, 2004; Lovett, 2004; Kogan, 2004). Studies have shown that lack of social support is often related to emotional distress among mothers following their child's disclosure and those who have a strong social network are better equipped to deal with the stress from the disclosure (Hiebert-Murphy, 1998; Manion, McIntyre, Firestone, Ligezinska, Ensom & Wells, 1996). However, within the South African context the family unit often consists of extended family members who share the responsibility of taking care of children and the child often depends on support from a range of relatives increasing the complexity of disclosure.

Types of CSA Disclosure

A broad range of categories of CSA disclosure can be found within international literature namely: *Purposeful disclosure*; *Accidental disclosure*; *Prompted/elicited disclosure*; *Behavioral/verbal disclosure*; *Purposefully withheld* and *Triggered disclosure* (Campis, Hebden-Curtis, Demaso, 1993; Sorenson and Snow, 1991; Keary and Fitzpatrick, 1994; Nagel, Putnam, Noll and Trickett, 1997; Alaggia, 2004). Some studies have found that purposeful disclosure is often the predominant mode (Higson-Smith & Lamprecht, 2004;

Sauzier, 1989) while others have found that this only occurs in a minority of CSA cases (Berliner & Conte, 1995; Sgori, 1982). The finding that children who are abused by a family member are less likely to disclose compared to those abused by strangers, has been the only consistent theme to emerge from the data (Collings et al., 2005). Since evidence in South Africa shows that most children are at risk of being sexually abused by a person they know, this finding highlights the complexity of CSA disclosure within this country that needs to be understood and addressed.

In a study conducted in South Africa by Collings and colleagues (2005), among a forensic sample of 1 737 (1 614 girls and 123 Boys) CSA survivors, only 30% of respondents made *Purposeful disclosures* (spontaneous and unambiguous verbal disclosure of abuse by the child). A further 43% were facilitated by *Accidental detection*, (involving observations by a second party through injuries, bruises, behavioral changes, involving changes in emotional and behavioral states, development of avoidance strategies and phobias, usually leading to the child being questioned or referred for a professional opinion. This shows the difficulty both children and caregivers face when dealing with CSA disclosure. Moreover, in a clinical study of 1 614 South African child rape victims, it was found that 13% of children disclosed to a reporting adult on the day of the abuse, while 22% disclosed after a delay of more than a month (Collings, Wiles & Wiles, 2004). *Delayed disclosure* may occur due to repression and delayed memories (Alaggia, 2004; Flathman, 1999). Delayed memory is determined by a range of mechanisms involved in the loss of traumatic memory through repression, psychological blocking and forgetting (Flathman, 1999). It has been well established that delayed or even non-disclosure of CSA has shown to be detrimental to the mental health of children and their caregivers.

The literature on the disclosure of CSA in South Africa is limited and it is often necessary to reflect on international data to understand this problem in the local context. However, application of the international data to our context has critical limitations. Collings (2006), states that there is a clear and urgent need to grasp the understandings of CSA disclosure, which can be used as a basis for the development of a more evidence-based approach to intervention and prevention by helping professionals who deal with these issues. It is pivotal to gain a better understanding of factors that impact CSA disclosure in order to create environments that are more supportive and encourage disclosure instead of discouraging it (Tang, Freyd & Wang, 2005). In an attempt to help fill this gap, this study aims to develop an understanding of the process and dynamics of disclosure of CSA and its impact on the child and caregiver. The purpose of the present study, therefore, is to understand the process of disclosure and what factors promote or inhibit disclosure of CSA in South Africa, with the aim of improving reporting and social support policies for abused children and their families.

METHODS

Study Design

A broader study that explored the psychosocial needs of the child and their caregiver post-sexual abuse through three separate in-depth interviews with each child and their caregiver was conducted by the South African Medical Research Council's (MRC) Gender and Health Research Unit. The study provided an opportunity to explore disclosure of sexual abuse even though it was not a specific objective of this study. For the purposes of the current paper, only data from the first in-depth interviews with the children and their caregivers were analyzed. The choice of qualitative research methodology is crucial in allowing the researcher to focus on participant experiences and the meaning(s) they ascribe to them while also allowing for a variety of data collection methods. Studies with children who have been exposed to trauma in South Africa have shown that qualitative methods, such as semi-

structured interviews, is a viable approach for engaging children, thereby determining their levels of psychological distress (Seedat, Nyamai, Njenga, Vythilingum & Stein, 2004; Cluver, Gardner & Operario, 2007). This methodology allowed the researcher to assess psychosocial factors which manifested in the post-sexual abuse period.

Study Sample

A purposive sample of girl children who experienced penetrative sexual abuse and presented to two sexual assault centres located in the Cape Town metropole, with their caregivers were recruited into the study. The participants resided in the surrounding areas which can be classified as disadvantaged areas with high rates of crime, violence and substance abuse. Thirty-one respondents (including children and their caregivers) were selected and interviewed. Children ranged between the ages of 8-17 years.

Data Collection

Separate, repeated in-depth semi-structured interviews were conducted with respondents (children and caregivers). A maximum of three child interviews and three caregiver interviews per child/carer were conducted. Initially one caregiver interview and one child interview was held, and then follow-up interviews were conducted at two monthly intervals over a six-month period. The initial interviews focused mainly on details around the incident and what happened directly after the incident occurred. Interviews were conducted by trained fieldworkers in three languages, namely: English, isiXhosa and Afrikaans. All interviews were tape-recorded and transcribed and translated into English. The duration of interviews was between 30-45 minutes. All participants were compensated by a voucher to cover transport and time costs. Interviews were only conducted with adult participants who signed consent forms and in the case of minor children only with children whose main caregivers signed consent. Socio-demographic information was collected at the beginning of each

interview. These initial interviews offered rich data on issues around disclosure and were thus analyzed for this paper.

Data Analysis

The current study entails a secondary analysis of the qualitative data from the broader study. Thematic analysis of interviews was conducted. Transcripts were analysed inductively which is a standard analytic technique characterized by a process of iteratively coding and sub-coding and interpretation of the findings (Silverman 2001). Initial codes will broadly correspond to questions as grouped in the scope of enquiry. Broad coding had been established, thematic categories were refined, with sub-categories being formed and relationships between these elucidated. This method of analysis has been used in a cross-cultural ethnographic study on CSA in South Africa and Namibia which has provided us with an important understanding of the social context of CSA (Jewkes et al., 2005).

Ethical Considerations

Ethical approval for this study was granted by the University of Cape Town's Faculty of Health Sciences Research Ethics Committee. For the main study ethical approval was granted by the South African Medical Research Council's Ethics Committee. Children were only recruited into the study if they were accompanied by a caregiver when they attended the sexual assault centre. Fieldworkers and interviewers were well trained in working with children in a sensitive manner to avoid re-traumatizing the child and caregiver. A list of child care services was given to all fieldworkers and interviewers and provided to the participants. Where children showed signs of distress and trauma, they were immediately referred for crisis intervention at specialised centres working with abused children and their families. Participation was voluntary and participants had the right to withdraw from the study at any time. In cases where the child's safety was compromised, ethical obligations led the

researchers to refer the child to a social worker for further support. Confidentiality was strictly maintained and all participants were referred for counselling to a service provider for children and their families.

FINDINGS

Participant Socio-demographics

The age of children ranged from 8-17 years. Nine primary caregivers were mothers (29%), one was a father (3.2%), 15 involved both parents (48.3%) and 6 were other relatives (19.3%). Nine children disclosed to a main caregiver (29%) while 22 disclosed to a known person (71%) (e.g., friend, teacher, relative, neighbour). Perpetrators predominantly consisted of known persons (58%) including acquaintances, family members and friends. Most children disclosed their abuse within 24 hours. Children disclosing immediately, were often sexually abused by a stranger while those disclosing after a few weeks or months were more often abused by a known person, in particular a family member, where 3 out of the 5 children who disclosed within a few months were sexually abused by a family member.

Four broad themes were established from the data. The first theme was factors promoting disclosure and offered a range of sub-themes such as circumstances around the incident; caregiver concerns around child's behavior and coercion by caregivers. The second theme was factors inhibiting disclosure where the sub-themes were fear of caregiver reactions; dysfunctional family environments; perpetrator threats and caregiver expectations. The last two themes focused on the impact of disclosure on the child and caregiver where sub-themes illustrated the psychological, emotional and physical impacts experienced by the participants post-disclosure.

Factors Promoting Disclosure

Circumstances around the incident

Circumstances around the sexual abuse played an important role in disclosure. In some cases children were abducted and kept captive for hours or days. When these children were finally freed or managed to escape, they would often fear going home as they were afraid of being punished for 'sleeping out' or 'coming home late'. Many of these children would seek help from the closest known person or even from strangers on the street if they were left stranded and lost. In some cases caregivers, with the help of family and community members, would search for children missing for one day up to a week, leading to immediate disclosure. The sexual abuse incident often caused children to come home late or sleep over at a friend's home. This unusual behaviour caused great concern amongst carers who would confront the child, wanting to know what happened. A mother of a 14 year old explains:

"(xxx) she doesn't come... (xxx) she doesn't come. That time I check it out, it was when I'm going to the toilet, past twelve. Then I was going to (xxx's) room to opening to check the bed, huh uh, (xxx) is not yet...and then I didn't sleep right. Hey I'm worried about (xxx) man...I don't know where my child is".

Caregiver concerns around child's behaviour

Sexual abuse often has devastating psychological, emotional and physical effects on the child. The process of disclosure is complex and caregivers initially become concerned about changes in behavior or other physical signs. For some of the caregivers in this study, this led to the caregiver creating a safe environment for the child to disclose what really happened and what was truly wrong. In one case a father was quick to scold and shout at his daughter for coming home late, however, he felt that something was wrong:

“My reaction was shouting at her because she had left and had me worried and now she was crying because she thought I was mad at her and that would get her off. I said to her - “get out of my room I do not want to hear anything”-. But as I was sitting there in my room I felt disturbed and I thought that I should go and talk to her. I saw that she was bruised and I asked her what had happened and she told me that she was raped”.

Some caregivers had a feeling that their child was “*not right*”, “*sick*” or that “*something was wrong*”: Children would display different symptoms from physical signs to changes in behaviour and attitude. A 12 year old girl explains:

“When I was at home, first day, my mother said she does not like the way I was, she even said I lost weight, she further asked if I had not been sick”.

Coercion by caregivers

As mentioned above, changes in the child’s behavior and physical signs also led to caregivers feeling worried that something was wrong. This concern could leave caregivers confused and frustrated about what was troubling their child. The reluctance of children to disclose when caregivers were aware something was worrying the child sometimes resulted in threats.

Caregivers would threaten to beat or actually physically punish the child in their desperation to establish what was “*wrong*”. This would occur because the children did not sleep at home, came home late or started showing changes in their behavior or not obeying the caregiver. Physical punishment was viewed as an acceptable means of parenting as many children feared beatings, influencing children’s willingness to disclose abuse. An angry mother of a 12 year old girl reports:

“We then asked her ‘ where are you coming from, where did you sleep?’ She does not answer. My sister slaps her and takes her inside and I wanted to hit her so that she can say where she is coming from, because I could not sleep she was not home and I did not know where she went...when I was about to hit her, my sister said ‘wait do not hit her she is going to say where she is coming from’. My sister hit her with a small pipe and she said...”

Factors Inhibiting Disclosure

Fear of caregiver reactions

From the children’s accounts, fear of caregivers’ reactions such as punishment or not being believed was the primary factor inhibiting disclosure. Fear of negative reactions such as being scolded, punished, blamed and not believed, inhibited disclosure thus many spoke about being “*afraid*” to disclose to caregivers. Social norms of harsh parenting practices, often influenced by cultural beliefs, include physical punishment in some South African communities, and underscore these fears. Some children would be raped in a place or at a time the caregiver had warned them about and this would inhibit disclosure as they feared being reprimanded for disobeying. This was particularly evident with the older children who would often stay out late at night with friends. A strategy used by many children was to disclose to another person whom they felt they could trust such as a teacher, friend or neighbor who could then act as an ally. These individuals acted as mediators who would eventually assist the child in telling the caregivers about the rape. Many children are reticent to talk about the abuse, indicating the difficulty children experience in talking about sex and sexuality with caregivers. This is compounded when the perpetrator is a family member or a known trusted person within the community. A 14 year old who was raped by a friend reported:

“When I got home I was afraid of my father. At first I lied and said I was dragged by four men”.

It is often difficult for children to disclose CSA when the perpetrator is a family member or a known trusted person within the community as they feel ashamed, fear not being believed, scolded, or even punished.

Dysfunctional family environments

Many children came from dysfunctional families with children's experience of familial instability also inhibiting disclosure. In some families either one of the parents or both parents were absent due to death, imprisonment or other social factors. Others came from homes where domestic violence was a common occurrence. In one case a 16 year old girl was living in very violent conditions within the home, where her mother was experiencing brutal domestic violence by the father. She was raped at the time of her parent's divorce and she became very angry and started using drugs. At this time her mother had no idea that she had been raped and thought she was acting out due to the divorce. These factors made disclosure difficult for the child as she felt she did not want to burden the mother. The mother reports:

“He (father) used to come in drunk and he used to wake me up ...grab me by the throat and I used to keep quiet because I didn't want them (children) to wake up. But all the time she was awake and she used to lay with a knife under her pillow and in her mind as a child she thought just one move! And I'll kill you. At that time (during divorce) I thought she was on drugs, maybe she's experiencing, experimenting on drugs and at that time I thought maybe she's involved with the wrong people to spite her father. Because she did everything in her power to spite him”.

The mother of this child is a victim of CSA and had never disclosed her abuse to anyone until this research was conducted and she disclosed to the researcher. Her own vulnerable emotional state could have influenced her inability to pick up cues from her own child.

Perpetrator threats

Threats from perpetrators on the child's life and that of their families were reported by both caregivers and children as a reason for the child not to disclose. Some children mentioned being "scared" or "afraid" to disclose because they feared being killed or their families being harmed by the perpetrator. Perpetrator threats commonly occurred among the participants, especially if the perpetrator was a family member or known person, and caused the children immense emotional and psychological distress and fear that was real, thus inhibiting the disclosure of the rape. An 8 year old explained:

"And so he said to me if I'm going to say then he's going to shoot us all dead in the house...and so he threatened me with the gun".

Caregiver expectations

Caregivers often placed responsibility on children to protect themselves from harm. Younger children are allowed to walk around unaccompanied and go on errands while older children in particular were given the freedom to stay out late and walk around in the streets. However, children were not able to protect themselves and were often harmed in their own communities. Caregivers appear to lack an understanding of the child's inability to protect themselves from potential perpetrators, placing blame on the child for not reacting 'appropriately' or for 'putting themselves' in a situation of danger. For example, mothers of a 9-year old and 13-year old commented respectively:

“Even at the time they were pulling you why did you not cry so that people would hear? You should have at least cried or after this was done to you, you should have come to me, your mother and tell me what has happened so that I could see what I can do”.

“I was constantly telling her ‘be aware, do not do this and that’. She has been told about this but why, why did it happen? She knows that she is supposed to do this. She is supposed to run away from a stranger. Do not chat to a man whom you do not know because when he is close there is no way out”.

Caregivers often did not understand the effects of rape on the child and how children respond to such trauma. Often children are too afraid to shout out for help at the time and they are also too afraid to disclose or show any form of emotion. Children do not have the physical strength to resist an attack and are placed in a compromising position since they often trust the perpetrator.

Impact of Disclosure on Caregiver

Psychological impacts

The trauma associated with the disclosure of CSA often impacts negatively on the caregivers emotional and psychological functioning. Many reported that they felt “*shocked*”, “*hurt*”, “*pain*” and “*worried*” after hearing about the assault. Caregivers mentioned “*not sleeping well*”, “*having visions*”, “*feeling sick*”, “*feeling stressed*”, “*sad*” and even feelings of denial after disclosure. Some were so distressed that it affected their ability to function at work, while others felt they would rather be at work, where they could be distracted from thinking about the sexual abuse. As a mother of a 14 year old explains:

“I was not alright at all. Being HIV positive, was better than knowing that my child had been raped”.

Two caregivers disclosed their own personal experiences of being raped. In both cases the researcher was the first person disclosed to. This indicates the complexity of CSA disclosure as one of the caregiver’s explains talking about her daughter:

“I suspected that she was raped...she didn’t care about herself as a woman and she’s still young...I think of myself when I was her age, I acted the same because it happened to me”.

Self-blame

Disclosure of CSA also led to self-blame for some caregivers and this had significant psychological consequences. A mother of a 17 year old who was attending a funeral in a rural area at the time of the assault displays guilt as she explains:

“Because I am responsible for her, I feel I have failed in that light. I, I should have, I told myself I should have never gone away because, I, I, don’t usually leave them alone”.

Disclosure of CSA also created tension between the mother and father within some households. Even though some children were fortunate enough to have both parents present in the household, the child’s well-being and safety was often placed onto the mother alone. When children were sexually abused fathers would blame the mother and say it was their fault for not taking proper care of the child. This left the mothers feeling very alone with no support and they often started blaming themselves for the child’s abuse. A mother of a 17 year old girl describes how she was blamed by the child’s father for the rape which clearly has affected her negatively:

“I am not getting the support, her father says that, I am the problem. Another thing, we are always fighting. He says I should not have allowed her to leave at that time and it is me, I allow everything and that is why this thing happened”.

Changes in parenting

All caregivers were concerned about the safety of their children and their families following the rape, as most perpetrators were still roaming the streets and in some cases threatening to harm the child. Many caregivers were so traumatized by these threats that they often did not want to report the assault to the police due to fear of reprisal by the perpetrators. Post-CSA disclosure, most caregivers become extremely overprotective of the movements of their children. Many children used to having little or no rules within the household, such as what time to come home and where to walk around with friends, were suddenly overwhelmed by rules created by their caregivers. Children did not understand or welcome this sudden change in parenting behaviour and it often led to tension within the parent- child relationship. When they disobeyed these rules, they would be viewed as disrespectful, defiant and completely uncontrollable by their caregivers. A mother of a 13 year old girl reports:

“I don’t want her to be outside at night, I want her to be near me all the time which is what she doesn’t want to do...she will come back saying she had just accompanied so and so. And I said to her ‘when this happened to you, you were accompanying someone but still’ ...and her father said she must no longer accompany people, she must stay in the house but still she is not doing that”.

Fear of stigmatization

Caregivers often reacted to the disclosure by keeping it a “*secret*” that needs to be “*hidden*” from family, friends and the community. This has a negative impact on the child as it may lead to feelings of shame and embarrassment. Some caregivers therefore did not want to tell others about the abuse and tried to keep it to themselves which in turn led to suppressed feelings with detrimental psychological effects. In these cases, the abuse was usually viewed as something to be ashamed of which others should not know about. This stemmed from the belief in many communities that child sex is taboo and caregivers felt afraid to be associated with the issue. Some mentioned that their child’s “*pride*” had been taken away, they felt she had been “*ruined*” and “*messed up*”. A mother of a 17 year old girl explains how she had not told anybody about the rape:

“I don’t basically have anybody that I told or that I can tell to be honest with you, I can’t even tell my own husband about it...it takes on me, it takes on me because there are so many things I want to know and but you cannot speak to anyone, you cannot speak to anyone”.

In one case a sister of a 10 year old girl was not happy with the fact that the child was telling people at school:

“I don’t feel okay, because she will talk about it sometime even if no one has asked her, even at school she would talk about it. I feel bad (crying)...because she will talk about it even if the teachers did not ask and I am thinking that it will affect her. I feel bad and it makes me feel as if we do not really take care of her at home”.

Many caregivers fear that their children will be stigmatized by family and other people in the community if they told anyone about the rape. One mother of a 13 year old girl explains:

“I think she may be talking about this to other people and that worries and scares me. Because if she goes around talking about it, she is going to grow and people will swear at her referring to the incident”.

Impact of Disclosure on Child

Caregiver-blame leading to self-blame

Some caregivers reacted to disclosure by blaming the child. They blamed the sexual abuse on the child for dressing “inappropriately” and “enticing men” with their developed bodies, reflecting views South African society holds on CSA. This perception is displayed in the reaction of a mother to her 13 year old daughter:

“And the way she dresses, she is beautifully structured, I know and clothes suit her. So I can see that people think she is older in the way they look at her. She will dress up and go and meet these groups of hers. She has a butt and when she is wearing a pant it suits her and I think men are going to think she is old but she is not. Even when my son sees her going out, you can see that he is looking at her and I would think ‘Oh my God, I am going to be in shit here...’ I would say to her she must not go out at night dressed like that because she will be raped. Before this thing happened”!

One mother clearly blamed her child for being raped and scolded her for coming home late from a friend’s house at the time of the assault, she said:

“Do you see this thing of going out at night, that you experience painful things now”.

This often led to self-blame and shame for the child. A 16 year old girl befriended a policeman who then sexually abused her inside the police barracks. She found it difficult to disclose her abuse because she felt that it was her fault for putting herself in that position:

“I don’t know I wasn’t really sure I, all I was thinking is this is a policeman, he’s far older than what I am and what was I doing there in the first place...but I was a very naughty child and so on, what was I doing there in the first place I mean there was somebody sitting in the lounge of the barracks that saw me come in with him, saw me come in and now when I leave, I’m not crying or anything I’m just walking out and he thinks it’s fine. Everything is fine so, and he heard nothing, didn’t see anything”.

Lack of support post-disclosure

Non-support from caregivers also occurred in certain cases after disclosure and children would seek support elsewhere or have no support at all. A 16 year old describes her quest for support after disclosing the rape to her mother:

“When Miss (teacher) was done, I told her what happened (crying). She then suggested that I report this incident at home. I went to report what happened and my mother said she does not understand why I went and she does not understand the reason why I accompanied (xxx) (friend), she does not have time to listen to me...”.

This lack of support from caregivers places the child at further risk of psychological harm.

The child is placed in a vulnerable position by having to search for appropriate support from other members of the family and community which may not be available.

DISCUSSION

Findings from this study provide valuable and important insight into the complexities of child sexual abuse disclosure. One of the main factors promoting disclosure was the circumstances around the sexual abuse and changes in the child's behavior, such as in cases where participants were abducted, and on return would be questioned by caregivers and/or others and expected to disclose what had happened. This lack of safety within communities impacts the lives of young girls on a daily basis. The threat of being abducted and kept captive is high and girls often feel more afraid of coming home late or not coming home at all rather than considering the sexual abuse that has taken place. These findings show us that the stereotypes placed on girls by family and community that they should not come home late or sleep out influences a girl's decision to disclose. Many times girls first need to cross the hurdle of explaining to their caregivers why they have not come home, or come home late before they can even consider talking about the sexual abuse. These stereotypes need to be broken down to enable girls to feel free to disclose in incidents such as these which is a common occurrence in many South African communities.

In cases where participants would be sexually abused away from home and would seek assistance immediately from strangers or the closest known and trusted person. This would lead children to immediately disclose what had happened to them or caregivers would find out through the police or other individuals who had assisted the child. In a study conducted in South Africa by Collings and colleagues (2005), among a forensic sample of 1 737 (1 614 girls and 123 Boys) CSA survivors, only 30% of respondents made *Purposeful disclosures* (spontaneous and unambiguous verbal disclosure of abuse by the child). Within this study this was not the predominant form of disclosure to the caregiver, often children would seek other mediators to inform their caregivers about the abuse.

Most children in this study disclosed to a friend or other person before they disclosed to their caregiver. A unique finding in this study was that friends, relatives and other community members would often also be used as mediators to deliver the news about the abuse to the caregivers. Other studies have shown similar findings where children find it difficult to disclose to their caregiver, preferring to disclose to a friend (Kogan, 2004; Hershkowitz, Lanes & Lamb, 2007). Moreover, this finding is important to future research and interventions on CSA disclosure in South Africa and is similar to other research studies (Collings et al., 2005; September, 2004), which shows that community members such as neighbours, friends and peers of children should be targeted and educated on how to appropriately respond to these situations when they arise.

Many caregivers would become concerned about the sudden change in their child's behavior due to the sexual abuse and would decide to create a safe space where they could confront the situation. This occurred in most cases within this study. This concurs with work by Jensen, Gulbrandsen, Mossige, Reichelt & Tjersland, (2005) where parents of children who have been sexually abused became concerned about what was troubling their child and would then intervene by subtly probing to find out what was wrong. In a study conducted in South Africa by Collings and colleagues (2005), among a forensic sample of 1 737 (1 614 girls and 123 Boys) CSA survivors, 43% were established through *Accidental detection*, (involving observations by a second party through injuries, bruises, behavioral changes, involving changes in emotional and behavioral states, development of avoidance strategies and phobias, usually leading to the child being questioned or referred for a professional opinion.

Caregivers often do not have the knowledge around symptoms and signs of sexual abuse and when their children start behaving differently, they are not able to understand these changes. Caregivers then become suspicious, concerned or even angry that their children are changing

and not speaking to them about what is wrong. Caregivers need to be more aware of the signs and symptoms of CSA and how it may impact disclosure.

In contrast, a finding which to our knowledge is unique to this study is caregiver coercion, where children would be threatened and even beaten if they did not disclose what had happened to them. Harsh parenting practices in South Africa also affect the child's willingness to disclose as they fear caregivers reactions and possible physical punishment which is a real threat. Harsh and rejecting parenting promotes disorganized insecure attachments and the development of an inability to regulate or interpret their personal feelings and that of others, since the caregiver becomes a source of fear and comfort, which has implications for the development of personality disorders (Ainsworth, 1978). Caregivers should be educated on signs and symptoms of CSA in children, and how to appropriately respond if they suspect or conclude that their child has been abused.

The two main factors found to inhibit CSA disclosure were fear of caregiver reactions and threats by perpetrators not to tell. Parental reaction or anticipated reactions are likely to influence the willingness of children to disclose sexual abuse (Distel, 1999) and retrospective analyses of CSA reported in adulthood have shown that fear of family rejection and disbelief are major factors inhibiting disclosure (Palmer, Brown, Rae-Grant & Loughlin 1999; Somer & Szwarcberg, 2001). In many cases participants' fears were realized where caregivers reacted with negative responses such as disbelief or lack of interest. The lack of support as well as the consequences of this by many caregivers within this study was also suggested by Heflin, Deblinger and Fisher (2000), who found in their study that parents' inability to support their child post-disclosure could be linked to their own distress and inability to cope with the abuse. This finding is similar to those reported by Collings and Wiles (2005), on a study of 856 CSA survivors seen at an urban crisis centre in KwaZulu-Natal, South Africa,

where 222 survivors (26%) experienced non-supportive reactions at the time of disclosure predominantly from mothers (43%).

Within this study the majority of children were threatened by their perpetrators not to disclose the abuse, as shown in other international studies (Lyon, 1996; Kaufman, Hilliker & Daleiden, 1996; Kelley, Brant & Waterman, 1993). This was especially the case where the perpetrator was known to both the child and caregiver. Many perpetrators had a trusting relationship with the child before the abuse such as being an acquaintance, friend, family member and they would use this power to control non-disclosure. However, in other instances perpetrators would use force, coercion and intimidation as a means to enact sexual abuse. Other studies have also shown how children are afraid to disclose when the perpetrator is known as they often feel they need to protect the integrity of the family or even have attachment and bonding issues with their abuser (Alexander, 1992; Hindman, 1989; Paine & Hansen, 2002 and Summit, 1983).

Most children within the study had dysfunctional family environments and resided in communities with high rates of unemployment, violence, poverty and a lack of physical and social infrastructure and services. These situations increase the child's vulnerability to a range of childhood adversities, particularly violence and sexual abuse within the community and may also negatively impact disclosure. Caregivers would often be pre-occupied or too distressed about other problems within their lives to offer the appropriate support to their child. All these factors influence parenting practices and availability of caregivers to focus on their child's needs. Moreover, some caregivers expected that their children should be responsible for their own safety when playing or walking around in the community.

However, with low-resourced communities such as those found in South Africa, including Cape Town, education around safety, sexuality and abuse are often neglected or ignored. The

poor conditions and physical environments in which most children live exacerbate the vulnerability of children to harm and abuse. Caregivers often lack the capacity to supervise their children adequately since structural factors negatively affect the quality of their supervision. These factors increase children's vulnerability to CSA.

Child sexual abuse disclosure had an enormous and detrimental impact on most caregivers within the study. Caregivers were often unprepared for the news that their child had been sexually abused, leading to immense distress and trauma. The psychological impacts of the disclosure included feeling sick, stressed, sadness, hurt, worried and not sleeping well. Disclosure of CSA even triggered memories for two caregivers who also experienced CSA but never disclosed it, and precipitated disclosure to the researcher at the time of the interview. This illustrates how detrimental child sexual abuse can be and, without proper mental health support, can remain with an individual throughout their adult lives.

The psychological impact of CSA disclosure often was so immense that some caregivers blamed themselves for the abuse of their child. In some cases fathers blamed the sexual abuse on the mother and would not support her emotionally, negatively impacting their marital relationship. These findings can be linked to various patriarchal, societal and cultural influences in South Africa which place the burden of child rearing on the mother (Seedat et al, 2009 and Jewkes et al, 2005). Research conducted at a child and family centre in the United Kingdom, also showed that parents of children sexually abused by a family member, experience significant levels of distress post disclosure and that it can often affect the marital relationship of the parents and dynamics within the whole family (Davies, 1995). When children in South Africa are sexually abused by a family member it causes tension within the whole family as there are often issues of blame and disbelief among family members, which

affects the child's willingness to disclose and chances of recovery. These children often feel responsible for the conflict caused within the family leading to feelings of guilt and shame.

Changes in parenting practices by many caregivers immediately occurred post-disclosure. Many caregivers feared that the perpetrators would hurt their child again or even retaliate after reporting the sexual abuse to the police. This created a great deal of anxiety and stress for the caregiver and many became over-protective of their children by creating new rules to control the child's mobility. Many caregivers also feared stigmatization from others in the family and community and this also caused a great deal of anxiety. Caregivers would keep the abuse to themselves and this led to a lack of social support which then negatively impacted them psychologically. In South Africa, the transmission of HIV is a real threat, especially for girls and women. HIV brings its own concerns of stigmatization and when a child is sexually abused this threat increases, and in turn increases stigmatization for the whole family. Caregivers thus face a double burden of dealing with the possibility that their child may have been infected with HIV as well as living with the reality that their child had been sexually abused. Stigmatization of CSA is a real threat to caregivers and child survivors which is overlooked by society. Not only does the abuse cause trauma to the child and family but what they need to deal with post abuse by relatives and community members is nothing short of abuse itself. Caregivers and the broader community need to be educated around the impact of stigmatization on children and caregivers affected by sexual abuse and how their reactions and behaviours could be changed to foster healing and not destruction.

Findings also show the impact of CSA disclosure on the child. Some caregivers blamed the abuse on the child and this often led to self-blame for some children. This lack of support from caregivers would impact the well-being of the child as support would then need to be found elsewhere. Studies have shown that in order to reap the full benefits of disclosure and

to minimize its adverse effects, the child must be the recipient of a positive reaction from significant others (Gries et al, 2000). Social support is one of the most important factors in facilitating recovery from CSA and children with less supportive families have been found to have more Post-Traumatic Stress Disorder and dissociative symptoms (Tang et al, 2007; Roesler, 1994).

LIMITATIONS

One limitation of this study may be that it was a secondary analysis of data from a broader study which did not specifically focus on CSA disclosure. However, valuable data was collected which could be analyzed for the purposes of this study. All children in this study presented to a sexual assault centre and reported their abuse to the police and care should be taken when generalizing to other populations who did not necessarily follow this path. This study mainly focused on an exploration of factors which promote and inhibit CSA disclosure and may not contribute extensively to the theoretical work in the field focusing on the conceptualization of CSA disclosure.

CONCLUSION

Child sexual abuse disclosure is a complex process influenced by many factors, such as where and how the incident occurred, children's responses to the abuse, caregiver reactions, threats by perpetrators, dysfunctional family environments and social ideologies, leading to detrimental impacts on the child and caregiver. It is evident that disclosure significantly impacts the child and caregiver psychosocially and that social support for both parties is extremely important for recovery. Sexually abused participants in this study have illustrated how difficult it is to disclose sexual abuse to their caregivers, and the findings suggest that caregivers need to be equipped with appropriate information in order to detect and effectively assist their children in these situations. Most children in this study disclosed to friends and

other people they felt they could trust, and people within the community and peers at school should be educated around how to deal with disclosure and the proper procedures to follow for support. This is an important factor, since many community members are also not equipped and educated to deal with and support children when disclosure occurs.

Government should implement policies to inform curricula and programmes within schools, households and communities on child sexual abuse risks, signs, symptoms, impacts and disclosure. This would aid the sensitization of communities around the currently taboo issue of sex and sexual abuse among children. Parenting programmes should be introduced and encouraged through schools and within the community to assist caregivers in how to appropriately deal with CSA. Mental health support services for the child survivor, family and immediate surrounding community should be put into place through appropriate and accessible NGO's. Programmes on preventing stigmatization should also be implemented by government in an attempt to support caregivers, children and families affected by child sexual abuse. These programmes should be implemented within schools and communities to spread awareness around the detrimental impact of CSA. Finally national campaigns on CSA should be implemented to foster a tradition of awareness and support among community members to eradicate stigma.

This study has provided a better understanding of some of the psychosocial issues that affect CSA disclosure within a specific province in South Africa, which may lead to the development of more appropriate support services for child sexual abuse survivors and their caregivers, family and community. One unique finding from this study was caregiver coercion and further research could be done on parenting practices and how this may impact CSA disclosure within families and communities within the South African context.

REFERENCES

- Ainsworth, M. D. S. (1978). Object relations, dependency and attachment: a theoretical review of the infant-mother relationship. *Child Development, 40*, 969-1025.
- Alaggia, R. (2010). An Ecological Analysis of Child Sexual Abuse Disclosure: Considerations for Child and Adolescent Mental Health. *Journal of the Canadian Academy of Child and Adolescent Psychiatry, 19*, 32-39.
- Alaggia, R. (2004). Many ways of telling: Expanding conceptualizations of child sexual abuse disclosure. *Child Abuse & Neglect, 28*, 1213-1227.
- Alexander, P. C. (1992). Application of attachment theory to the study of sexual abuse. *Journal of Consulting and Clinical Psychology, 80*, 185-195.
- Battiss, B. (2005). *Hypnotherapy and Childhood Sexual Abuse: The experiences of adult survivors*. Thesis D Litt Et Phil, p.21. etd.rau.ac.za/theses/available/etd-091205-095638
- Berliner, L., & Conte, J. (1995). The effects of disclosure and intervention on sexually abused children. *Child Abuse & Neglect, 19*, 371-384.
- Campis, L. B., Hebden-Curtis, J., & Demaso, D. (1993). Developmental differences detection and disclosure of sexual abuse. *Journal of American Academy of Child Psychiatry, 5*.

- Cluver L, Gardner, F., & Operario, D. (2007). Psychological distress amongst Aids-orphaned children in urban South Africa. *Journal of Child Psychology and Psychiatry*. 48, 755-763.
- Collings, S. J. (2006). How do sexually abused children disclose? Towards an evidence-based approach to practice. *Acta Criminologica*, 19, 33-41.
- Collings, S. J., Griffiths, S., & Kumalo, M. (2005). Patterns of disclosure in child sexual abuse. *South African Journal of Psychology*, 35, 270-285.
- Collings, S. J. & Wiles, W. A. (2005). *Non-supportive disclosure in child rape: The effects of children's disclosure strategies*. Paper presented at the 10th ISPCAN European Regional Conference on Child Abuse and Neglect, Berlin, Germany.
- Collings, S. J., Wiles, W. A. & Wiles, E. A. (2004). *Patterns of disclosure in child rape: implications for primary prevention and community education*. Paper presented at the 15th International Congress on Child Abuse and Neglect, Brisbane, Australia.
- Davies, M. G. (1995). Parental distress and ability to cope following disclosure of extra-familial sexual abuse. *Child Abuse & Neglect*, 19, 399-408.
- Distel, N. E. (1999). Disclosure of childhood sexual abuse: Links to emotion expression and adult attachment. *Dissertation Abstracts: Section B: The Sciences and Engineering*, 60, 2938.
- Flathman, M. (1999). Trauma and delayed memory: A review of the "repressed memories" literature. *Journal of Child Sexual Abuse*, 8, 1-23.

- Freyd, J. J. (1994). Betrayal-trauma: Traumatic amnesia as an adaptive response to childhood abuse. *Ethics & Behavior*, 4, 307-329.
- Goodman-Brown, T. B., Edelstein, R. S., Goodman, G. S., Jones, D. P. H., & Gordon, D. S. (2003). Why children tell: a model of children's disclosure of sexual abuse. *Child Abuse and Neglect*, 27, 525-540.
- Gries, L. T., Goh, D. S., Andrews, M. B., Gilbert, J., Praver, F., & Stelzer, D. N. (2000). Positive reaction to disclosure and recovery from child sexual abuse. *Journal of Child Sexual Abuse*, 9, 29-51.
- Heflin, A. H., Deblinger, E., & Fisher, C. D. (2000). Child sexual abuse. In A. Freeman & F. M. Dattilio (Eds.), *Cognitive behavioral strategies in crisis intervention* (2nd ed, pp. 166-195). New York: Guilford Press.
- Hershkowitz, I., Lanes, O. & Lamb, M. E. (2007). Exploring the disclosure of child sexual abuse with alleged victims and their parents. *Child Abuse & Neglect*, 31, 111-123.
- Hiebert-Murphy, D. (1998). Emotional distress among mothers whose children have been sexually abused: The role of a history of child sexual abuse, social support and coping. *Child Abuse & Neglect*, 55, 423-435.
- Higson-Smith, C., Lamprecht, L., & Jacklin, L. (2004). "Access to specialist services and the criminal justice system. In: Richter, L., Dawes, A. & Higson-Smith, C. (Eds.). *Sexual abuse of young children in Southern Africa*. Cape Town: HSRC Press, 333-354.

Hindman, J. (1989). *Just before dawn*. Oregon: Alexandria Associates.

Jensen, T. K., Gulbrandsen, W., Mossige, S., Reichelt, S., & Tjersland, O. A. (2005).

Reporting possible sexual abuse: A qualitative study on children's perspectives and the context for disclosure. *Child Abuse & Neglect*, 29, 1395-1413.

Jewkes R, Penn-Kekana L, & Rose-Junius H. (2005). "If they rape me, I can't blame them":

Reflections on gender in the social context of child rape in South Africa and Namibia. *Social Science and Medicine*, 61, 1809-1820.

Jewkes, R., & Abrahams, N. (2002). The epidemiology of rape and sexual coercion in South Africa: an overview. *Social Science & Medicine*, 55, 1231-1244.

Jones, D. (2000). Editorial: Disclosure of child sexual abuse. *Child Abuse & Neglect*, 24.

Jonzon., E., & Lindblad, A. (2004). Disclosure, reactions, and social support: Findings from a sample of adult victims of child sexual abuse. *Child Maltreatment*, 9, 190-200.

Kaufman, K. L., Hilliker, D. R., & Daleiden, E. (1996). Subgroup differences in the modus operandi of adolescent sexual offenders. *Child Maltreatment*, 1, 17-24.

Keary, K. & Fitzpatrick, C. (1994). Children's disclosure of sexual abuse during formal investigation. *Child Abuse & Neglect*, 18, 543-548.

Kelley, S. J., Brant, R., & Waterman, J. (1993). Sexual abuse of children in day care centers. *Child Abuse & Neglect*, 17, 71-89.

- Kogan, S. M. (2004). Disclosing unwanted sexual experiences: Results from a national sample of adolescent women. *Child Abuse & Neglect, 28*, 147-165.
- Lyon, T. (1996). The effect of threats on children's disclosure of sexual abuse. *The APSAC Advisor, 9*, 9-15.
- Manion, I. G., McIntyre, J., Firestone, P., Ligezinska, M., Ensom, R., & Wells, G. (1996). Secondary traumatization in parents following the disclosure of extrafamilial child sexual abuse: Initial effects. *Child Abuse & Neglect, 11*, 1095-1109.
- Matthews, S. (2007). *Child Sexual Assault: Exploring the needs of the girl child and their caregiver in the period after rape*. Gender and Health Research Unit: Research Protocol. Medical Research Council.
- McNulty, C., & Wardle, J. (1994). Adult disclosure of sexual abuse: A primary cause of psychological distress? *Child Abuse and Neglect, 18*, 549-555.
- Mokoae, M., Warria, A., Bower, C., Ward, C., Loffel, J., & Dawes, A. (2009). *South Africa country report on the situation on prevention of child maltreatment study*. HSRC WHO. Cape Town.
- Nagel, D. E., Putnam, F. W., Noll, J. G., & Trickett, P. K. (1997). Disclosure patterns of sexual abuse and psychological functioning at a 1-year follow-up. *Child Abuse & Neglect, 21*, 137-147.

- Paine, M., & Hansen, D. (2002). Factors influencing children to self-disclose sexual abuse. *Clinical Psychology Review, 22*, 271-295.
- Palmer, S. E., Brown, R. A., Rae-Grant, N., I., & Loughlin, M. J. (1999). Responding to children's disclosure of familial abuse: What survivors tell us. *Child Welfare, 78*, 259-282.
- Roesler, T. A. (1994). Reactions to disclosure of childhood sexual abuse: The effect on adult symptoms. *Journal of Nervous and Mental Health Disease, 182*, 618-624.
- Sauzier, M. (1989). Disclosure of child sexual abuse: For better or for worse. *Psychiatric Clinics of North America, 12*, 455-469.
- Seedat, M., Van Niekerk, A., Jewkes, R., Suffla, S., & Ratele, K. (2009). Violence and injuries in South Africa: prioritizing an agenda for prevention. *The Lancet, 374*, 1011-1022.
- Seedat, S., Nyamai, C., Njenga, F., Vythilingum, B., & Stein, D. (2004). Trauma Exposure and Post-Traumatic Stress symptoms in urban African schools. *British Journal of Psychiatry, 184*, 169-175.
- September, R. (2004). The report of the parliamentary task group on the sexual abuse of children 2002: A commentary. In L. Richter, A. Dawes, & C. Higson-Smith (Eds.), *Sexual abuse of young children in southern Africa* (pp. 304-331). Cape Town: HSRC Press.

- Sgori, S. M. (1982). *Handbook of clinical intervention in child sexual abuse*. Lexington, MA: D.C. Health & Co.
- Silverman, D. (2001). *Interpreting Qualitative Data; Methods in Analysing talk, text and interaction*. Sage Publications. London.
- Somer, E., & Szwarcberg, S. (2001). Variables in delayed disclosure of childhood sexual abuse. *American Journal of Orthopsychiatry*, 71, 332-341.
- Sorensen, T., & Snow, B. (1991). How children tell: The process of disclosure of child sexual abuse. *Child Welfare*, 70, 3-15.
- South African Police Services. (2009). *Police Crime Statistics*. Pretoria.
- Summit, R. C. (1983). The Child Abuse Accommodation Syndrome. *Child Abuse & Neglect*, 7, 186.
- Tang, S. S., Freyd, J. J., & Wang, M. (2007). What Do We Know About Gender in the Disclosure of Child Sexual Abuse? *Journal of Psychological Trauma*, 6, 1-26.
- Townsend L. & Dawes A. (2004). Individual and contextual factors associated with sexual abuse of children under 12: a review of recent literature. In Richter L., Dawes A. & Higson-Smith C. (Eds). *Sexual abuse of young children in southern Africa*. HSRC Press. Cape Town. South Africa.
- World Health Organization, (2002). *World report on violence and health*. Geneva, World Health Organization.