An outcome assessment of a residential care programme for sexually-abused children in South Africa

RESEARCH REPORT

Children's Institute, University of Cape Town
December 2016

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Acknowledgements

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ABBREVIATIONS

CSA	Child sexual abuse
CYCW	Child and youth care worker
DSD	Department of Social Development
MDT	Multi-disciplinary team
NACCW	National Association of Child Care Workers
NPO	Non-profit organisation
PTSD	Post-traumatic stress disorder
SAPS	South African Policy Service
SDQ	Strengths and Difficulties Questionnaire

EXECUTIVE SUMMARY

Violence against children is widespread, and the impact of violence on children extends beyond the physical injuries and has lasting psychosocial consequences.

Child sexual abuse (CSA) is a pervasive problem affecting the health, social and psychological wellbeing of children globally, and affecting large numbers of children in South Africa. CSA has lasting impacts on the child, and has serious implications for the caregiver-child relationship as it can compromise the caregiver's capacity to parent effectively.

The Children's Act outlines government's obligations to prevent violence against children, protect child victims from further harm, and support and treat children who have experienced violence to restore them to physical and psychological wellbeing. Early access to therapeutic support for traumatised children helps mitigate negative effects such as violence and risky behaviour, depression, and anxiety and suicide.

A key challenge in South Africa is the severe shortage of social service and mental health professionals, particularly in rural areas. Little is known about current models of therapeutic care for CSA victims in South Africa, or their efficacy in facilitating psychological recovery.

This study assesses a local therapeutic programme for sexually abused children living in rural areas, to establish its impact and efficacy in the therapeutic management of sexual assault and to provide children with post-intervention care and support.

The National Association of Child Care Workers (NACCW) and Childline South Africa in collaboration with the Department of Social Development have developed a residential therapeutic programme for sexually abused children.

The programme is part of the Isibindi "Circles of Courage" model, which aims to develop a workforce of community-based child and youth care workers (CYCWs) to respond to the overwhelming needs of vulnerable children.

The programme is conceptualised as a short-term intensive, residential programme providing therapeutic intervention and follow-up support to sexually abused children.

The partnership's multi-disciplinary model combines the counselling and therapeutic skills of the Childline therapists with the social support and life-space care offered by the Isibindi CYCWs. The CYCWs are present before, during and after the residential programme, providing responsive child care and support, and modelling and mentoring to caregivers. The seven-day programme offers a unique approach to treatment, including individual and group-based sessions.

A 12-week aftercare programme is implemented by CYCWs to reinforce the therapeutic gains made during the programme. Social workers play a key role, especially to ensure the child's safety within the family and community. The residential therapeutic programmes in KwaZulu-Natal and the Eastern Cape were recently evaluated.

A sample of children participating in the programme (the intervention group) and those receiving usual, state-provided care (the comparison group) were followed over a 10-month period.

The findings identify some positive outcomes, as well as challenges and constraints of the programme.

Positive outcomes

Children in the Isibindi programme reported abuse earlier than those in the comparison group. This finding may point to the positive and supportive relationship and value that the CYCW brings within the life space of the child.

Many intervention group children and caregivers reported feeling supported and heard, and felt that their wellbeing had improved during and after the residential programme.

In addition, primary school children (7-12 years old) showed improvements in behaviour problems which may be due to the programme.

But the same improvements were not evident for adolescents participating in the programme, apart from a slight improvement in resilience outcomes.

These findings suggest that the residential programme, in its current format, may be better suited for younger children, who are more dependent on family support, than for adolescents. The valuable role of the CYCWs and their ability to build meaningful relationships within the family environment is key.

Critical challenges and constraints

While children showed some behavioural improvement, no significant change in post-traumatic and depressive symptoms was found that can be attributed to the intervention. It is therefore possible that the intervention, in its current design, is not sufficient to improve mental health outcomes. Several factors contributed to these outcomes for children participating in the evaluation.

1. Children exposed to continuous risk and multiple traumas

- Exposure to violence and trauma remained high within homes, schools and communities.
- The presence of the perpetrator compromised the safety of children in their homes and communities, and ongoing exposure to the perpetrator is a major deterrent to psychological recovery.
- Children were exposed to multiple traumas, and persistent fear and anxiety were common emotions expressed by children.

Children and their families experienced multiple incidents and forms of trauma, with ongoing exposure to trauma and "real" danger where perpetrators remained in the child's environment. This lends itself to the concept of *continuous traumatic stress* rather than PTSD (where the emphasis is on traumas that occurred in the past and where no real threat of present danger exists).[1]

2. Abuse by trusted persons is damaging

In South Africa, children are most at risk of sexual abuse by a person known to them, often occurring within their home or the home of someone trusted. When perpetrators are known to the child, which was a common theme in this study, it exacerbates the trauma and is likely to prolong the healing process.

These forms of sexual abuse may lead to *complex trauma*[2] when the interpersonal trauma is recurrent and perpetrated by a caregiver or someone close. The impacts were often severe and multifaceted.

3. Intergenerational trauma and compromised parenting

- Intergenerational trauma was evident, with caregivers experiencing re-traumatisation when their child was abused. The parent-child relationship was adversely affected in these cases, compromising the caregiver's ability to provide nurturing care and support.
- There was a higher turnover of caregivers over time for the intervention group, indicating that changes in care arrangements are common among particularly vulnera-

ble families.

- Low levels of caregiver nurturing and support, and several cases of harsh parenting were evident.

4. Inadequate social service response to trauma

Social service practitioners (in both the intervention and comparison group) provided limited therapeutic care and support to traumatised children and families. Social workers and CYCWs indicated several common challenges that hampered their delivery of quality services. These included:

- Limited knowledge and experience of how trauma effects child development, and how best to support traumatised children.

- Poor supervision and guidance, poor case management, and poor development of child protection plans were key concerns for social workers in the comparison group.

- Personal trauma – CYCWs particularly noted how their own experiences of trauma affected their capacity to support traumatised children.

Key recommendations

Effective services and support is essential to ensure that children and families benefit from available services, and to enable better mental health outcomes for children and families in South Africa.

Four primary recommendations should be prioritised to improve the impact of social services to traumatised children and their families:

1. *Ensure safe environments for sexually abused children*

Minimise children's continuous exposure to risk or harm, as it is detrimental to the psychological wellbeing of traumatised children and undermines therapeutic support.

2. *Review sexual abuse treatment and intervention responses*

Review the design, content and impact of existing therapeutic programmes in South Africa. Therapeutic approaches showing effectiveness in other low- and middle-income country (LMIC) contexts should be tested locally.

3. *Improve human resource capacity to respond to continuous and complex trauma*

Improve social service practitioners' capacity to identify and respond appropriately to continuous, complex and intergenerational trauma; and clarify roles and responsibilities for different cadres of practitioners.

4. *Implement community- and family-based responses*

Adopt a social-ecological approach and design therapeutic programmes that include caregivers, families and communities. This includes greater investment in effective family strengthening and parenting programmes.

1. INTRODUCTION

Violence against children is construed as a pervasive problem that affects large numbers of children in South Africa.[3] The *World Report on Violence Against Children* conceptualises children's experiences of violence as occurring across a variety of settings, including the home, school, care and justice systems, as well as in the wider community.[4] Children often experience violence across multiple settings, and the impact of violence extends beyond the physical injuries and visible scars to lasting psychosocial consequences.[5] Psychological consequences such as depression, anxiety disorders, substance abuse, suicidality as well as unwanted pregnancy are all associated with child victimisation for girls, while boys are at increased risk for externalising behaviour such as truanting, gang involvement and crime.[6]

CSA is considered to be a pervasive form of violence against children, yet the exact magnitude is unknown. The recent UBS Optimus Study produced the first national prevalence estimates on child maltreatment though a combination of a household and school-based survey, with the highest rates reported from the self-administered school-based sample. The findings from the school survey estimates that between 17% and 35% of children experience some form of sexual abuse; 21-35% of children report experiences of physical violence; and emotional abuse ranges between 16-26% and 12-15% experience neglect.[7] The household study, using a more representative sample, reports that a slightly lower but still concerning rate of 26% of children experience some form of sexual abuse. The study concludes, based on the school sample, that 42% of children report some form of maltreatment.[8] Routine data from South African Police Service (SAPS) crime reports shows that, for the 2012/2013 year, 22,781 children were victims of sexual offences, representing 44% of all reported sexual offences.[9] Other studies reveal that between 35 and 45% of children have witnessed violence against their mothers, and 15% have been neglected by drunken parents, thereby confirming that exposure of children to emotional violence and neglect is commonplace.[10]

Violence is intergenerational, and children exposed to violence in their early years are at risk of re-victimisation as they get older. Girls, in particular, are at risk of sexual assault and intimate partner violence, and it also impacts on their emotional availability as parents.[11] Boys have been shown to be at increased risk of becoming perpetrators of violence – especially rape and intimate partner violence – and are more likely to engage in risky behaviour within the community context.[12]

1.1 The South African child protection system

The South African government has an obligation to prevent violence against children, protect them from further harm if they have already been a victim, and to support and treat children who have experienced violence to try to restore them to physical and psychological wellbeing. The Children's Act of 2005 makes provision for this continuum of care and emphasises the need to strengthen prevention and early intervention services for children and their families, as well as therapeutic services to reduce the long-term impact of abuse. It designates government as the lead duty-bearer re-

sponsible for service delivery, by providing services itself or by ensuring that services are provided by other actors, such as the non-profit organisation (NPO) sector.

Every stage of the continuum of care is critical to ensure that all children have access to services that are responsive to their specific needs. Evidence suggests that few children who have experienced sexual abuse have access to adequate therapeutic support and intervention.[13] Anecdotal reports indicate that therapeutic services for abused children are insufficient to meet the demand, and due to the overloaded system, children are placed on lengthy waiting lists once they have been identified as in need of such services. Services are also predominantly located in urban centres, creating an additional barrier for children in rural areas. Frequently, only the most urgent cases are prioritised and attended to, resulting in many children not accessing the services they are entitled to receive. Children who require follow-up care after the initial "debriefing" are also likely to fall through the cracks.[14]

One of the primary challenges contributing to this context is a severe shortage of social service professionals, and the national Department of Social Development (DSD) has acknowledged that these shortages are affecting the adequate implementation of the Children's Act.[15] The government recognises social work as a scarce skill and large-scale plans are underway to increase the number of social workers.[16] For example, DSD-funded bursaries are offered to social work students and additional social development allocations from National Treasury are intended to employ these graduates.[17] However, many provinces find that the additional funds are inadequate to absorb the new graduates. In the Eastern Cape, the available 2014/15 funds were only sufficient to cover the costs of already employed social workers.[18] The province is subsequently unable to reach the national norm of one social worker to 3,000 clients. KwaZulu-

Natal faces a similar dilemma. In the 2013/14 financial year, 1,663 social workers were employed through public funds in the Eastern Cape, with slightly over 1,400 employed by the department, and the remaining 200 or so employed in the NGO sector.[19] Importantly, many of these professionals serve a range of vulnerable groups, not only children, and are likely to be involved in prevention, early intervention and statutory services, and perform administrative functions.[20] There are serious concerns about the foster care backlog[21] and the subsequent administrative burden placed on social workers. Anecdotally, these social workers are struggling to meet the demands of other cases.

1.2 A short-term therapeutic residential programme

The Isibindi model, developed by the National Association of Child Care Workers (NACCW), is an innovative programme that builds the capacity of CYCWs as part of the social services workforce to deliver community-based child and youth care services to create safe and caring communities and to better protect children. In response to the lack of therapeutic services for children from rural communities, where services are largely absent, a short-term therapeutic programme was developed by Childline South Africa and delivered in partnership between NACCW, Childline South Africa and the Department of Social Development. This therapeutic programme is delivered to children who have been sexually abused, providing an alternative to the usual model of care for children exposed to sexual abuse. Usual or standard care are viewed as the provision of psychosocial support services by the Department of Social Development or a designated child protection agency once a child has reported sexual abuse to the service.

This study is one of the first evaluations to explore the impact of the provision of therapeutic services for sexually-abused children in

South Africa, through the lens of a particular model of service provision – a short-term intensive residential programme.

Given that little is known about current models of care in South Africa or their efficacy in facilitating healing and psychological recovery of traumatised children, this evaluative study fills an important knowledge gap about service provision for CSA.

While an evaluation of the therapeutic residential programme had previously been conducted, it consisted of a small sample of 15 participants. This evaluation, using a sample of 80 participants, assesses the residential programme to establish its impact and efficacy in the therapeutic management of sexual assault and to provide children with post-intervention care and support.

2. AIM OF THE STUDY

The aim of this study is two-fold. Firstly, to conduct an impact evaluation of the therapeutic residential programme for sexually abused children as integrated into the Isibindi model.

Secondly, to develop recommendations to strengthen the child protection response of CYCWs, as determined by the findings of the outcomes of the evaluation, to strengthen the child protection response of the key implementing partners.

Through quantitative measures, our aim was to measure change in Post-Traumatic Stress Disorder (PTSD) symptomatology, behaviour and resilience, to assess psychological and behavioural adjustment in the sample of children over time.

Semi-structured interviews with CYCWs and social workers aimed to explore the implementation of the after-care plans and child protection plans respectively; and to understand how children and caregivers are coping with re-integration into the community.

Qualitative interviews were also conducted with caregivers to explore the felt impact of the intervention on caregivers and children, and to gain insight into the contextual factors that may affect child outcomes.

3. METHODS

This was a longitudinal study, with a quasi-experimental research design. A pre-post intervention design was conducted, using a baseline assessment prior to the residential programme, with two follow-up assessments after the child and caregiver had participated in the residential programme. Children and caregivers from both intervention and comparison groups were interviewed at each of the three assessment points, using quantitative and qualitative research instruments. Psychological and behavioural screening and diagnostic instruments were used to assess post-sexual-abuse recovery in children. Furthermore, the caregivers of the children were interviewed at the three intervals, using various instruments to assess improvement in parent-child interaction and parenting techniques. CYCWs were interviewed in instances where children had been placed in alternative care.

3.1 Study sites

Study participants were recruited from the Alfred Nzo, Chris Hani and OR Tambo rural districts in the Eastern Cape, as well as the Umkhanyakude and Amajuba rural districts in KwaZulu-Natal.

Table 1: Selected study sites

CATEGORIES	DISTRICTS				
	Umkhanyakude District (KZN)	Amajuba District (KZN)	Alfred Nzo District (EC)	OR Tambo District (EC)	Chris Hani District (EC)
Population size	643,760	514,977	828,711	1,961,815	804,765
Race (African)	98.8%	93%	99.1%	99%	93.4%
Unemployment rates	64.6%	26.5%	28%	29.8%	60.9%
Poverty rates (socioeconomic quintiles)[22]	Quintile 1	Quintile 3	Quintile 1	Quintile 1	Quintile 1
Gender (M/F)	46/54%	48/52%	46/54%	46/54%	47/53%

Sources: Trade and Investment KwaZulu Natal (n.d); Department of Cooperative Governance and Traditional Affairs (2011); Eastern Cape Socio Economic Consultative Council (2014); Massyn N, Peer N, Padarath A, Barron P, Day C; McCann, M (n.d.); Alfred Nzo District Municipality (2013)[23]

The **Alfred Nzo District** has poor socioeconomic conditions and low levels of development, with most the affected households located in rural areas. It is the poorest district and has the second lowest access to infrastructure in the Eastern Cape. The illiteracy rate is high and over 18% of the entire population are functionally illiterate. Most of the employment is within the informal sector. Infant mortality rates are high, there is poor access to social infrastructure, and a backlog in providing services and access to services. Less than half (43%) of its residents have access to household sanitation services, with 42% having access to potable water.[24]

The **Chris Hani District** is largely rural with a low rate of urbanisation. The district's largest employer is through community services. Most its residents live in poverty (77%) and 30% of households have a monthly income of between R201-R1,000, and 28% between R1,001-R2,500 per month. Slightly more than half (52%) of Chris Hani residents have access to basic sanitation services, while a much smaller percentage (18%) have access to piped water inside their homes.[25]

In the **OR Tambo District,** over 70% of its population is rural, with approximately 60% of the district's population living in poverty. While these rates are high, poverty rates have been steadily declining since 2005. Household numbers have increased at a faster rate than the population growth, increasing the demand for household basic services. One in ten (10%) of OR Tambo residents have access to flushing toilets or chemical toilets, with only 5% enjoying access to piped water inside their homes, and just over 5% have access to piped water in their yards.[26]

The **Umkhanyakude District** is mostly rural with only 0.4% rate of urbanisation. Eighty-three percent of the population live below the poverty line. The household access to infrastructure has, however, increased from 18% in 1996 to 44% in 2009, primarily due to better access to electricity infrastructure, as well as improvements in access to water and sanitation. Just over a quarter (26%) of Umkhanyakude District residents have access to sanitation below the basic level. In addition, 15% of households below the Reconstruction and Development Pro-

gramme (RDP) housing level and 46% above the RDP housing level have access to piped water.[27]

The **Amajuba District** is largely urban, with 60% of its households situated in urban areas; however, income levels in the district remain low. The Amajuba district has the second high-est access to infrastructure in the KwaZulu-Natal province. Half (50%) of Amajuba District residents have access to flushing toilets con-nected to sewerage systems, while 64% of resi-dents have access to piped water either inside their houses or in their yards.[28]

3.2 Study sample

The residential therapeutic programme was carried out over the June-July 2015 school holi-day period, and enrolled between 20 and 25 children per programme cycle. The CYCWs iden-tified child and caregiver dyads likely to attend each programme cycle and proceeded with re-cruitment into the study, per selection criteria as agreed with the research team. In addition, a comparison group was selected and matched, as far as possible, for age, sex, socioeconomic status, and district. Participants for this group were identified from the same district where Isibindi sites were located, or neighbouring dis-tricts that did not have an Isibindi site. They consisted of sexually-abused children who were provided with publicly available child protection services or "usual care" through local Depart-ments of Social Development. These standard services offer general psychosocial support ser-vices that may include home visits, counselling and psycho-educational support.[29] It is assumed that therapeutic intervention is likely to be on-going for this group of children and their care-givers (as opposed to the once-off intensive res-idential programme), and therefore change over time should be evident.
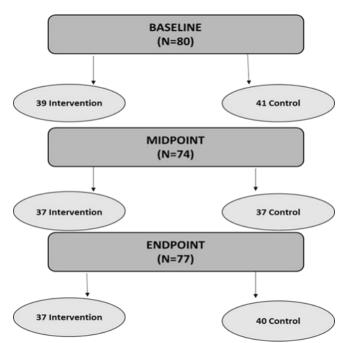
At the baseline assessment, 20 children and their caregivers were selected for the interven-tion group from KwaZulu-Natal, with 19 chil-dren and their caregivers from the Eastern Cape. In addition, 18 comparison group children and caregivers from Kwazulu-Natal, and 23 chil-dren and caregivers from the Eastern Cape were included in the first assessment. At the second assessment point (Midpoint), 74 chil-dren and their caregivers were interviewed. At the third and final assessment point (endpoint), 77 children and their caregivers were inter-viewed. The sample size at each assessment point is illustrated in diagram 1 on page 12.

Even though the Isibindi programme works with children as young as five years, for the pur-poses of this study, the sample included chil-dren aged 7-18 years only. This evaluation was designed to include children as participants; however, children younger than seven years would not be sufficiently mature to participate meaningfully. At midpoint, we found that some intervention families had moved or care ar-rangements had changed, for example 18 chil-dren (23%) were no longer in the care of the same caregiver as at baseline. It was challenging to trace families, especially when children and the original caregivers were separated. There are several reasons for attrition at midpoint. These include migration to different provinces, harsh weather conditions resulting in bridges and roads being washed away, thus preventing access to families, and unexpected family obli-gations.

However, concerted efforts were made, to-gether with Isibindi staff and social work man-agers, to ascertain the whereabouts of all par-ticipants and track them for inclusion at mid-point.

By endpoint, 44% of children in the interven-tion group had different caregivers, and two intervention group dyads who had relocated to different provinces remained untraceable. One comparison group dyad could not be reached as

Diagram 1: Sample sizes at baseline, midpoint and endpoint

torrential rains had made the gravel roads impassable at the time of the endpoint fieldwork.

3.2.1 Participant recruitment

Intervention study participants, with whom Isibindi CYCWs had regular contact and who had indicated interest in the research, were introduced to the fieldworkers. The fieldworkers then obtained consent and assent from the caregivers and children, respectively. Comparison group participants, identified through the state, were contacted telephonically to make an appointment for a briefing on the research and to obtain consent and assent. This contact appointment was done either at the local Social Development Office, or at the home of the child and caregiver.

3.2.2 Exclusion criteria

- Children with severe intellectual disabilities or behavioural disorders were excluded (this is a criterion for programme selection).
- Severely traumatised children were excluded.[30]
- Children who had been removed from their home prior to baseline.
- Children younger than seven years of age and older than 18 years of age at the time of recruitment were also excluded.

3.3 Data collection

Participants from the intervention group were interviewed at the Isibindi safeparks[31] within communities or at their homes.

Assistance was received from the Isibindi mentors in scheduling these interviews. Control group participants were interviewed either at the local Social Development Offices (DSD offices) in the community or at the participant's home. Assistance was received from selected social workers in scheduling interviews. The interviews conducted with children and their caregivers used a combination of quantitative and participatory qualitative methods.

The quantitative component used standardised screening tools to measure aspects of wellbeing in the child and caregiver, while qualitative data with children were collected through participatory activity-based approaches such as

the use of vignettes and narratives. Child interviews began with asking the child to draw a picture of a safe space (age dependent), thus allowing a discussion to ensue and the fieldworker to draw on the vignette to facilitate the interview questions. Qualitative information was also collected from caregivers. The fieldwork tools that were administered are a compilation of subscales from various standardised screening tools designed to measure severity of symptomatology, performance and psychosocial adjustment in terms of three specific domains. These include internalising (i.e., post-traumatic stress disorder and other emotional difficulties) and externalising (i.e., conduct and peer problems, and pro-social behaviours) factors, as well as resilience. See table 2 on page 14 for further details.

The following tools were employed. The child PTSD Checklist, a 28-item scale derived from the DSM-IV criteria uses a four-point likert scale. This checklist rates the presence in the past month of 17 symptoms required by Diagnostic and Statistical Manual of Mental Disorders (DSM)-IV for the diagnosis of PTSD.

The scale has been derived from the DSM-IV criteria, uses a four-point likert severity scale, was previously used in South Africa[32] and has been found to be diagnostically useful. Using the DSM-IV criteria for PTSD, the symptom clusters and their clinical cut-offs (1 re-experiencing, 3 avoidance and 2 hyper-arousal) are measured.

A conservative symptom threshold of 'most of the time' (measured as 2) was used for determining symptom presence (0 symptom not present, 1 present sometimes and 3 most severe).

The Strengths and Difficulties Questionnaire (SDQ)[33] is an internationally well-validated screening instrument for internal and external child behaviour problems. The SDQ has proven its effectiveness in the South African context, including in a recent study evaluating mental health problems in HIV/AIDS affected children.[34] The SDQ consists of 25 items relating to five hypothesised subscales: pro-social behaviour, hyperactivity, emotional problems, conduct problems and peer problems.[35] Higher mean scores predict poor functioning in these areas of assessment, except for pro-social behaviour.

The hyperactivity sub-scale was excluded from the SDQ as it was included in the PTSD Checklist. The caregivers of children between the ages of 7-12 years completed this questionnaire on behalf of their child, while this was a self-report questionnaire for adolescents aged 13-18 years.

The Child Depression Inventory (short-form) assesses the depressive symptoms of children and adolescents. It was a self-assessment, completed by all children and consists of 10 items.

The Connor-Davidson Resilience Scale for adolescents is a self-report scale comprised of 25 items, and was only completed by children older than 13 years of age.

The Alabama Parenting Questionnaire-9 is a nine-item shortened scale of the full Alabama Parenting Questionnaire (42 items), and measures three factors of parenting behaviour: positive parenting, inconsistent discipline and poor supervision.[36]

Midpoint assessment took place approximately four months post-programme attendance (October 2015), while the endpoint assessment was conducted approximately 9-10 months after the children and caregivers participated in the residential programme (March/April 2016).

Baseline qualitative questions were largely exploratory to determine impact of the sexual abuse on the child's behaviour and schooling, as well as caregiver's coping and the impact on parenting.

Questions at midpoint and endpoint assessments focussed on social and psychological improvements of the child after attending the residential programme. It also looked at the effects of the programme on specific themes, such as relationships with caregiver and family, as well as changes in school and peer relationships.

Semi-structured interviews were conducted with CYCWs (intervention group) and social workers (comparison group) at the midpoint assessment. Questions were framed on how the child has been coping, as well as on the child's psychological, behavioural and social adjustment. Inquiries were also made about implementation of the Child Protection Plans (social workers) and Follow-up Plans (CYCWs).

Table 2: Child and caregiver: research instruments and administration intervals

Outcomes: Psychological, social and behavioural	Children: age 7 to 12 years (*Intervention and comparison*)	Children: age 13 to 18 years (*Intervention and comparison*)	Caregiver	Administration at intervals
Post-traumatic stress	The Child PTSD Checklist	The Child PTSD Checklist	N/A	Baseline, midpoint and endpoint
Peer and conduct problems	*Caregiver to complete*: Peer and conduct problems subscales of the Strengths and Difficulties Questionnaire	Peer and conduct problems subscales of the Strengths and Difficulties Questionnaire	Peer and conduct problems subscales of the Strengths and Difficulties Questionnaire *(Parent report)*	Baseline, midpoint and endpoint
Pro-social behaviour	*Caregiver to complete*: Pro-social subscale of the Strengths and Difficulties Questionnaire	Pro-social subscale of the Strengths and Difficulties Questionnaire	Pro-social subscale of the Strengths and Difficulties Questionnaire *(Parent report)*	Baseline, midpoint and endpoint
Depression	The Child Depression Inventory *Caregiver to complete*: Emotional problems subscale of the Strengths and Difficulties Questionnaire	The Child Depression Inventory Emotional problems subscale of the Strengths and Difficulties Questionnaire	Emotional problems subscale of the Strengths and Difficulties Questionnaire *(Parent report)*	Baseline, midpoint and endpoint
Resilience	Semi-structured interview to probe coping and resilience	10-item Connor-Davidson Resilience Scale	N/A	Baseline, midpoint and endpoint
Parenting practices/ parent-child relationship	N/A	N/A	The Alabama Parenting Questionnaire - 9	Baseline, midpoint and endpoint

3.4 Data handling and analysis

All semi-structured interviews were recorded (using an audio recorder), transcribed and translated into English. Transcripts were inductively analysed through a process of coding and sub-coding. Initial codes were broadly related to interview questions. After broad codes had been established, thematic subcategories were developed. Subcategories were analysed as stand-alone categories, in addition to exploring and analysing the relationships between themes.

Raw quantitative data was captured into a Survey Monkey database, and after a thorough cleaning process data were exported into the STATA version 13 statistical package, used for the analysis. Initial descriptive analysis was conducted to explore the demographics of the control and intervention groups. Two-sample T-tests and Pearson's Correlation was conducted to determine any differences between the two groups. Demographic characteristics were assessed using frequency and descriptive statistics. Two-sample T-tests for correlated samples were used to explore the changes in mental health symptomatology, behaviour and parenting at the different assessments intervals, and to assess whether changes were significant, with significance level set at p <0.05.

3.5 Ethical considerations

The guidelines on ethical research involving children outlined by Childwatch International Research Network, the UNICEF Office of Research, the Centre for Children and Young People at Southern Cross University, and the Children's Issues Centre at the University of Otago guided this study.[37] In addition, the study is subject to the University of Cape Town's[38] standards for conducting ethical research and the code of conduct for conducting research with human subjects, to ensure the safety of the child participants and to prevent and protect participants from harm. Ethical clearance was obtained from the Faculty of Health Sciences' Ethics Committee in early 2015 (HREC REF 133/2015). For all study participants, participation in the study was voluntary, informed consent was obtained (and in the case of children, assent was obtained), and confidentiality was maintained.

4. DISCUSSION OF KEY FINDINGS

4.1 Demographic profile of the study participants

The study included both girls and boys aged 7-17 years at recruitment. Nevertheless, we recruited only three boys into the study, one in the comparison and two in the intervention group. While we acknowledged that both girl and boy children are sexually abused, reporting rates suggest that more girls than boys report sexual abuse.[39] As the study intended to interview children directly, the lower age limit of seven years was decided on as younger children, who are less verbal, would not be able to fully participate.

Table 3: Demographic profile of intervention and control group

	Comparison n= 41 (%)	Intervention n = 39 (%)	*p*-value
Age (years)			
<10	10 (24.4)	7 (18.0)	
10-14	18 (43.9)	19 (48.7)	0.776
15-17	13 (31.7)	13 (33.3)	
Primary Caregiver/s			
Parent/s	27 (65.9)	18 (46.2)	
Relative/s	5 (12.2)	5 (12.8)	0.293
Grandparent/s	8 (19.5)	14 (35.9)	
Unknown	1 (2.4)	2 (5.1)	
Is someone employed in the household			
Yes	18 (45.0)	17 (43.6)	
No	22 (55.0)	22 (56.4)	0.900
Receipt of a Social Grant			
Yes	34 (82.9)	29 (74.4)	
No	5 (12.2)	8 (20.5)	0.109
Unknown	2 (4.9)	2 (5.1)	
When did the abuse occur			
< 6 months	5 (12.2)	11 (28.2)	
6 months-1 year	4 (9.8)	1 (2.6)	0.134
> 1 year	32 (78.0)	27 (69.2)	
Who was the abuse first reported to			
CYCW	0 (0.0)	10 (25.6)	
DSD	8 (19.5)	8 (20.5)	
Health	0 (0.0)	2 (5.1)	
SAPS	22 (53.7)	14 (35.9)	0.004
SAPS & DSD	2 (4.9)	3 (7.7)	
SAPS & Health	5 (12.2)	2 (5.1)	
SAPS & Health & DSD	4 (9.8)	0 (0.0)	

Table 3 above describes the demographic characteristics of the sample by comparing the two groups. For each variable, *p*-values were computed by a chi square test for significant differences between the two groups, and a *p*-value of 0.05 and below would be considered a significant difference between the groups. Overall, none of the demographic variables showed a significant difference between the two groups at baseline, except who the abuse was reported to, indicating that the comparison and intervention groups can be considered to be similar. The age distribution shows no significant age difference between the comparison and intervention groups. The overall mean age of the sample was 12.4 years (CI 11.7 – 13.1

years), indicating that we had a larger proportion of older children in the study. The age distribution shows that 24% of the comparison group and 18% of the intervention group were under the age of 10 years, with between 75% (comparison) and 82% (intervention) of the sample above the age of 10 years.

Caregiver arrangements, although not significantly different between the two groups, shows that fewer children of the intervention group (43%) live with a parent or parents compared to two-thirds (66%) of the comparison children living with a parent/parents. A difference is also noted in the number of children living in the care of grandparents: over a third (36%) of the intervention group, compared to 20% of the comparison group, lived with a grandparent. Levels of poverty are similar in the two groups, with 45% (comparison group) compared to 44% of the intervention group having someone employed in the household. A non-significant difference in receipt of a grant was found, with slightly more children (83%) in the comparison group compared to 74% of the intervention group receiving a social grant.

When the abuse occurred shows that for most children the abuse occurred more than a year ago and, although not statistically significant, more than one-quarter (28%) of the intervention group compared to 12% of the comparison group reported the abuse within six months of the incident. We assume that the relationship with the CYCW is possibly facilitating earlier reporting in this group of children. This assumption is supported by the larger number of children reporting abuse in the Isibindi districts included in the study. To ensure we reached our required number of comparison dyads, we had to extend the number of districts we recruited from as the districts originally identified did not have sufficient numbers to meet our target. Disclosure of child sexual abuse is a complex process; research in South Africa shows that nearly half of the children presenting at a clinical setting failed to disclose the sexual abuse immediately, fearing caregivers' reactions.[40]

This study found that most children in the intervention group purposefully disclosed to someone close to them. It would appear that the CYCW working with the child in their life space fulfils this critical role. The process of disclosure is further influenced by multiple factors such as a fear of the caregiver's reaction and that they will not be believed, which is related to the caregiver-child relationship. Overall most cases were reported only to SAPS as a point of entry into the child protection system or in conjunction with other services such as DSD and/or health services. Nevertheless, there was a significant difference between the two groups in whom the cases were initially reported to. For the intervention group, the largest proportion of cases were reported to SAPS (36%), while just over a quarter (26%) of children felt comfortable reporting to a CYCW. This is important as it confirms the supportive role that the CYCW fulfils as an available, caring individual involved in children's life spaces.

4.2 Mental health effects and outcomes

Table 3 (page 18) shows the outcomes of the mental health self-reports at three intervals.

Depression was measured using the Kovacs's Children's Depression Inventory (CDI) short form. Each item has three responses with scores of 0 to 2 for a total composite score of 0 (not depressed) to 20 (very high risk of depression).

A cut-off of 8 was used for this study as this is equivalent to a standardised t-score of 62-66, which corresponds to identifying the upper 10% of the distribution in a non-clinical sample.[41] Using this measure, clinical depression was found to be present in 22% in the comparison group compared to 15% of the intervention group of children at baseline, with depression

Table 4: Self-reported Mental Health Assessment by intervention and comparison group

	Baseline N= 80		Midpoint N= 74		Endpoint N= 77	
	Control n=41	Intervention n=39	Control n= 37	Intervention n=37	Control n= 40	Intervention n=37
Depression Inventory						
<8	32 (78.0)	33 (84.6)	32 (86.5)	32 (86.5)	34 (85.0)	34 (91.9)
≥8	9 (22.0)	6 (15.4)	5 (13.5)	5 (13.5)	6 (15.0)	3 (8.1)
PTSD Mean Symptom Scores:						
- Re-experiencing (5)	2.2	2.7	1.6	1.9	1.7	1.4
- Avoidance (7)	2.3	2.1	1.9	2.1	1.9	2.1
- Hyper-arousal (5)	1.6	2.1	1.6	1.6	1.2	1.3
PTSD Diagnosis						
Full symptom	13 (31.7)	12 (30.8)	9 (24.3)	12 (32.4)	9 (22,5)	9 (24.3)
Partial Symptom	19 (46.3)	21 (53.8)	23 (62.1)	19 (51.4)	23 (57.5)	21 (56.8)

decreasing to 15% in the comparison and 8% in the intervention group. Using a t-test for two samples, this decrease was shown to be significant for both groups (*p* =0.07 comparison group vs p=0.08 intervention group). Although the decrease is slightly higher for the intervention than for the comparison group, the decrease in clinical depression was found not to be statistically significant between the two groups as the rate of decrease was similar.

This suggests that the change we are seeing is not due to the intervention or the support the intervention group has been receiving, but rather as the result of the normal pattern of recovery. Although the comparison group is receiving social work intervention, this usually does not include sufficient emotional support to effect a decrease in clinical depression.

Post-traumatic stress disorder was measured using the child PTSD Checklist.[42] Using the DSM-IV criteria for PTSD, the symptom clusters and their clinical cut-offs (1 re-experiencing, 3 avoidance and 2 hyper-arousal) were used to assess the presence of PTSD. A conservative symptom threshold of 'most of the time' was used. An assessment of PTSD can only be made if symptoms persist for a month after the trauma; if symptoms were present for less than a month, a diagnosis of Anxiety Stress Disorder can be made. All the baseline interviews were conducted more than a month after the sexual assault incident took place. Therefore, the PTSD measure could be used for the full sample.

At the baseline interview, nearly a third of children had full-symptom PTSD in both the intervention and comparison groups. Full-symptom PTSD decreased somewhat by endpoint, to 23% in the comparison group and 24% of children in the intervention group. A paired sample t-test showed that the difference in scores, although declining over time, was not significant for either the intervention (*p*=0.80) or the comparison group (*p*=0.77).

Of note, 46% of the comparison and 54% of the intervention group fulfilled the criteria for partial symptom, meaning that they were symptomatic in one of the three symptom clusters. This shows that overall approximately 80%

of children met the clinical criteria for either full symptom or partial symptom at baseline. At endpoint, 58% of children in the comparison group and 57% in the intervention group met the partial-symptom criteria, indicating that more than 80% of all children still met the criteria for either full- or partial-symptom PTSD, with no statistically significant difference between the two groups.

Alarmingly, we found that children showed a statistically significant increase in partial PTSD (p <0.000 control vs p< 0.001 intervention) between baseline and endpoint, albeit with a small increase for the intervention group.

4.2.1 Mental health adjustment

Most caregivers describe a great deal of flux in the lives of children immediately after the disclosure of sexual abuse. The abuse often involves someone close to the child and commonly occurs in the family context.[43] The narratives from caregivers and children describe situations where children are caught in the middle of family conflict, impacting on the child's mental health.

One mother describes:
"Her (the child) father's family disowned her because they said I was feeding her with lies and she fell for it. (The father) is walking free. We don't know how he won the case. We were only told the case was closed." Comparison, caregiver of 12-year old.

In addition, some families continue to protect perpetrators when they are a close relative. This can impact on children's safety and recovery post-sexual abuse. The continued presence of perpetrators has an effect on children's ability to recover post-disclosure as they continue to be fearful and are also at risk of continued abuse. A young girl from the comparison group (16 years old) said: *"it has been hard…because the perpetrator is free."*

Similarly a mother talking about her daughter said:

"The perpetrator is walking free, he got out on bail, but after three years there hasn't been any development on the case. I have been attending court but nothing ever happens. My child is traumatised because she saw this man and he blew his hooter at her, she was terrified…." Comparison, caregiver of 12-year old.

Perpetrators' continued presence increases the potential for trauma to be ongoing, thus having a negative effect on recovery.

A mother reports:
"I never leave Y with him (referring to the perpetrator). I take her with me everywhere I go. If I go to a funeral I leave her with the neighbour. I don't want to test him by leaving my child with him and have the same thing happen again." Comparison, caregiver of eight-year old.

This highlights the continued risk for many children when perpetrators live in the same household or community and are not arrested, thus compromising children's safety through criminal justice system failures and, frequently, families' collusion to protect perpetrators. The continued presence of perpetrators clearly impacts children's recovery. For any therapeutic intervention to be effective and to optimise the support provided through social support networks like the Isibindi CYCW programme, the physical safety of the child is paramount.[44] Therefore the safety of the child must be ensured if the programme hopes to have an effect on children's recovery post-sexual abuse.

Fearful behaviour and continuing to be "scared" of perpetrators were common, with such fears leading to anxiety for children. This was displayed through behaviour such as not wanting to play outside for younger children and difficulty in separating from caregivers. For some children this meant wanting to sleep with the caregiver at night. For others, bedwetting was described. The internalisation of the abuse can lead to more severe mental health outcomes for some children.

One mother reported:
"Things have become easier, but I am troubled by X, she does not talk when she is sad, I can see tears in

her eyes. I don't know if it is because of what happened or is she naturally like that. … One day a young child came and called me, saying that X is at home saying she wants to kill herself." Comparison, caregiver of 17-year old.

This was not the only child with suicidal tendencies. Another child was admitted to a psychiatric unit for an attempted suicide. Threats of suicide and withdrawal should be noted as risk factors not to be minimised and caregivers should be alerted to such risks.

Emotional support by caregivers is important for the mental health recovery of children post-sexual abuse.[45] The baseline interviews reflect caregivers who are concerned about the child's experience and struggle to understand the child's change in behaviour, but most caregivers describe attempts to be supportive and show an interest in the child's wellbeing. Caregivers were particularly concerned about children's display of anger and withdrawn behaviour and found such behaviour difficult to manage. The disclosure of sexual abuse provided many givers with some explanation for children's behaviour, as one caregiver described:

"I would scold and punish her if she gets naughty before hearing about this (referring to the rape) at the hospital. Now I have a better understanding of her behaviour and I no longer shout at her." Comparison, caregiver of 12-year old.

Most caregivers described behaviour as *"settling down"* or, as the above caregiver noted, "easier" by endpoint. With some children, it was as if caregivers could not deal with the continued reminder of the sexual abuse, and reported that by midpoint and endpoint that the child was *"ok",* despite signs of ongoing distress as present in the narratives. Levels of trauma are high in most communities in South Africa, and caregivers' own experiences of trauma and, in some instances, of sexual abuse and intimate partner violence, affect their ability to provide the emotional support to children to assist with recovery.[46]

One mother explained:
"Eish it is hard…. (pause) Sometimes I think of killing my children because of what happened to me, now it is happening to X (crying). I did not plan to have her. I lost both my parents and I was then abused. Now they (her children) are abused as well. What did I do to the Lord? (Silence, crying.) I even think about killing myself…" Intervention, caregiver of 13-year old.

Caregivers often experience negative emotional reactions to the disclosure of child sexual abuse, which could inhibit their ability to respond to the child appropriately. A traumatic incident can result in caregivers feeling overwhelmed, depressed and anxious, which can compromise their capacity to parent.[47] The intergenerational experience of trauma affects a caregiver's ability to manage and support their own child who has experienced sexual abuse. Children should therefore not be treated on their own, but caregivers should also be assessed to determine previous trauma. This should be considered when treatment plans are developed for children and families. Reactions of caregivers to the child's disclosure of sexual abuse is interconnected with their own experiences of trauma and the hurt this evokes, as described by one caregiver:

"We fight a lot and I end up saying bad things, like telling her that what happened to her (referring to the sexual abuse) was no accident, she wanted it as the perpetrator was her boyfriend. I regret saying those things to her but it is because of the hurt and pain I am feeling especially when she shuts me off, I can tell what I say hurts her too." Intervention, caregiver of 13-year old.

Similarly, another caregiver reported:
"I am better now (parent speaking about her mental health) but when she is not around I get very sick. I will go and look for her; I only get rest when she is at school ……I get headaches thinking about what had happened to her. This will not go away." Comparison, caregiver of 13-year old.

Children with less supportive families are found to be at increased risk for PTSD and dissociative symptoms.[48] In this family context of limited social support and high levels of unemployment and poverty, children were often silenced as families choose not to "talk" about the abuse, making healing difficult.

The concern is that untreated and unrecognised trauma can result in long-term negative mental health consequences[49] that our mental health services have limited capacity to manage effectively. Our current response to the trauma children and their families face are limited. Unless we consider the ongoing threat and danger most children continue to experience, as is the case with many children in this study, we cannot hope to make a substantial difference in children's journey to recovery.

Where danger is an inescapable part of children's daily lives, we must consider complex or continuous trauma as more appropriate ways to understand the nature of the trauma, which will thus influence our therapeutic approach to supporting recovery for children. [50]

4.3 Child behavioural and resilience outcomes

Table 5: Behavioural outcomes in the study sample

	YOUNGER CHILDREN (Parent Report)					
	BASELINE		ENDPOINT			
	Intervention n=21 Mean, (SD)	Comparison n=21 Mean, (SD)	Intervention n= 20 Mean, (SD)	Comparison n=20 Mean, (SD)	*p*-value t-test	
					Intervention	Control
Emotional problems total score	5.6(2.4)	5.2(3.1)	3.3(2.6)	4.6(2.1)	0.0042	0.4528
Conduct problems total score	4.1(2.7)	3.2(1.8)	1.6(1.6)	2.1(2.1)	0.0009	0.1266
Peer problems total score	3.7(2.4)	3(2.1)	1.4(1.8)	2.7(2.2)	0.0009	0.4679
Pro-social total score	7.8(2.4)	7.5(2.3)	8.5(1.4)	8.8(2.1)	0.2229	0.1638
	OLDER CHILDREN (Self Report)					
	BASELINE		ENDPOINT			
	Intervention n=18 Mean, (SD)	Comparison n=19 Mean, (SD)	Intervention n=18 Mean, (SD)	Comparison n=18 Mean, (SD)	*p*-value t-test	
					Intervention	Control
Emotional problems total score	5.7(3)	4.9(2.4)	4.4(3.1)	4.3(3)	0.2317	0.1797
Conduct problems total score	3(2.6)	2.8(2.1)	2.3(2.5)	2.5(2.3)	0.1697	0.5234
Peer problems total score	4.2(2.6)	3.5(2.4)	3.2(2.4)	3.7(2.7)	0.1814	0.9054
Pro-social total score	7.8(2.1)	6.6(2.3)	7.7(2.7)	6.8(3.2)	1.0	0.5888

The SDQ was completed by the caregiver for children 12 years and younger and as a self-assessment by children aged 13 years and older. The subscales measured were: emotional problems, conduct problems, peer problems and pro-social behaviour, and each area has a total score of 10.[51] Apart from the pro-social score, high scores indicate severe behavioural problems.

For younger children, at baseline there were no significant differences in the mean scores between the intervention and comparison groups in any subscale areas. However, we observe a significant decrease from baseline to endpoint for the intervention group in the mean symptom scores for emotional (p=0.0042), conduct (p <0.000) and peer problems (p < 0.000), while no significant difference (p=0.2229) was found for pro-social behaviour in this group.

No significant difference was noted in any of the sub-scale domains for the comparison group. This would suggest that the intervention had a positive effect on the child's behaviour in the areas of emotional, conduct and peer problems.

However, it should be noted that this data is based on parent reports; it is therefore possible that an element of bias may be skewing these results.

For adolescents, the baseline assessments show no significant difference in mean scores between the two groups for the sub-scale areas; emotional, conduct, peer problems or pro-social behaviour. Although we observed some reduction in mean symptom scores in all sub-scale areas from the baseline to endpoint assessments for both groups, this reduction was not statistically significant.

This indicates that although we observed some reduction in behavioural symptoms for the intervention group, we cannot state with certainty that the intervention had an effect on adolescents.

4.3.1 Understanding the behaviour of traumatised children

The qualitative interviews with primary care-givers provides a deeper understanding of children's behaviour. All children in the study come from poverty-stricken backgrounds and their exposure to trauma extends beyond the home. It is important to acknowledge that the socioeconomic context of children's lives influences their behavioural outcomes.

Research has shown that there is a relationship between low socioeconomic status and poor parenting, maternal involvement and interaction with children.[52] It is important to acknowledge this as we engage with the caregivers' perceptions and accounts of their children's behaviour and adjustment. In addition, we note that there is a wide age range of children and developmentally what is considered "normal" behaviour, particularly for adolescents, is critical to make sense of behaviour. Below are examples of caregivers' descriptions of their children's behaviour in relation to the sexual abuse incident.

A caregiver of a 16-year-old child (comparison) expressed that:
"She is changing a lot, she swears a lot. She was even taken out of the school. Her teacher said the incident disturbed her mentally."

Another caregiver highlighted the following about her child's behaviour:
"Her wellbeing is not … it's not what it was before because she has anger a lot now, she doesn't want to listen, she doesn't want to hear anything and she is so demanding, she demands everything she wants no matter if you tell her you can't afford it, she will not hear that. I have a grandson living with us. She fights with him like nobody's business. P is wrong but she doesn't care. So, this thing (CSA incident) *really did change her."* Comparison, caregiver of a 13-year old.

Further conduct problems are highlighted by another caregiver of her 11-year-old daughter (intervention):
"After what happened she became a very

cheeky child and talks back. She likes beating others and shouting at other kids. Her body makes her look like a 15-year old even though she is 11.

At baseline, most caregivers note a change in their children's behaviour since the sexual abuse incident, and this is visible in children's behaviour at home, their behaviour and performance at school and their interactions with their peers, siblings and household family members. Caregivers' reports describe intense anger, aggression and frustration from both younger and adolescent children.

It is well described that a supportive family environment encourages recovery post-sexual abuse and, conversely, an unresponsive home environment can intensify the impact of trauma.[53] For children this is most notable in behaviour changes in the home and in interactions with caregivers and siblings, followed by the school and community environments.

Some of the antisocial behaviour described above could be argued as being "normal" adolescent behaviour. Frick and Viding (2009)[54] note that children who show conduct problems at a younger age will usually exhibit this behaviour from the early years, with conduct problems steadily increasing into adolescence. Similarly, children who start showing conduct problems during adolescence are likely to exhibit anti-social behaviour throughout adolescence. In the context of this study, normal child behaviour difficulties coupled with multiple traumas within vulnerable contexts make caregiver assessments about child behaviour change (improvement or decline) somewhat difficult. Frick and Viding (2009) further indicate that anti-social behaviour within the different age groups are linked to contextual risk factors in relation to the developmental process.

4.3.2 Perceived changes in children's behaviour

At the midpoint and endpoint assessments, some caregiver reports suggest an improve-

ment in children's behaviour since the last assessment point. This was found for both the comparison and intervention groups. Many caregivers perceived "big" changes in children's behaviour; perceptions which were perhaps not aligned with reality. For example, a caregiver of a 12-year old (comparison) said:

"No, since your last visit I have seen a lot of changes because N is getting better; she's not that child she was before. I took them to their grandmother during the school holidays and the pictures in her head about the incident are starting to diminish and she's not that scared anymore like she was."

This was not found consistently, though, as some caregivers from the intervention group noted that there was no improvement in behaviour after the therapeutic programme. Several caregivers report the continued presence of "disobedient" behaviour. For example, a caregiver reported:

"Things are good because the child is coping at school but she is still stubborn, short tempered and violent too! But she likes advising others. At the same time, she gets easily upset and starts hitting real quick." Intervention, caregiver of a 15-year old.

Another caregiver highlighted the following about her 12-year-old child (intervention):

"I won't lie, there is no change (after the residential programme); reason being, T is a very stubborn child, she doesn't want to listen, she always wants to be pushed, she can't just do something on her own. She's a child who would cry when I teach her something. She doesn't want to do anything. There is no change in her."

"Talk" was a concept which arose from the midpoint qualitative data, with caregivers highlighting how their children appear more open to talking, communicate more effectively and engage better with the family and household. This observation could be based on caregivers' perceptions that children are healing or returning to "normalcy" over time. These shifts and assumed improvement in behaviour could be a result of children adjusting to the trauma,

whether through healthy or unhealthy coping mechanisms. These conduct shifts are exemplified in the below quotes from comparison group caregivers.

"No besides that, before she didn't like talking about the incident, but now she'll talk about it even if no one asked about it. She's a free-spirited child now. She even tells me that if anything reminds her of the incident at school she'd just go and play or talks with the other kids to avoid thinking about it." Comparison, caregiver of a 12-year old.

"Before I'd see her just sitting by herself not talking to anyone but now she talks and I told her that she should always tell me if there is something bothering or upsetting her." Comparison, caregiver of an 11-year old.

From the intervention group, there is also reported improvement in children's ability to talk and engage with others. The power of "talk" is often observed in terms of positive changes in the children. While verbalising could indeed be an indication of emotional healing, it should be noted that children could be sharing at a superficial level, and disclosing what they think others want to hear, while avoiding sharing meaningfully and truthfully. While children's ability to speak more freely could be viewed as positive, we should exercise some caution as this could be surface-level adjustments.

At endpoint there is reportedly continued improvement in behaviour. The caregiver of an 11-year old (comparison) noted the following about her child:
"She's now able to play with other children. Previously she'd just hit them; but now she's able to talk and play with children without hitting them."

Another caregiver noted:
"She used to be scared…You find out that she's even scared of other children at school. She used to have that but she doesn't have it anymore; before she used to be angry, if you talk to her she gets annoyed, but now I see she is a happy child." Comparison, caregiver of a 13-year old.

At endpoint, for the intervention group, many caregivers had positive things to say about their children's behaviour. An improvement in overall conduct in the home and with family, and willingness to do chores are noted often. As noted previously, improved behaviour is strongly linked to caregivers' ideas of the roles and duties children should be performing, rather than the child's psychosocial and mental wellbeing. Children's improved communication is also highlighted. The caregiver of an 11-year old (intervention) highlighted the following:
"I have seen change there, because she is now an open person now, she speaks about things now. Even when something happens she is able to say something happened. The behaviour that she had, she used to be a child that is always angry."

The caregiver of a seven-year old (intervention) highlighted the following:
"The change is that she is no longer the same, even at forgetting things, she is not forgetting things now. What I am saying is that this child she is no longer the same as before when she seemed like there is something bothering her. She used to forget, when you send her to take something she would not know what you have sent her for. Even when I am sick, she cooks. Even now I told her because it was said that you are going to go to our house. I told her to wake up and clean the floor with cow poo, she woke up and cleaned it."

4.3.3 Trauma-induced behaviour is persistent

The excerpt directly above points to some aspects of PTSD, which is discussed earlier in this report. Frightened, quiet and seemingly introspective and lethargic behaviour was noted several times by caregivers at endpoint. Behaviours such as persistent sleeping, not engaging socially and not communicating are latent signs of depression and PTSD. It is the child's way of saying that while they may not necessarily show overt suffering, they are not doing well and are possibly still struggling to adjust after a traumatic incident. Internalising the experience through withdrawn behaviour and lethargy is indicative of psychological difficulty, especially when these behaviours are out of the ordinary for an individual child. Bedwetting is another

example of how trauma impacts on the child's physical and mental wellbeing, long after the occurrence of the physical trauma. Perry (2003[55]) asserts that it is difficult for children to directly avoid reminders of incidents. Within the rural and impoverished contexts, where perpetrators are often family members or people in the community and are rarely prosecuted or imprisoned, this is a pertinent point. Perry (2003[56]) highlights that a child will withdraw into themselves in many ways so that there are fewer opportunities to be reminded of the traumatic event and, in so doing, avoid reoccurrence of the emotional pain. See excerpts below from three separate caregivers that showcase some of these behaviours.

"I have noticed that she gets frightened easily and sometimes she would just sit by herself out of nowhere. She likes sleeping a lot. She would come back from school and sleep. Sometimes we don't even talk." Intervention, caregiver of a 14-year old.

"It was the wetting of the clothes, while she was sleeping. It only happened during that time and it doesn't happen now. Also I have seen that she doesn't want to be around people all the time, sometimes she would just sit by herself and you will find her crying, she does that." Comparison, caregiver of a 10-year old.

"It's just that she wets the bed; every single day P would wet the bed. She wets the bed, she talks by

herself and she hallucinates. When I ask her, she'd say she was just dreaming. It's like she hallucinates then speaks to herself even when no one is in the room. When I ask her what's wrong she'd say nothing; she also breaks the dishes. She'd just freeze off and stare outside on our neighbours; that's where she's starts breaking the dishes because she'd lost attention of what she's doing." Comparison, caregiver of a 16-year old.

Bedwetting is highlighted more frequently at the midpoint and endpoint assessments. These qualitative results corroborate the statistical findings from the PTSD checklist (discussed earlier), that there is no substantial improvement in children's psychological wellbeing over time.

4.3.4 Resilience outcomes in adolescents

Most children included in this study faced various forms of adversity in addition to the sexual abuse they experienced. Childhood adversity encompasses a range of experiences such as neglect, abuse, orphaning, witnessing violence, and the death of a parent, amongst other experiences, and poses a threat to long-term psychosocial wellbeing.[57] Yet, not all children experience long-lasting harm after an adverse experience, and this adaptive response is proposed to be due to internal resilience. Resilience can be conceptualised as coping skills that support positive responses when faced with an adverse event.[58] Resilience is thus an important

Table 6: Resilience outcomes in 13-18-year olds

	Baseline N=38				Endpoint N=40			
	Control n=20 (%)		Intervention n=18 (%)		Control n=20 (%)		Intervention n=20 (%)	
Adolescents (13-18 yrs)	≤60 (Low)	>60 (High)	≤60 (Low)	>60 (High)	≤60 (Low)	>60 (High)	≤60 (Low)	>60 (High)
	12(60)	8(40)	13(72)	5(28)	15(75)	5(25)	11(55)	9(45)

factor that can facilitate children's healthy recovery from adverse experiences.

Resilience was measured using the 25-item CD-RISC assessment instrument developed by Connor and Davidson in 2003.[59] Using a likert scale of 0-4 for 25 items, the maximum resilience score possible is 100. A cut-off of 60 and greater was created to indicate high resilience, while scores below 60 are considered medium to low resilience. This assessment was only conducted with children aged 13 years and older as a self-assessment tool.

Table 6 (page 25) shows that, at baseline, 40% of adolescents from the comparison group showed high resilience compared to 28% of the intervention group. High resilience scores decreased to 25% for the comparison group by endpoint, but increased for the intervention group to 45%. A paired sample t-test shows that the increase in resilience scores from baseline to endpoint is significant for the intervention group (p = 0.0158). While the scores for high resilience decreased among the comparison group, this decrease was not significant. We should treat this finding with caution due to the small sample size, as we would need to confirm this finding in a larger sample. Resilience is an important element for a positive outcome for children when they face adversity, and is a

key outcome of interventions to reduce the impact of adverse events and build capacity.

4.4 Parenting support

Literature shows that caregivers of children who have been traumatised can themselves experience trauma due to the traumatic event that has happened to their child – their own responses can either enhance or hinder their child's recovery process.[60]

As the effect of abuse on children is likely to translate into behavioural and emotional difficulties, it is important for the caregivers of these children to receive assistance with understanding the effects of the trauma, behaviour management techniques, and with responding positively and consistently in a manner that supports and promotes the healing process.

Due to the child's safety and protection concerns, it is also useful for caregivers to be guided in relation to supervising and monitoring their children's activities.

The Isibindi-Childline residential programme includes a component of parenting support for the caregivers of the children re-

Table 7: Parenting outcomes by intervention and comparison group

	Baseline		Endpoint	
	Control N= 41 (%)	Intervention N = 39 (%)	Control N = 40 (%)	Intervention N = 37 (%)
Children (7-18 years)	**Unresponsive parenting**			
Positive Parenting	7 (17)	13 (33)	15 (38)	14 (38)
Poor Supervision	40 (98)	35 (90)	40 (100)	36 (97)
Inconsistent Discipline	34 (83)	35 (90)	34 (85)	35 (95)

ceiving therapeutic intervention. The caregivers of the children who participated in the July 2015 programme were therefore assessed, using the Alabama Parenting Questionnaire (short form), in three domains of parenting: their positive parenting skills (for example, praising the child when he/she behaves well); supervision and monitoring; and the consistent use of appropriate discipline techniques.

The caregivers available at the time of the children's interviews completed the assessments. This was not necessarily the same individual at each time point, and it was beyond the scope of the study to investigate why caregivers had changed. Not all caregivers attended the residential programme, and therefore did not receive the parenting intervention; in some instances, a caregiver attended the programme but a different caregiver was available for the interviews.

These methodological complexities mirror the social contexts of many children in South Africa, where care is provided by multiple caregivers, and frequent changes in caregiving relationships occur. In this study, only 46% of caregiver interviews were conducted with the same individual from baseline to endpoint for the intervention group. Due to these challenges, the findings on parenting behaviours must be treated with caution. However, the findings provide us with some insight into the relationship between care arrangements and the presence of a consistent, responsive caregiver.

The findings suggest that one-third of the caregivers interviewed were struggling to implement positive parenting practices, and that 90% were having difficulty supervising and consistently disciplining their children at baseline. Overall, the outcome assessment shows little improvement in parenting practices over time for both the comparison and intervention groups. In fact, the findings suggest that parenting practices had worsened between baseline and endpoint, for both groups.

4.4.1 Improvements in parenting practices

The qualitative interviews indicate post-programme improvements in some caregivers' parenting practices, due to an increased understanding of the impact of the trauma on the child's behaviour, and use of different discipline methods:

"She is a respectful child but sometimes she gets very agitated and irritated and I tell her, 'A you can't talk to me (like that), I'm your mother'. She gets like that even on her younger siblings at home. But being very educated on the matter by the programme I'm more understanding of the situation, I don't think the anger has completely worn off there is still a bit it inside her." Intervention, caregiver of 14-year old.

"Like I said she has those mistakes. Like when I leave for work and I'd tell her to do the chores around the house, but when I get back I find that she hasn't washed the dished then say I won't give you pocket money she'd quickly run and do the dishes." Intervention, caregiver of eight-year old.

4.4.2 Continued use of harmful parenting practices

Despite some indication of positive parenting behaviours at mid- and endpoint, there are accounts of caregivers who are struggling to respond appropriately to behaviours that they experience as challenging. Some caregivers continue to use harmful and inappropriate discipline techniques, as illustrated below:

"Besides not listening... she doesn't listen at all. If you say to her, 'P stop what you are doing', she would say, 'okay'. And she never forgets to ask for forgiveness, but she won't stop what she's doing. I am also forced to take a stick and beat her. In terms of respect, she respects (me), but sometimes she becomes naughty." Comparison, caregiver of eight-year old.

"She is a child who is listening, when you talk, she listens. She is not a stubborn child, she is a

good child. Even if you shout at her she doesn't have a long face… she would be quiet for a moment and after that she's alright." Comparison, caregiver of eight-year old.

"As I say, that you must also scare her, because I also scare her. My words to her was that, 'You see what you are doing, running after boys, even at school you walk with boys… because you don't go to school alone, you go with the little one', the one who is five years old. He would say, 'Mama, P plays with boys.' And this playing with boys now has appeared because as the schools are closed those boys sit here by my yard and call P outside the yard. I said, 'I will kill you with my hands if you go and play with those boys', and they would run away and never come back [the boys]." Comparison, caregiver of eight-year old.

"I found out, when she went out 'til late and came back with a woman from the neighbourhood… I remember shouting at her and I hit her. I don't want to lie, she's very respectful and she listens; one time I sat her down and I explained it to her that the reason for disciplining her in that harsh manner was because I don't want them going through the hardship I had experienced growing up." Intervention, caregiver of 14-year old.

While some caregivers have good intentions and desire to protect their children, as indicated in the above quote, the disciplinary methods used are harmful and, in some instances, abusive.

The data also suggests that caregivers lack insight into the effect of their parenting behaviours on their children, and have poor awareness of alternative forms of discipline.

4.4.3 Caregiver perceptions of child behaviour

Caregivers' perceptions of appropriate and expected behaviour influences their attitudes and interactions with their children, and their ability to parent effectively and supportively.

This tension is illustrated by this excerpt from an interview between an intervention caregiver (of a 12-year-old child) and a research assistant at endpoint:

Participant: I do not know if there is a problem [with] her, because the child, sister, is not changing, as I have told you that when I tell her to do house chores: wash dishes, clean the floor and so on, she hears but she does not do. Even the sister [inaudible speech] has been showing her but she does not change.

Interviewer: When did that start happening, was she like that before she got abused or she was like that after she was abused?

Participant: She was like that after being abused. She is still not fine, she listens well when you are talking but (does) not do anything…Initially, sister, if I said she must do something she would stand up and do it. I did not have to tell her what to do she used to do everything here in the house, clean the floor and so on. Now she only does something… if I tell her to do something I have to be there next to her and she will do it. If I leave she won't do it.

These findings point to the need to deepen interventions with caregivers in relation to their parenting skills and their level of understanding of the needs of their children.

In particular, the effects of the trauma on children's behaviour, attitudes and development should be better understood by caregivers to strengthen their capacity to support and nurture their children, which is essential for the healing process.[61]

In some instances, caregivers themselves had experienced trauma (see mental health section), which would impact on their perceptions of their child's trauma and on their ability to respond appropriately.

Such cases indicate the need for correct identification of these caregivers and for offering them the appropriate therapeutic support.

4.5 Social services and support

This study did not include specific measures to assess the extent and delivery of social services, counselling and other support received by participants. Key questions were, however, included in the qualitative interviews conducted with caregivers, as well as in the interviews conducted with selected child and youth care workers and social workers. While identifying and recruiting children for the comparison group, the DSD social workers originally assigned to a case were contacted to request their participation in the study; those who consented were subsequently interviewed telephonically. Similarly, CYCWs providing care to a child in the intervention group were also contacted, consent was obtained and telephonic interviews were conducted. A total of 19 interviews were conducted with CYCWs (10) and social workers (9).

The discussion below highlights the primary themes related to social services and support arising from the analysis of the qualitative interviews.

4.5.1 Caregiver experiences of the residential therapeutic programme

Some caregivers reported experiencing positive change, and expressed that they "felt better" because of their participation in the residential therapeutic programme.

Caregivers indicated that they felt emotionally supported, that they no longer felt isolated as they were now aware of others who had experienced similar traumas, and that the experience of sharing their story (and that of their child) had resulted in emotional release and the start of a healing process. Many caregivers also reported that their children received valuable support.

*"It was comforting to know that there are other people out there who have been what I've been through and that we weren't the only ones. It was also good seeing her (the child) transform and healing. I've seen her take out some of the books she got there (at the pro-*gramme) and start writing; she never tells me what she writes though. But she's doing very good seeing that she was always stressed, even mentally. You would have noticed (that) she was badly affected. There are many kids and their caregivers from our neighbourhood we saw there, people have really been keeping quiet about this thing." Intervention, caregiver of 15-year old.

Similarly, other caregivers reflecting on both their own and their children's experiences said: *"It helped me a lot in that I am not only healed, but my child is also healed emotionally and psychologically. The programme helped me a lot; it was eye opening."* Intervention, caregiver of 16-year old.

"I'd say the people there were able to counsel everyone who attended when you had a problem; both the caregiver and the child got helped." Intervention, caregiver of 13-year old.

"...I liked everything; I even got counselling myself because as a mother of these children I have never had a chance to talk (about) my feelings. I think that's one of the reasons why I'd told my kids that I wish the perpetrators could just die. So, with the advice and counselling I got from there (the programme) I don't have that feeling anymore." Intervention, caregiver of 15-year old.

"Even for me things are better, I'm healed emotionally, because I felt lost but we got so much help from the people there (at the programme)." Intervention, caregiver of 16-year old.

Although some caregivers expressed gratitude for participating in the programme and the emotional support they received over the week, this intense support was not sustained in the long term.

Most families did not have continued contact with a therapist or a community-based social worker, with the only continued support provided by the CYCW.

4.5.2 Challenges experienced by social services

4.5.2 Challenges experienced by social services practitioners

The section below discusses the challenges experienced by social workers (comparison group) and CYCWs (intervention group). It should be noted that there is a vast difference in the level of training between social workers and CYCWs. Social workers graduate with a minimum of a four-year university degree and usually have some clinical training and practical experience in counselling. Social workers involved with this study were designated child protection social workers, and should be skilled in risk assessment and safety planning based on the Children's Act regulations. CYCWs obtain a Further Education Training Certificate in Child and Youth Care Work (FETC: CYCW) after completing 14 unit standards, usually delivered in modular form.[62] Some CYCWs participating in the study were learner CYCWs undergoing practical training while completing their modules, and were therefore not yet fully qualified.

Capacity limitations:

In several instances, social service practitioners expressed their frustration because they felt inadequate to engage with cases of sexual abuse. They expressed difficulty with both younger and older children and struggled particularly to communicate with and build rapport with a child who had experienced sexual abuse. These comments were mostly made about children under the age of 10 years, or older adolescents.

a)   Social workers

A great deal of emphasis is placed on the child "telling and retelling" the incident, a practice known as debriefing, which has been considered for many decades to be therapeutic. However, evidence indicates that debriefing is not effective for reducing post-traumatic stress, and should in fact no longer be a compulsory

treatment for trauma survivors. For many children, talking about the sexual abuse incident is not easy and happens most comfortably within a relationship of trust. In some instances, children in the study were not verbally expressive and social workers blamed the children for not being able to communicate what happened to them. For example:

"I enjoy working with a child who's able to speak out, because some of them, they do not speak. Ya, I enjoy dealing with a child who can speak, yes. Because A was very young and she had no clue what happened to her. That's why the case was referred...."

"Like the child who's not speaking, it's very hard to work with a person like that. Because I ask them a question – "what happened?" and the child just shut up the mouth, and you are trying to provide services..." Comparison, social worker, seven-year-old child.

The application of child-centred approaches based on the developmental and other needs of children was not evident in many social workers' practice. The limited contact most social workers had with children also meant relationships between the social worker and the child remained formative, providing limited opportunities for therapeutic engagement. Social workers did not seem able to address the impact of the trauma on the child and family, and although a few of them showed awareness of the impact during the interviews, it was not given priority. This is most likely due to the lack of long-term contact with children and their families, and prioritising the immediate needs of children experiencing trauma, thus working within a crisis intervention model.

a)   Child and youth care workers
Some CYCWs experienced similar challenges in responding to children and youth who were not verbally expressive.

"When I (first) met S, I don't know how to help, how to answer, but now I can. And what was challenging

is, it's a youth now (referring to the child). Sometimes they don't want to share anything with me, but he's getting used to me now. I don't know, maybe because I'm a female, I don't know." Intervention, child and youth care worker, 18-year-old child.

In some instances, the qualitative data points to missed opportunities for child and youth care workers to offer sensitive responses to children experiencing trauma. See this excerpt below as an example:

Interviewee: Ya, X was angry with what happened to her so I sat down with her and I told her "what happened to you, it's not your…" eh um, what do I say…

Interviewer: It's not your fault?

Interviewee: It's not your fault but it happens, but you must remain calm and you're going through you and me dealing with this situation, so if you let me help you to look after yourself, stay home, do the right thing, this thing is going to go right. Child and youth care worker, 18-year-old child.

While the above CYCW tried to provide reassurance and guidance, this response is not necessarily providing the appropriate support to a child experiencing trauma. The CYCW is not acknowledging the teenager's anger and pain and is instead encouraging her to be calm. She is also perhaps communicating false hope by noting that if the teenager does the "right thing", that this will result in a positive outcome.

Similarly, the qualitative interviews also highlighted CYCWs' limited skills and experience with engaging with trauma and its effects on child behaviour and development.

For example, some CYCWs indicated that the concerned child no longer talks about the incident, and interpreted this to mean that the child is making progress. As described in earlier parts of the report, caregivers similarly concluded that a child was making progress if they no

longer mentioned the incident. While no longer talking about the incident may seem positive, it is important to consider the child's progress holistically; for example, participating in risky behaviour is a likely sign that the trauma has not been addressed.

The narrative of the child below illustrates limited understanding of how to respond to trauma. Even though the child had run away from home and school after her return from the programme, the CYCW is under the impression that this child has recovered:
"Now she's doing fine 'cause, she's staying at home with her mother, she's helping her mother and ya. And I was doing some activities with her to make her forget about what happened to her and she always told me she want to go back to Durban, she misses Durban so much… No, she's not showing anger because we don't talk about it now, about what happened. We do some activities with her. I think she's helped now, she's okay." Child and youth care worker, 18-year-old child.

The above extract could, of course, also reflect the CYCWs eagerness to report that the child in her care is making progress.

It is also possible that the eagerness to help children "forget" is not conducive to recovery post-trauma.

While it is not within the ambit of CYCWs' responsibilities to provide therapeutic support, it is however important for CYCWs to: understand trauma-induced behaviours; identify signs of healthy (and unhealthy) recovery; offer appropriate and sensitive responses within their daily interactions with the child; and discuss concerns and signs of distress with the Isibindi mentors, prior to making referrals where appropriate.

While it is understandable that it can be challenging when children are non-verbal, both social workers and CYCWs had similar capacity limitations to deliver support services to children experiencing trauma.

For young children in particular, they are not likely to have the verbal ability to adequately express themselves, and are likely trying to make sense of what had happened to them. Practitioners therefore need to be employing child-centred techniques to assist children to comfortably express themselves at their own pace and level of development. Aside from the developmental considerations, children who have experienced trauma are likely to have difficulty to verbally recall or describe the incident. Building a relationship of trust is particularly important for children who have been violated by adults, and this is likely to require more than one contact session with the child. This data illustrates that social service practitioners have limited capacity to support children experiencing trauma.

Practitioners' own experiences of trauma:

In a few instances, CYCW noted that working with children who are traumatised evokes feelings and memories of trauma they themselves have experienced. One CYCW shared that her own traumatic experiences posed a challenge to engaging with the child at a deeper level.
"Most of the time, there's feelings coming back that you never thought would come back, so it is a bit challenging....In the child protection programme, it's like, you can't work with the child when having to deal with your own feelings. As CYCWs they also give us someone who is actually going to give us like therapy, so it becomes very hard because from then onwards you have to reveal your own pain in order for you to be able to work with the child...In a way, they are very helpful (CYCW support sessions offered during the residential programme). For me, I think it was very helpful for me because my past was very hard growing up, challenges that I had to face before I reached where I was, and family issues. So, once I've taken it out in the child protection (programme) that I had in April, after coming back from the child protection programme I think there was a release in

my pain, so I was able to work more with children. Eventually when they show me their pain, I'm like... I can deal with this pain. Not like when they're showing pain, then I'm also feeling that sadness. I do feel that sadness but I'm a bigger person now, the child can rely on me." Child and youth care worker, 14-year-old child.

Although social workers did not discuss their own experiences of trauma, with the high levels of trauma present in South Africa, one would expect similar experiences among social workers. However, the superficial level of engagement with traumatised children might offer some protection from vicarious trauma.

Poor supervision and guidance:

a)   Social workers

Prompting practitioners about their experience of supervision and support was challenging, as this line of questioning was often met with resistance, especially from social workers. We found that a few social workers needed reassurance that the interviews were being conducted confidentially, as they appeared afraid of disclosing information that might jeopardise their positions. However, one social worker disclosed to the researcher and noted that:
"Okay but you know what, I honestly, I honestly do feel we...because it's not only the case load but you know um.....I feel...okay we do have a co-ordinator in the office for child care and protection but they don't know what to do. I feel...okay although cases are different, you understand, but I do feel that...because the first thing we have to do is remove the child from the place, we just do it according to our discretion. I feel if we knew, even if, ya, if we knew what to do...when to do it...you understand. You know sometimes you feel that, you know...I should be doing more...but what is that 'more', you understand."

She talks further about the lack of guidance from supervisors:
"We could make a plan to (get) that guidance.

But maybe it's because, eh, our supervisor was-n't there. Because we've got acting (supervisors)... sometimes they're just like us, at our level. So sometimes they consult, they know they... we're at the same level, really, you understand." Social worker, 13-year-old child.

b) Child and youth care workers

The research did not reveal much about the supervision and mentorship of CYCWs. Few shared their experiences, but where it was discussed, CYCW narratives suggested that perhaps they were not sufficiently discussing their concerns or challenges with their mentors and supervisors.

In one instance, the CYCW noted that the child no longer wanted to live in the community. The CYCW did not have clarity on why the child wanted to leave the area, but assumed it was because of the sexual abuse incident that had taken place in the community.

She was also not certain about the whereabouts of the perpetrator; the child might have been at risk. However, this was not identified as a serious issue during the interview. She asked the researcher whether there might be an alternative place of stay for the child, but had not discussed the situation with her mentor (18-year-old child).

In another case, a CYCW had been unable to attend the residential programme. However, once the child concerned had returned home, she was tasked with implementing the follow-up activities with the child. She noted that this task was challenging for her, and that she did not feel equipped to perform this task. However, she had not discussed her uncertainty with her mentor.

"Oh, the activities that we are doing we talk about our feelings, the session that we are do-ing, it is a pity that I was not there (at the resi-dential programme). The lady that went to child protection they (gave me) brief feedback, we don't even have the guidelines book for the workshop done, the follow-up. So, she was just

giving us a brief of what we should have done, so that's what I was doing with L...The only thing that was so challenging was I was not there, I was only doing that thing because I was told we had to do the follow-up, we didn't even have any guidelines..." Child and youth care worker, 11-year-old child.

CYCWs are at the coalface of dealing with traumatised children and families, and are sometimes the only support for children and families experiencing trauma. The CYCW/ mentor relationship is thus critical for providing CYCWs with the necessary guidance and support, given the limited training some CYCW's have, whilst being expected to offer ongoing support to children recovering from trauma.

Case management and workload concerns:

a) Social workers

In several interviews with social workers, it was evident that cases are referred for management to colleagues within respective departments, and movement of cases between social workers was common. The reasons for referrals are varied. However, in some instances, it hindered progress with the case and had several negative implications, particularly as continuity is essential for developing a relationship of trust as part of the therapeutic process. For example, some social workers we interviewed knew very little about the case and could not respond to requests for basic information about a child and family. In a few instances, the social workers said they were not the case managers but also could not identify who the current case managers were. There was also evidence of infrequent contact with the concerned child and family.

A few social workers spoke of the challenges they were experiencing with managing child protection cases, noting, for example, their lack of adequate training on child protection case management.

"...its stuff like case load, not being given enough training on, on... okay, we did study.

We did study at university, obviously but...if you don't get trained, you don't get trained on exactly what do we do. You use your discretion, you do what's best for the child..." Comparison, social worker, 13-year-old child.

The lack of specialised training to manage child abuse and trauma impacts service delivery, as one social worker admitted:

"...You are a social worker who needs to do everything, you know, concerning child protection but I think [pause] we've gotten a whole lot of these cases... it's not given all the attention it should be given...Because things (cases) are not seen as well, but we do prioritise... I just think the monitoring – you find that monitoring works on the month (a monthly basis), you know. It should not be like that, it should really depend on the case, on, you know, on each case. How often should you be visiting a child, and all that." Comparison, social worker, 13-year-old child.

b)   Child and youth care workers

High caseloads were not exclusive to social workers, but was also raised as a concern by CYCWs. The CYCWs spoke of their very long working days, as they needed to visit a set number of families per week. Although some CYCWs had responsibility for a small number of families (for example, eight families), depending on the needs of the family they would be visited three or more times per week. The distance between families, especially in rural communities, is a key consideration as this adds to the time CYCWs spend on the road.

Child protection and follow-up plans:

a)   Social workers

A few social workers noted that they had developed a child protection plan for the child concerned. While it is positive that a plan had been drafted, plans did not seem to be detailed, and often excluded services to the family. It is very concerning, given that the Children's Act requires that social workers rendering child pro-

tection services should develop child protection plans, that some social workers did not have a child protection plan. In one instance, a social worker was not familiar with the term *child protection plan*, as indicated in the excerpt below:

Interviewer*: Did you ever construct a child protection plan for X?*

Interviewee*: Protection plan? Like what?*
Interviewer: The protection plan is something where you have a list of different tasks that you would like to carry out as part of your services to the child. So, were there any tasks that you wanted to do with X, to eh, assist with her recovery?

Interviewee*: I haven't done something* like this (background noise).

Interviewer*: Excuse me? Please say that again.*

Interviewee*: I said I provided social work services only, I have not done something like that.*
     - Social worker, seven-year-old child.

b)   Child and youth care workers

For the Isibindi-Childline residential programme, follow-up services are an essential element to ensuring the safety of children and ongoing emotional support. A follow-up plan for each child is developed jointly by the multidisciplinary team at the end of each residential programme, and usually stipulates actions for different members of the team, to ensure the child's safety, support and re-integration into the family and community.

This follows a case conferencing model, and district social workers, who bear the primary responsibility for facilitating children's protection, are especially invited to participate in the joint planning sessions. However, social workers do not always attend, making communication about the follow-up plan and eliciting co-operation to implement the plan extremely difficult. CYCWs shared that at a local level they

often struggle to contact social workers to report new information or to follow up on services meant to be delivered, and experience defensiveness and hostility when they engage with social workers about services not yet carried out. Under these circumstances, implementation of the follow-up plans is particularly challenging.

While a multi-disciplinary approach is ideal, if one partner within the team is not contributing to the task at hand, it is very challenging to hold them accountable. The dynamics between stakeholders are likely to be difficult when junior or less experienced practitioners are trying to ensure that practitioners with higher qualifications, especially when they are government officials, are fulfilling their roles. It may therefore be necessary to consider new approaches to team case management that have built-in accountability measures or systems.

5. CONCLUSIONS & RECOMMENDATIONS

The key findings emanating from this study are summarised below.

5.1   Mental health outcomes

The intervention group children showed earlier disclosure of sexual abuse than the comparison group, with about a quarter making their first report to CYCWs. This finding may point to the positive and supportive relationship and value that the CYCW brings within the life space of the child. Many intervention group children and caregivers reported feeling supported and heard, and felt that their wellbeing had improved, during and after the residential programme.

However, this study did not show a statistically significant improvement in PTSD symptomatology over time, indicating that the intervention is not sufficient to improve posttraumatic and mental health symptoms. The nature of the trauma that children and families are experiencing is complex, continuous and occurs in multiple forms. Risk of exposure to violence and trauma remains high, particularly as perpetrators remain at large. Fear and anxiety were common emotions expressed by children. The compromised safety of children in their homes and communities, and exposure to the perpetrator are major deterrents to postabuse recovery. Many caregivers' responses were harsh and inappropriate; some caregivers blamed their children for the abuse, or beat them, after disclosure. Trauma is often intergenerational, with caregivers experiencing retraumatisation when their child encounters trauma. The parent-child relationship is greatly impacted in these cases, with the caregiver's

ability to provide nurturing care and support compromised.

5.2 Behavioural and resilience outcomes

Only younger children (aged 7-12 years) in the intervention group showed statistically significant reductions over time in problem behaviour (conduct, peer and emotional problems), which is encouraging. The improvement over time could potentially be attributed to the intervention, which combines the residential programme and the follow-up support provided by CYCWs. However, this finding must be balanced with the fact that the SDQ for this age group is based on parent reports, which is likely to be biased. The pattern is different for adolescents: for most subscales, decreases over time are evident for both groups. However, the differences over time are not statistically significant: we therefore cannot say with certainty that the intervention has had an impact on behaviour for this age group. On the other hand, resilience scores for adolescents in the intervention group only show a significant increase over time. However, the sample size is very small, and this finding must therefore be treated with caution. This finding may be suggesting that the intervention has a positive effect on resilience outcomes for adolescents.

The findings may be suggesting that the intervention (the residential programme with the follow-up CYCW support) is better suited for younger children than for adolescents. However, this needs further exploration and confirmation because of the relatively small sample size. The valuable role of the CYCW in building a positive, caring relationship within the family environment is critical. Developmentally, younger children are generally more receptive and are more dependent on family relationships and family context and are therefore more likely to embrace the CYCW, while adolescents place greater value on peer relationships and contexts external to the family. It is also likely that the adolescents are exposed to longer-term trauma and that unhealthy coping mechanisms are more entrenched.

5.3 Parenting support outcomes

The sample of caregivers for both groups participating in the study showed poor parenting skills and behaviours at baseline. In particular, inconsistent discipline and poor supervision scores ranged from 83% to 100%. By endpoint, the scores did not show any improvement. A significant challenge in understanding the data for the intervention group is that, in most cases, the caregivers interviewed over time were not the same individual, indicating that there are often multiple caregivers involved in children's lives, and that families are in a state of flux.

The large proportion of caregivers indicating poor parenting scores is of great concern. In addition, caregiver responses from the qualitative data indicate high levels of harmful, authoritarian parenting, and several abusive interactions. This has significant implications for traumatised children in need of nurturing, responsive caregiving, which is essential to facilitate a healthy recovery process.

5.4 Social services and support

Caregivers attending the residential programme reported that they received support, information and counselling while attending the programme, and often experienced an emotional release that facilitated their own healing. These sentiments were commonly expressed during the caregiver interviews; however, these effects do not appear to be sustained in the long term as caregiver practices did not show improvement.

Social service practitioners indicated several common challenges that hampered their delivery of quality services. These include capacity limitations, such as lack of skills and understanding in how to engage with a traumatised child; and understanding children's developmental needs. Practitioners, particularly CYCWs, also noted that they had their own experiences of trauma, which affected their capacity to support traumatised children. Poor supervision and guidance were another concern, particularly for social workers serving the

comparison group. Social workers noted that they often did not receive guidance and support when needing to make critical decisions about a child's safety. There were several case management concerns, including high caseloads, mismanaged or frequent referrals between social workers, and poor training. Child protection plans were not being developed or were poorly developed, as was the case in most instances for the comparison group. Well-documented follow-up plans were in place for all children in the Isibindi programme. However, CYCWs noted that implementation of these plans was often challenging.

5.5 Key recommendations

This study assessed the outcomes of the Isibindi-Childline residential therapeutic programme, and the child protection services delivered for the comparison group, by the provincial Departments of Social Development. Since several role-players are involved, the recommendations outlined here will address the implications for practice for each role-player as appropriate, drawing on the findings of the study.

The set of recommendations, drawing on a socio-ecological approach, are focussed on four core areas to facilitate improved delivery of social services to children experiencing trauma. These are:

1. Ensuring safe environments for sexually abused children.

2. Reviewing sexual abuse treatment and intervention responses.

3. Improving social service practitioners' capacity to respond to continuous and complex trauma.

4. Implementing community-and family-based responses.

5.5.1 State policy-makers and decision-makers

The South African Constitution provides children with the right to be free from violence, and Section 28 (1)(d) affords children the right to be protected from further harm and to be supported and treated when they have experienced abuse. As such, government officials, policy-makers and decision-makers are key duty-bearers for the realisation of these rights and have an obligation to ensure the provision of services that respond to children's best interests.

1 Ensure safe environments for sexually abused children

Continuous exposure to risk or harm is detrimental to the psychological wellbeing of traumatised children and undermines the provision of therapeutic support. In many cases, perpetrators are not held accountable and continue to pose a threat to children's safety. This is due to failures of the criminal justice system, which often leads to secondary victimisation and undermines children's right to protection. The criminal justice system and child protection system must be strengthened to facilitate the incarceration of perpetrators within a reasonable time frame. The State has an obligation to ensure a functioning criminal justice system that aims to arrest, convict, sentence and rehabilitate perpetrators of violence against children. The Judicial Matters Amendment Act of 2016 makes provision for the establishment of specialised sexual offences courts. The implementation of these provisions will go a long way to reducing secondary victimisation, and ensuring that all children have access to such courts will improve criminal justice outcomes and ensure better protection for children.

2 Review sexual abuse treatment and intervention responses

Given the widespread occurrence of child sexual violation in South Africa (about 1 in 4 children based on the UBS Optimus Study household survey[64]), traumatised children are entitled to access quality therapeutic support in a timely manner. In particular, Section 28 (1)(d) of the South African Constitution notes the State's obligation to support and treat children who have experienced violence so as to restore

them to physical and psychological health.

The availability of services should match the high level of need. This study indicates that children receiving therapeutic support through the Isibindi-Childline residential programme and those receiving services from the Department of Social Development are not demonstrating sufficient mental health recovery for long-term, healthy adjustment. A key factor impacting on the outcomes of these services is the complex, multi-layered and continuous nature of the trauma that children and families experience. In addition, the intergenerational nature of trauma exacerbated levels of caregiver and child trauma and made caregiver-child interpersonal relations more complex. These service responses were not appropriate to adequately address these forms of trauma; it is likely that a consistent and sustained response would be more effective.

Since this was a relatively small study, we therefore recommend that further efforts are made to review existing models of therapeutic services available in the country. It is critical to revisit the design and content of existing programmes to assess their suitability to address complex and continuous trauma. The provision of evidence based therapeutic services are urgently needed, as well as considering models of therapeutic services proving to be effective in other low-resource contexts. It is essential to strengthen current therapeutic models to ensure better long-term outcomes for children, and support the development of evidence-based models of therapeutic services that are effective and appropriate for our context.

3 Improve social service practitioners' capacity to respond to complex and continuous trauma

A critical finding from this study is that social services practitioners serving both the comparison and intervention groups had limited skills to support children experiencing complex and continuous trauma. The study has highlighted the need to improve the capacity of practitioners to understand, identify and respond sensitively to complex, continuous and inter-

generational trauma. While it is critical that all role-players play a role in identification and response, it will be essential to clarify specific roles and responsibilities for different cadres of practitioners to ensure that the necessary services are implemented in a collaborative and coordinated fashion. The use of para-professionals to deliver mental health programmes is showing potential in low-income settings,[65] and should be explored in the South African context to address human resource constraints in under-resourced communities.

The qualitative interviews with social workers revealed the need for further training, support and guidance to develop competence in the management of child sexual abuse cases. The question arising is, whether social workers should develop a specialisation in child protection, including understanding and performing appropriate risk assessments; assessing and facilitating the participation of the family and community context; and developing expertise in child trauma and appropriate therapeutic responses more specifically.

4 Implement community- and family-based responses

The study findings show that trauma is often embedded in a complex social context, and in several cases highlighted by this study, family or community members had some involvement in the sexual abuse incident. In some cases, perpetrators were protected by, or were in fact, family members. In addition, levels of violence and exposure to trauma and risk in communities and families remain high. This implies that an important shift in focus is needed from only providing therapeutic support to traumatised children, to directing responses to caregivers, families and communities. The qualitative interviews with caregivers revealed the caregiver's own experiences of trauma and the need to address intergenerational trauma for a caregiver to be in a position to support the child effectively.

Parenting outcomes show the need to strengthen support services to caregivers, and

to specifically focus on improving parenting behaviours in caregivers of both younger and older children. This study's results indicate that caregivers performed poorly on all the responsive parenting domains, although they received parenting support during and, in a limited capacity, after the residential programme. While the quantitative data must be viewed with caution as the same caregiver did not consistently participate in the interviews, the qualitative data reveals concerning accounts of harsh and abusive responses to traumatised children and inappropriate expectations and discipline practices. Harsh parenting is likely to undermine the recovery process for traumatised children, and perpetuates negative child behaviours.[66]

Caregiver support and interventions that promote responsive parenting are recognised as a valuable contribution to family strengthening.[67] While the reality of children being cared for by multiple caregivers is common in South Africa, parenting programmes are showing promise for improving parenting skills and reducing risky behaviours in children and parents.[68] There is a growing evidence base that points to positive outcomes of parenting interventions implemented in LMIC contexts,[69] and especially for the use of multiple delivery vehicles, including home-visiting and integration with health services, for example. The skills gained through parenting interventions are often transferred to other adults within the family; it is also important to target the primary caregiver or parental figure and to gain family support for the programme.[70] This study highlights the need to identify appropriate family strengthening and parenting interventions that are best suited to the care arrangements and social contexts of most families in South Africa.

5.5.2 The Isibindi programme implementers

1. Ensure safe environments for sexually-abused children

To enable children to receive maximum benefit from the residential therapeutic programme as it is currently conceptualised, it is recommended that risk assessment processes are strengthened and conducted prior to children entering the programme. The development of a simple risk-assessment tool might be needed, especially if CYCWs are required to conduct these assessments as the first point of contact for children in communities. A safety plan should be developed as an outcome for each risk assessment to outline the actions needed to protect children from further harm. Ideally, risk assessments should be conducted by a multi-disciplinary team (MDT). It might be possible for CYCWs to administer the tool, while social workers or specialists interpret the information and initiate further action. Legal experts, such as Legal Resources Centre staff, could be brought in to the MDT to offer legal advice and support, in local areas where this is feasible, to assist in securing positive criminal justice outcomes.

Assessment of risk should particularly consider whether children are safe or unsafe within their home environments. Where children are considered to be at risk of ongoing sexual abuse, after following the necessary protocols, such as referring to a social worker, the CYCW should work with the family to ensure the physical safety of the child.

Considering the study's findings, it is necessary to distinguish between children who are safe, where the perpetrator is no longer a threat and the risk of continued abuse is minimal, and children who are unsafe and at continued risk. The findings suggest that a different programmatic approach is needed for unsafe children, where the emphasis should be on developing a protective, nurturing and loving caregiver-child relationship whilst fast-tracking the protection of the child.

Identification, referrals and support services

A basket or cluster of effective programmatic responses will be beneficial to 'catch' children through a range of possible entry points. This approach can assist with identifying children who have experienced CSA and referring them timeously. Such a package of services can be flexible in terms of the composition of the

teams, and in relation to individual and local contexts. Exploring the use of different professionals, and students, such as psychology masters' students, would be valuable in terms of accessing skilled practitioners who can provide therapeutic support in different contexts and methodologies, e.g., community-based therapeutic groups for caregivers experiencing trauma. It would be useful to pilot this type of approach in local contexts where there are signs of effectiveness.

2 Review sexual abuse treatment and intervention responses

The treatment and therapeutic intervention is the domain of Childline South Africa. The Isibindi team will engage with Childline regarding the study's findings and discuss the possibilities for programmatic changes.

3 Improve social service practitioners' capacity to respond to complex and continuous trauma

The study has highlighted key areas for the capacity development of CYCW that would enhance their response to children experiencing trauma. Similar to the development of a disability-focussed CYCW, it is possible to develop an auxiliary CYCW with a specialisation in child protection. Such a CYCW would be skilled to perform a range of tasks, including identifying and assessing traumatised children; conducting appropriate referrals; networking, identifying and using resources optimally; and offering an appropriate level of therapeutic support to children experiencing trauma. Level six training for such CYCWs would be preferable.

Isibindi CYCWs should also receive basic upskilling in the area of child and family trauma. It would be extremely valuable for CYCWs to recognise the signs of trauma, including intergenerational issues, to raise awareness of the presence of trauma in families and make the necessary referrals. Identifying children and adolescents in emotional distress is critical.

The study has also drawn attention to the need to improve responses and support for ad-

olescents. It would be important to strengthen CYCWs' capacity for behaviour management, and their understanding of the effects of trauma on behaviour, particularly during adolescence.

Capacity would also need to be developed in the area of caregiver support and improving the child-caregiver relationship. Isibindi is partnering with the Sinovuyo Teen programme in the Eastern Cape, and the programmatic theory, principles and methods could be extrapolated to influence Isibindi CYCW practice more generally.

4 Implement community- and family-based responses

The Isibindi team plays a strong role in community development and supporting children and families within the context of the community. Strengthening this supportive and educational role to promote the creation of safe environments for children is critical, in terms of prevention of the first-time occurrence of CSA and the prevention of ongoing abuse. This can be achieved through strengthening current community-based activities, such as the Safe Parks programme.

Integrating a gender-based approach to community engagement will be most valuable for shifting community perceptions and patriarchal norms. This would be important to assist with the development of a culture of understanding children's rights, valuing and respecting children's voices and contributions within families and communities.

A stronger focus on caregiver support and parenting practices is necessary to develop positive parenting skills and nurturing, and empathic responses to children that would combat harsh discipline, especially when children have experienced trauma.

Such an approach can be developed within the current family strengthening activities that Isibindi CYCWs provide. The existing partnership with the Sinovuyo programme has potential as a foundation for expanding this area of work.

5.5.3 Childline South Africa programme implementers

Review sexual abuse treatment and intervention responses

The study indicates that the residential therapeutic programme has a limited effect, and it is not showing a positive effect on mental health outcomes, nor on behavioural outcomes of older children. As such, we recommend a review of the current therapeutic component, to ensure that sufficient attention is given to treating complex and continuous trauma and to enable long-term, healthy child outcomes.

Within the review process, it will be necessary to consider whether the programme goals are appropriate given the limited duration of the programme, and other constraints.

A shift in emphasis is needed to offer structured caregiver support, particularly for children who live in unsafe environments. Literature shows that providing effective caregiver support, and imparting the necessary knowledge and skills to the caregiver, is critical to create an enabling and nurturing environment that facilitates recovery in traumatised children.[71]

The component of caregiver support is an integral part of Trauma-Focussed Cognitive Behavioural Therapy (TF-CBT) when used to treat children experiencing ongoing trauma.[72] This type of intervention should be considered and piloted in South Africa.

It is also likely that the therapeutic intervention delivered during the residential programme will produce improved benefits if a structured, regular, post-programme intervention is added to the existing programme. Specific attention should be given to the delivery of the programme to adolescents, to enable improved long-term outcomes. For example, continued adolescent support could take the form of regular, facilitated therapeutic support groups in local areas.

Finally, this study was conceptualised and implemented as an outcomes assessment, with a focus on whether the residential therapeutic programme is showing effectiveness in supporting children's psychosocial recovery post-sexual abuse. It therefore did not assess or compare the different elements of the programme and post-programme activities, or assess the contributions of the respective stakeholders involved in implementing the programme.

While the qualitative data gives some insight into the complexities and challenges with service delivery, it is insufficient to draw clear conclusions about the roles of stakeholders contributing to the programme.

A process evaluation is a possible next step, which would provide a clear focus on the programme's operations, implementation and service delivery, and the interrelatedness between the different components of the programme. ∎

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An outcome assessment of a residential care programme for sexually-abused children in South Africa