

**CHILDLINE'S COUNSELLING SERVICES
FOR SURVIVORS OF CHILD SEXUAL
ABUSE IN ZIMBABWE: A DESCRIPTIVE
STUDY**

by

JULLIET MASAMA

Submitted in accordance with the requirements for

the degree of

MASTER OF ARTS

in Psychology

at the

University of South Africa

Supervisor: Mr Khuze G. Skosana


August 2014

DECLARATION

I declare that

Childline's counselling services for survivors of child sexual abuse in Zimbabwe: A descriptive study

is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.



01 AUGUST 2014

.....
SIGNATURE

.....
DATE

J. MASAMA

Student number: 42955963

DEDICATIONS

This research study is dedicated to my husband, Jan Van Ongevalle, and our three children, Bram Tawana, Tine Lana and Yara Tamuda. I also dedicate it to my parents, Austin K. Masama and Esther Masama.

Thank you all for being there for me every time I needed you. You have offered me the support, strength and encouragement I needed during the difficult periods of the execution of this study.

Jan, you provided me with a shoulder to lean on.

ACKNOWLEDGEMENTS

Without the help, support and encouragement of a number of people, this dissertation would not have been completed. I have gone through difficult times during the course of this study but I remained guided and energised to consider the importance of finishing it. I am very grateful for having accomplished this study, which enlightened me regarding the experiences of children and families affected by child sexual abuse and the types of services which child survivors of sexual abuse need. I would therefore like to extend my sincere gratitude to the following people:

My supervisor – Mr K. G. Skosana, you have been my pillar of support. You provided me with knowledge. Your guidance in this study is well appreciated. Without it, I would not have acquired such a big step in my life. Throughout the study period, you emphasised to me the need to continue studying. You gave me advice and wisdom to become who I am today.

My family – Jan, you helped me in many ways. You advised and linked me to different literature sources. You took care of our three children, Bram Tawana, Tine Lana and our last child Yara Tamuda who was born while I pursued this study. You gave me the space to study and I sacrificed a lot of our family life. Thank you for your love and support.

My parents – Austin and Esther Masama and my siblings, some of you were my role models. You provided me with emotional support and encouraged me when I felt very low. Now you can all witness my achievements. Lastly, my late grandmother, you have been so supportive, I wish you could have witnessed my accomplishments. May your soul rest in eternal peace.

Childline staff members – for the assistance and support you gave me. With special thank you to the counsellors/social workers who were willing to share with me their work experiences. You inducted me into the organisation and I learnt a lot from you. Thank you all for the good work you are doing for the innocent children survivors of child sexual abuse in Zimbabwe. Tara, you were so supportive, as a director of Childline Zimbabwe, you gave me the space to study. You allowed me to come to you to discuss my study. You shared your expertise, advised and encouraged me to do this study. Thank you to my counselling supervisors, Dr Jonathan Brakarsh and Dr Dickson Chibanda, you guided me in the preliminary stages of this study. Through your valuable input, I acquired the necessary steps to commence this study.

All the research participants – it was your voluntary participation that made this study a success. My sincere gratitude goes to all the child survivors of child sexual abuse and their caregivers for their support and effort. It was amazing that you were all willing to share your personal, sensitive and emotional information with me throughout this study. I thank you for the trust you put in me. You are heroes and heroines for you are the very few survivors who had the opportunity to contribute your traumatic experiences in an effort to help the suppressed millions of child survivors to come up and express their rights.

----- To all of you -----

Thank you very much

SEXUAL MOLESTATION OF BOY CHILDREN

Daryn is 9 years old. Mukai is 10 years old. The two boys are cousins. Daryn's mother is sister to Mukai's father. Ever since they were toddlers, the two boys have been taken care of by their grandparents (Mr and Mrs Magotcha) who lived in a low-density suburb of Harare. The two boys grew up together with their grandparents and both boys are maternal orphans.

Jairos was a tenant at the Magotch's house and lived in a smaller cottage built on the premises. Jairos was a member of the Apostolic Faith religious sect. He mostly lived alone in Harare since his two wives stayed in his rural home doing subsistence farming.

Daryn and Mukai had known Jairos ever since they came to live with their grandparents.

The grandparents regarded Jairos as their own son since he had stayed with them for a very long time. The boys would also occasionally bring food to Jairos' cottage where they would remain for a while watching TV then bringing the plates back to their grandmother after Jairos had finished eating.

Jairos started asking the children to come to his cottage on regular basis. Together they would watch TV while they all smoked marijuana. After each drug use Jairos would engage the two boys in sexual activity (sodomy).

Jairos also showed the boys a big knife that he kept under his bed. He told Daryn and Mukai that he would cut off their heads if they ever disclosed their sexual involvement with him.

Jairos sometimes gave the boys a little bit of money for buying sweets after school. The children were abused for several times but they thought it was normal to do that.

When Jairos visited his rural home for a few weeks, the boys engaged in sexual acts with each other. Due to the children's rampant mischief that included stealing, being absent from school and being stubborn at home and at school, the grandparents questioned them but the boys would just keep quiet.

After some time of increasing mischief, the grandmother beat them up heavily one day and that was the time when they disclosed that they were sexually abused by Jairos.

(Daryn and Mukai, Childline Zimbabwe clients, 13 March 2009).

ABSTRACT

This study explored Childline Zimbabwe's provision of psychosocial support to sexually abused children. This was done by reviewing counsellors' practices regarding face-to-face counselling, counselling approaches, referrals, follow-ups, case recording and through measuring client satisfaction levels.

A qualitative case study approach was adopted with mixed methods to collect data from counsellors and clients. Data analysis was informed by grounded theory and followed an inductive process of coding and categorising the data into relevant themes. The outcomes of this study showed that referral of clients represents a major strategy of addressing child sexual abuse cases. The engagement of clients in face-to-face counselling stages however remained limited due to difficult work environments and challenges related to individual counsellors' capacities. This posed questions about Childline's role as a counselling or referral organisation.

This study contributes to counselling of sexually abused children with information over the counselling interventions necessary in addressing survivors of sexual abuse.

KEY WORDS: child, child sexual abuse (CSA), Childline Zimbabwe, counselling and counselling services

TABLE OF CONTENTS

<i>Declaration</i>	<i>i</i>
<i>Dedication</i>	<i>ii</i>
<i>Acknowledgements</i>	<i>iii</i>
<i>Abstract</i>	<i>vi</i>
<i>Table of contents</i>	<i>vii</i>
<i>List of tables</i>	<i>xiii</i>
<i>List of figures</i>	<i>xiv</i>
<i>List of appendices</i>	<i>xv</i>
<i>Abbreviations and acronyms</i>	<i>xvi</i>

CHAPTER 1

CHILD SEXUAL ABUSE – AN INTRODUCTION	1
1.1 INTRODUCTION.....	1
1.2 DEFINITION OF CONCEPTS.....	3
1.2.1 Child.....	3
1.2.2 Child sexual abuse (CSA).....	3
1.2.3 Childline Zimbabwe.....	3
1.2.4 Counselling/counselling services.....	3
1.3 CHILD SEXUAL ABUSE: AN OVERVIEW.....	4
1.4 BACKGROUND TO THE SERVICES PROVIDED BY CHILDLINE ZIMBABWE.....	9
1.5 BACKGROUND TO THE STUDY.....	11
1.6 STATEMENT OF THE RESEARCH PROBLEM.....	12
1.7 RESEARCH QUESTIONS.....	13
1.8 AIMS OF THE STUDY.....	13
1.9 RATIONALE/SIGNIFICANCE OF THE STUDY.....	13
1.10 THE RESEARCH DESIGN.....	14
1.11 THE OUTLINE OF THE STUDY.....	14
1.12 CONCLUSION.....	15

CHAPTER 2

THEORIES, TYPES, CAUSES, AND EFFECTS OF CHILD SEXUAL ABUSE	17
2.1 INTRODUCTION.....	17
2.2 THEORETICAL APPROACHES OF CHILD SEXUAL ABUSE.....	17
2.2.1 Biological approach.....	18
2.2.2 Cognitive – behavioural approach.....	19

2.2.3	Behavioural approach	21
2.2.4	Psychodynamic approach	24
2.2.5	Systems (family) approach	28
2.2.6	Multifactorial theories	31
2.3	TYPES OF CHILD SEXUAL ABUSE.....	37
2.3.1	Rape	37
2.3.2	Incest	38
2.3.3	Sodomy and indecent assault	39
2.3.4	Statutory rape and abduction	41
2.3.5	Child pornography.....	42
2.3.6	Exhibitionism, voyeurism, oral sex and forced masturbation.....	43
2.4	FACTORS CONTRIBUTING TO CHILD SEXUAL ABUSE	44
2.4.1	Social factors.....	44
	2.4.1.1 <i>Unemployment and poverty</i>	44
	2.4.1.2 <i>The acceptance of violence in society</i>	45
	2.4.1.3 <i>Social and geographical isolation</i>	45
	2.4.1.4 <i>Unequal gender relations</i>	46
2.4.2	Individual factors	47
	2.4.2.1 <i>Substance abuse and mental retardation</i>	47
	2.4.2.2 <i>Disability</i>	48
	2.4.2.3 <i>Age and stage of development</i>	48
	2.4.2.4 <i>Children born out of extra marital affairs</i>	49
2.4.3	Family factors.....	50
	2.4.3.1 <i>Overcrowding</i>	50
	2.4.3.2 <i>Step-children</i>	50
	2.4.3.3 <i>Marital problems</i>	51
	2.4.3.4 <i>Second marriages</i>	51
	2.4.3.5 <i>Divorce</i>	52
2.4.4	Cultural factors	53
	2.4.4.1 <i>Early traditional marriages</i>	53
	2.4.4.2 <i>Sibale</i>	54
	2.4.4.3 <i>Ritual sexual abuse</i>	54
	2.4.4.4 <i>Child sex rings</i>	55
	2.4.4.5 <i>Excessive discipline and respect for adults</i>	56
2.5	THE EFFECTS OF CHILD SEXUAL ABUSE	57
2.5.1	Psychological effects of child sexual abuse	57
2.5.2	Emotional effects of child sexual abuse.....	58
2.5.3	Physical effects of child sexual abuse	58

2.5.4	Behavioural effects of child sexual abuse	59
2.5.5	Social effects of child sexual abuse	59
2.6	CONCLUSION	60

CHAPTER 3

	COUNSELLING SEXUALLY ABUSED CHILDREN	62
3.1	INTRODUCTION	62
3.2	THERAPY FOR SEXUALLY ABUSED CHILDREN	63
3.2.1	Initial assessment phase	65
3.2.2	Therapy for the child.....	65
3.2.3	Review of therapeutic outcomes.....	65
3.3	COUNSELLING THERAPIES FOR SEXUALLY ABUSED CHILDREN	66
3.3.1	Gestalt therapy.....	66
3.3.2	Group therapy	67
	3.3.2.1 <i>Qualities and attributes of group therapists.....</i>	<i>70</i>
3.3.3	Play therapy	71
	3.3.3.1 <i>Play therapy strategies.....</i>	<i>72</i>
	3.3.3.2 <i>Stages in the play therapy process.....</i>	<i>74</i>
	3.3.3.3 <i>Play therapy room and its materials.....</i>	<i>77</i>
3.3.4	Symbolic representation	77
3.3.5	Cognitive behavioural play therapy (CBPT)	78
3.4	COUNSELLING TECHNIQUES	80
3.4.1	Allowing the child to explore	80
3.4.2	The use of silence	80
3.4.3	The use of positive verbal encouragers	81
3.4.4	Focusing	82
3.4.5	Open-ended questions	83
3.4.6	Assessment.....	83
3.4.7	Termination	84
3.5	THE COUNSELLOR'S ROLES IN COUNSELLING	85
3.6	COUNSELLING PROCESS AND STAGES	87
3.6.1	Delaney (2009) counselling process and stages	89
3.6.2	Family support trust (FST) counselling model.....	90
	3.6.2.1 <i>Joining.....</i>	<i>90</i>
	3.6.2.2 <i>Defining the problem(s).....</i>	<i>90</i>
	3.6.2.3 <i>Widening the view of the problem.....</i>	<i>91</i>
	3.6.2.4 <i>Solutions.....</i>	<i>91</i>
3.7	ETHICAL STANDARDS IN COUNSELLING	92

3.7.1	Confidentiality.....	93
3.7.2	Informed consent	94
3.7.3	Voluntary participation.....	95
3.8	CHILDLINE ZIMBABWE TREATMENT TEAM: THE HOLISTIC APPROACH.....	95
3.8.1	Working with communities.....	98
3.8.2	Advocacy work.....	98
3.9	CONCLUSION.....	99

CHAPTER 4

RESEARCH METHODOLOGY.....100

4.1	INTRODUCTION	100
4.2	QUALITATIVE RESEARCH DESIGN – CASE STUDY	100
4.3	AIMS OF THE STUDY.....	103
4.4	SAMPLE	103
4.4.1	Sampling criteria	105
4.4.2	Sampling procedure	105
4.5	DATA COLLECTION TECHNIQUES – MIXED METHODS APPROACH.....	106
4.5.1	Semi-structured interviews	107
4.5.2	8-item satisfaction scale questionnaire (ISSQ)	107
4.5.3	Document analysis.....	109
	4.5.3.1 Case reports.....	109
	4.5.3.2 General statistics for child sexual abuse cases	110
4.5.4	Participant observation.....	110
4.6	PROCESS OF DATA ANALYSIS.....	111
4.7	RESEARCH CONTEXT	113
4.8	RELIABILITY AND VALIDITY	115
4.9	ETHICAL CONSIDERATIONS.....	116
4.9.1	Informed consent and voluntary participation	117
4.9.2	Confidentiality.....	117
4.9.3	Psychological and physical harm.....	118
4.9.4	Professional codes of conduct.....	118
4.10	CONCLUSION.....	119

CHAPTER 5

THE PRESENTATION OF THE RESEARCH RESULTS.....121

5.1	INTRODUCTION	121
5.2	THEME 1: THE COUNSELLING PROCESS.....	122
5.2.1	The counsellor’s goals of counselling.....	123

5.2.2	Satisfaction of counsellors by the counselling aspects	125
5.2.3	Termination of counselling relationships.....	127
5.3	THEME 2: THE REPORTING OF CHILD SEXUAL ABUSE CASES.....	128
5.4	THEME 3: REFERRAL OF CASES	131
5.4.1	The treatment team	131
5.4.2	Childline Zimbabwe referral criterion	132
5.4.3	The roles of each stakeholder and the problems with collaboration.....	133
5.5	THEME 4: THE COUNSELLING APPROACHES	139
5.5.1	Counselling approaches.....	139
5.5.2	Counselling techniques	143
5.6	THEME 5: THE FOLLOW UP OF CHILDREN'S CASES	147
5.6.1	Counsellor challenges during follow up	149
5.7	THEME 6: THE RECORDING OF INFORMATION ON CASE REPORTS.....	151
5.7.1	The genogram.....	153
5.8	THEME 7: COUNSELLING SERVICES RECEIVED	154
5.8.1	The effects of Childline Zimbabwe interventions on children clients	154
5.8.2	Satisfaction of clients.....	155
	5.8.2.1 <i>The counselling process</i>	156
	5.8.2.2 <i>The services offered</i>	156
	5.8.2.3 <i>Confidentiality of sessions</i>	159
5.9	CONCLUSION.....	160

CHAPTER 6

	CONCLUSIONS AND RECOMMENDATIONS	161
6.1	INTRODUCTION	161
6.2	COMPREHENSIVE CONCLUSIONS OF THE RESEARCH	162
6.2.1	The counselling process and its stages	162
	6.2.1.1 <i>Building counsellor–child client relationships</i>	162
	6.2.1.2 <i>Collection of background information</i>	164
	6.2.1.3 <i>Provision of psychosocial support: the actual counselling</i>	167
	6.2.1.4 <i>Termination of counselling relationships</i>	171
6.2.2	Referral	173
6.2.3	Factors influencing counsellors' work	175
	6.2.3.1 <i>Individual capacity for counsellors</i>	176
	6.2.3.2 <i>Organisational situation</i>	177
	6.2.3.3 <i>External factors</i>	178
6.3	RECOMMENDATIONS.....	180
6.3.1	Recommendations for counsellors	180

6.3.2	Recommendations for Childline Zimbabwe	182
6.4	LIMITATIONS OF THE STUDY AND SUGGESTIONS FOR FURTHER RESEARCH	184
6.5	FINAL CONCLUSIONS OF THE RESEARCH STUDY	186
	REFERENCES.....	188

LIST OF TABLES

Table 2.1:	The processes of SPICC in the spiral of therapeutic change.....	34
Table 2.2:	Phases of the SPICC model	35
Table 3:	Childline Zimbabwe treatment team.....	96
Table 4:	Age and gender of counsellors	104
Table 5.1:	A summary of all the child sexual abuse cases used in this study.....	121
Table 5.2:	Average counsellors' satisfaction scores in percentages for each item	126
Table 5.3:	Number of cases that have been referred to different organisations by all the 5 counsellors	132
Table 5.4:	The total number and types of follow-up done by individual counsellors	148
Table 5.5:	Average child clients' satisfaction scores in percentage for each item	155

LIST OF FIGURES

Figure 2.1: A simple genogram adapted from CONNECT (2001) and McGoldrick and Gerson (1985)	29
Figure 2.2: Influences on an individual family member's perceptions, thoughts and behaviours	30
Figure 2.3: Different counselling approaches	33
Figure 2.4: A unified theory of sexual offending	36
Figure 3.1: The process of child therapy	64
Figure 3.2: Stages in the play therapy process	75
Figure 4.1: Age distribution of the selected child clients	104
Figure 4.2: The selected sample for child clients	104
Figure 5.1: The number of cases reported by each type of Childline's case informants	130
Figure 5.2: The anatomically correct dolls; adapted from Migima (2010)	146

LIST OF APPENDICES

Appendix 1:	Semi-structured interview for counsellors.....	206
Appendix 2:	Semi-structured interview for clients and care-givers	207
Appendix 3:	The 8-item satisfaction scale questionnaire (ISSQ) for counsellors.....	208
Appendix 4:	The 8-item satisfaction scale questionnaire for clients and caregivers	209
Appendix 5 A:	Informed consent form for participants	210
Appendix 5 B:	Additional consent to audio recording	212
Appendix 6:	Ethics.....	213
Appendix 7:	Ethics around research findings	215
Appendix 8:	Professional code of conduct	216
Appendix 9 A:	Demographic data for counsellors.....	217
Appendix 9 B:	Types of child sexual abuse dealt with	218
Appendix 10 A:	Demographic data for children	219
Appendix 10 B:	Type of child sexual abuse experienced	220
Appendix 11 A:	Childline drop-in report form.....	221
Appendix 11 B:	Drop-in follow-up form (follow-up and home visit continuation form).....	223
Appendix 12:	Helpline fill-in form	225
Appendix 13:	Client's data form	227
Appendix 14:	The information recorded on case reports.....	229
Appendix 15:	Case referral form	230
Appendix 16:	Examples of the recorded observations	232
Appendix 17:	Examples of information recorded in the log book / audit trail.....	233

ABBREVIATIONS AND ACRONYMS

ACCESS:	Alliance for Children's Entitlement to Social Security
CHI:	Child Helpline International
CONNECT:	Zimbabwe Institute of Systemic Therapy
CSA:	child sexual abuse
DSW:	Department of Social Welfare
FST:	Family Support Trust (based at a government hospital)
ISSQ:	item satisfaction scale questionnaire
NGO:	non-governmental organisation
OVC:	orphans and vulnerable children
POS:	place of safety
Sgt:	sergeant (title used in the police force)
UNICEF:	United Nations Children's Fund
VFU:	Victim-Friendly Unit (a Zimbabwe Republic police department)

CHAPTER 1

CHILD SEXUAL ABUSE – AN INTRODUCTION

1.1 INTRODUCTION

“I am now 10 years. I was about 8 years when one day I was walking home from school. When I got to this scary bushy area, about 4 km from home, I met Dhaudi, a man who was mentally disturbed. Dhaudi ran behind me and he raped me. I screamed so hard but no one came to my rescue. When I got home, I cried and told my mother what had happened. I don’t know what then happened but the same night, I saw my father assaulting my mother with clenched fists. My mother cried and called my little brother and me; we disappeared in the darkness. That fateful night we slept in a maize field. In the morning, we went to report the case to the local Gutu police station. The police later on arrested Dhaudi. I stopped going to school and we now stayed at my mother’s parents. Later on my mother got married in a faraway village. Her new husband did not want to support my little brother and me. My grandparents then sent me to a distant aunt Joo in Harare. Although aunt Joo sent me to school, after school and during weekends, I worked as a vendor selling vegetables at the market. Aunt Joo used to physically assault me on a regular basis. She registered me as an orphan at the Department of Social Welfare. One day, personnel from the Department of Social Welfare together with Gogo Madube came to aunt Joo’s house. Gogo Madube was a foster parent who told me that she was willing to take care of me since she was alone and a pensioner. I was happy and I immediately agreed to go with her. The same day I was registered under Gogo Madube’s household at the Department of Social Welfare. One day, when Gogo was away from home, I was raped by a neighbour’s son. I did not tell Gogo because I was afraid she would chase me. I don’t know how Gogo got to know about it. With a belt, she beat me on my vagina while she said, “This is the part which makes you interested in men.” She then examined my vagina inserting her fingers in it. Gogo rubbed chilli peppers on my vagina saying that it was medication that made my vagina tight again since it had become too wide. I was sore and I developed big wounds on my vagina. Gogo then treated the wounds with some ointment. Gogo is my only hope, she is now planning to send me back to school although she sometimes shouts at me threatening to send me away. She says that she does not want to stay with me anymore because of my loose morals and sexual behaviour.” (Extract from a Childline Zimbabwe case report, May 2009).

Child sexual abuse (CSA) remains a complex experience and children's reactions to sexual abuse are varied and unique to every child (Waterhouse, 1993). CSA leaves the abused child with a multitude of effects. Globally, CSA is debilitating the lives of many children both in Africa and elsewhere, as it has become a social and public health problem (Gwirayi, 2010). A report by UNICEF (2008 cited in Gwirayi, 2010) states that the national statistics of rape cases involving minors in Zimbabwe had increased from 2 192 in 2003 to 3 112 in 2006.

The reports of child sexual abuse in Zimbabwe have increased over the past few years. According to Musoko (2011, p. 10), "A silent plaque is striking at the fabric of Zimbabwean society. Statistics reveal that the incidence of child sexual abuse has soared over the past 10 years and is traumatizing thousands of children mostly young girls". CSA has been reported in various communities of Zimbabwe. Children of all ages and from all walks of life have been affected and continue to be affected by CSA. Many organisations are involved in preventing and addressing the rampant effects of CSA and in protecting the rights of children. In recent years, UNICEF has partnered with government departments, non-governmental organisations (NGOs), hospitals, police and schools in support of the Zero Tolerance against Child Abuse national campaign. Among the NGOs is Childline Zimbabwe, whose counsellors/social workers provide counselling services to the children who are survivors of sexual abuse and their families.

The present study firstly focused on the approaches used by Childline Zimbabwe of helping children who have been sexually abused or molested. The cases that the researcher investigated were only those that were being attended to by Childline Zimbabwe in the four-month period from March 2009 to July 2009. Secondly, the study focused on children and the caregivers who have suffered or were still suffering the consequences of sexual abuse. In most scenarios, the family at large was involved during counselling of sexually abused children although the focus in this study was centred upon the child. Lastly, the study focused on the counsellors who deliver the counselling services to the child clients and/or their caregivers.

This chapter presents the general introduction and overview to CSA in Zimbabwe. The background to the counselling approaches employed to help such children is provided in an effort to draw attention to Childline Zimbabwe's work with vulnerable children who are survivors of sexual abuse. The statement of the research problem, the research questions, the aims, significance of the study and the research design adopted in this study are explained. Also provided in this chapter is the chapter outline for the whole research study.

1.2 DEFINITION OF CONCEPTS

The definitions of the concepts upon which the present study was based are set out below.

1.2.1 Child

A *child* is anyone whose age is between 0 and 16 years (Delaney, 2009). In Zimbabwe, the legal age of maturity is 18 years. This means that individuals are considered able to determine and shape their future only when they reach 18 years of age (Hove, 1992). In this research, a *child* is also referred to as a *child client/survivor*.

1.2.2 Child sexual abuse (CSA)

Brakarsh (2006, p. 4) defines *child sexual abuse* as “when a child under the age of sixteen is used for sexual gratification by another person”. Child sexual abuse also includes acts or advances of a sexual manner to a child of 16 years and below. The law condemns CSA by stating that children under the age of 16 are not consenting adults, and therefore cannot consent to mutual sex (Save the Children Sweden, 2005). Any child below the age of consent (according to the Zimbabwean law, the sexual offences Act, [Chapter 9:21] of 2001; 16 years of age) may be deemed to have been sexually abused when any person, by design or neglect, involves the child in any activity intended to lead to the sexual arousal and gratification of that or any other person. This definition takes precedence even if there has not been genital contact and whether or not the child initiated the behaviour (Waterhouse, 1993).

1.2.3 Childline Zimbabwe

Childline Zimbabwe is a non-governmental organisation that forms part of Child Helpline International (CHI) whose main objectives are to build, develop and maintain a network of child helplines throughout the world (Delaney, 2009). Childline Zimbabwe works towards promoting child-targeted services that are delivered in ways that encourage and uphold children’s rights by way of free telephone and face-to-face interventions (Delaney, 2009). Childline helps abused children and children in various difficult situations to access the necessary assistance, such as counselling and referral. In this study, Childline Zimbabwe is also referred to as ‘Childline’.

1.2.4 Counselling/counselling services

Counselling is a process that is “directed towards people who experience difficulties as they live through the normal stages of life-span development” (Cormier & Hackney, 1993 cited in

Rukuni & Maunganidze, 2000, p. 5). This is achieved by the counsellor facilitating an interpersonal relationship with the client who is actively seeking help in a setting that allows the help to be given and received (Rukuni & Maunganidze, 2000).

Counselling services refers to the actual help that counsellors give to clients. It involves what transpires in a counselling relationship between the counsellor and the client where the counsellor's work with clients may include services aimed at development, crisis support, psychotherapy, guiding or problem solving (Chantler, 2005; McLeod, 1993 cited in Rukuni & Maunganidze, 2000). Counselling services may also involve listening, giving advice, educating and directing the client (Brakarsh, 2006), and helping the client to make his or her own informed decisions through the counselling process.

1.3 CHILD SEXUAL ABUSE: AN OVERVIEW

Sexual involvement with children is an act of abuse since children are legally regarded as not being able to consent to mutual sex (Brakarsh, 2006; Save the Children Sweden, 2005). Children also do not have the mental capacity for understanding what sexual activities are all about (Madu, 2001). In a more specific way, child sexual abuse occurs across cultures and socio-economic backgrounds. Although young girls are more vulnerable to sexual abuse and exploitation, more awareness is raised about boy children as well (Save the Children Sweden, 2005).

Child sexual abuse is a global phenomenon as it is reported in various countries. The World Health Organization (2004 cited in UNICEF Pacific, 2006) reported that in 2002, at least 150 million girls and 73 million boys under the age of 18 years were sexually molested worldwide. For instance, among the Pacific Island countries, such as Fiji, Cook Island, Papua New Guinea, Samoa, Tonga, Vanuatu and others, there is a growing awareness of children's rights and protecting children from violations of these rights, especially sexual abuse and exploitation. The same report further illustrated that at global level, child sexual abuse and exploitation are due to gender inequality, low status of children (particularly girls), high economic pressures on families and child-parent separations due to conflicts and movement in search of employment, among various other factors. In another report (UNICEF, 2010), it was estimated that the incidence of child marriage was especially high in the developing world, where more than one third of women between 20 and 24 years were married or in marital union before the age of 18, 46% of these were from South Asia, while 39% were from sub-Saharan Africa.

In the traditional Zimbabwean context, sexual abuse generally covers only the actual vaginal penetration of a female by an adult male. In the past, the other variations of sexual molestation were not viewed as sexual abuse. Zimbabwe has different ethnic groups with own cultures. Some sexual acts, such as the fondling of young girls' breasts by their brothers in-law are culturally acceptable amongst some of these ethnic groups. This cultural practice is called 'Chiramu' in Shona or 'Sibale' in Ndebele. In recent years, the law has been acting against any sexual act by any person to a child, and such acts are now considered a criminal offence (Chiremba & Makore-Rukuni, 2002).

Child sexual abuse is still a taboo in many parts of Zimbabwe and many other countries. People are often not comfortable discussing sexual issues about themselves or of a family member. Chiremba and Makore-Rukuni (2002, p. 18) state, "some did not report because of the stigma attached to being raped, and parents did not want people pointing fingers at the family".

Nowadays, the media in Zimbabwe has started reporting on cases of child sexual abuse. The *High Density Anchor* of September (2001, cited in Chiremba & Makore-Rukuni, 2002, p. 17) highlighted that the increase of sexual abuse cases in Zimbabwe's Mashonaland West Province has prompted the "police to appeal to the family institution to try and curb the problem, as most of the perpetrators are known to the victims". The perpetrator may be the child's father, brother, uncle or guardian. One police assistant inspector in the same report (cited in Chiremba & Makore-Rukuni, 2002, p. 17) stated, "... most of the cases only came to light after some time". Because of these issues, Chiremba and Makore-Rukuni (2002) add that some of the families chose to ignore such cases, especially if the perpetrator is a close family member. Therefore, the responses to child sexual abuse tend to differ according to one's culture, social status, age, family setup or background.

Child sexual abuse is a major social problem. According to Madu (2001), in 1998, the South African Police Services reported that girls under the age of 12 years cannot legally consent to sex; therefore, it will always be rape, irrespective of circumstances. Child sexual abuse encompasses a variety of acts: contact acts, such as sexual kisses, sexual touch, oral, anal and vaginal intercourse (Madu, 2001) and non-contact sexual acts, such as voyeurism and exhibitionism (Burgess, Groth, Holmstrom, & Sgroi, 1978; Chiremba & Makore-Rukuni, 2002). In addition, incest, rape, sodomy, sexual intercourse with children, open and gross lewdness and libidinous or homosexual practices or behaviours towards children, indecently exposing and assaulting children, taking indecent photographs of children and encouraging them to become prostitutes or to look at pornographic material all cover sexual abuses of children

(Burgess *et al.*, 1978; Lanning, 2010). Therefore, counselling is targeted specifically to provide emotional and psychological support to the child who is a survivor of sexual abuse.

One common feature of child sexual abuse is statutory rape (see section 2.3). Brakarsh (2006, p. 4) defines statutory rape as “consensual sex with a girl between the ages of 12 and 16 years. Statutory rape is also the unlawful sexual intercourse with any girl under the age of 16 years with her consent”. This is considered unlawful because children are regarded as not old enough to make informed decisions about sexual matters.

It is important for children as survivors of child sexual abuse to learn to accept that the abuse is not their fault and that they are not to blame (Trinity College Dublin, 2003). In most cases when a child is abused, they report it to someone they feel comfortable with. Sometimes the child herself or himself tries to look for help from a Childline service or someone they think can help, for example, the police, a teacher or a church leader.

Research studies by UNICEF (2010) and Save the Children Sweden (2005) have shown that child sexual abuse generally happens to vulnerable children. There are four main factors that influence and increase vulnerability of children to sexual abuse. These are: factors in society, factors in the family, cultural factors, and child dispositional factors (Brakarsh, 2006). These factors are further discussed in details in section 2.4.

Prevention of victimisation of survivors of child sexual abuse is the role of caregivers and all health-service providers and to a larger extent, the state. Children need to be supported in all aspects of their lives. Those that have been sexually abused need to be re-assured so that they may regain their self-confidence and maintain self-esteem. A safe environment should be created at all times and children need to regain their self-worthiness. This is achieved by the caring and comfort they receive from adults (Brakarsh, 2006).

Generally, adults take responsibility over the welfare of children and abuses of children by adults are not tolerated by most societies. “There can be little doubt that children are too unprepared and too vulnerable to fully appreciate the consequences of sexual involvement with an adult” (Berlin & Krout, 1994, p. 13). In short, Finkelhor (1984) claims that male domination in society, the pervasiveness of pornography, the portrayal of children as sex objects through advertisements, and the degree of power and control of adults (especially men), which are manifested in terms of children, all contribute to CSA. Regarding these factors, Terry and Tallon (2004, p. 85) argue that “social isolation, arbitrary parental authority over children, patriarchal values, single-parent households, and negative images of the social worth of children all promote and exacerbate CSA”. Barbaree and Marshall (2006) propose that child sexual crimes result in multiple, interacting factors that converge at one time, in the

correct context for offence to occur – all linked to the salient causal factors such as the offender's developmental experiences, biological processes, cultural norms and attitudes about sex and gender roles and the psychological vulnerabilities. In addition to these causes of CSA, Burgess *et al.* (1978, p. 5) conceptualise some of the individual causes of CSA as:

The theoretical contributions on pedophilia have related the etiology of the sexual desire for underage persons either to psychological concepts of arrested psychosexual development, intellectual deficiency, or mental illness (psychosis), or to physiological conditions of functional disturbance, such as impotency, degenerative diseases, such as alcoholism and senility, or organic insult, such as cerebral trauma.

To this point, Simon, Sales, Kaszniak, and Kahn (1992, p. 12) append “various types of personality disorganization and sexual identity confusion ... may interact with situational factors (e.g., alcohol abuse, drug abuse, marital or relationship discord, and accessibility of young girls) to increase the likelihood of molestation within a dysfunctional family”.

Menard, Bandeen-Roche, and Chilcoat (2004) further state that the prominence of CSA is caused by adult psychopathology and CSA operates primarily as a sign of many coexisting deleterious influences rather than CSA itself causing problems in the family.

Furthermore, the sexual abuse of a child can also incite the divorce of parents in patriarchal societies. According to Save the Children Sweden (2005), customary law tends to treat family members differently in relation to their gender roles and statuses thereby protecting men's social position and promoting inequality and discrimination of women and children. Kanyowa (2003) states that in patriarchal set-ups, the man is the breadwinner and it is he who makes decisions, while the woman is the care-giver who carries out the man's decisions. Kanyowa (2003) also comments that complementary relationships based on gender inequalities have been very rigid due to the belief that men are the stronger sex who must be always in charge while women are the weaker sex. Chiremba and Makore-Rukuni (2002) highlight that women are seen by society as neglecting their role of taking responsibility over the welfare of children. Hence, if a child is sexually abused; the father blames the mother for lack of care. In support of this view, Chiremba and Makore-Rukuni (2002) propound that Freud's oedipal complex plays a role since it concentrated on neglecting mothers and 'seductive daughters' (which literally means that girl children sexually tempt their fathers) while it ignored men's sexual desires and the patriarchal power they possess in society. Nowadays, this trend continues in some parts of Zimbabwe. In a more recent study by Hanzi (2006, p. 12) it is said, “The family as an institution has facilitated child abuse and exploitation in Zimbabwe through cultural practices and customs as a survival tactic.” According to Hanzi (2006), examples of such practices include virginity testing, child marriages, payment of dowry, marriages of young girls

to older men in exchange for food or money, and pledging of the girl children. Hanzi (2006) adds that abuses in the name of culture continue to happen as a tradition and more specifically in rural areas and among the Shona people who constitute the largest tribe in Zimbabwe with about 76% of the population. The Shona tribe is also predominantly patriarchal (Hanzi, 2006).

Children younger than 5 years of age do not know that the sexual activity is wrong, but those who are older are aware that the sexual act involving children is wrong. Children normally become trapped between affection and loyalty to the abuser on the one hand, and the sense that the sexual act is wrong on the other. This is evident since the child keeps the perpetrator's actions a secret just as instructed by the perpetrator (Conradie, 2001). Children may attempt to stop the sexual abuse situation. Hing (2010) highlights three types of children's reactions to CSA and claims that a child may escape backwards (regression); escape forwards, that is, fight the perpetrator (aggression) or escape inwards, that is, play dead (isolation). Due to his/her loyalty and attachment to the abuser, the child's belief and fear that the abuser's threats (for example, violence, death or loss of love) would actually happen limits the child's efforts to stop incestuous relationships.

Grooming is a tactic that most abusers use in order for them to gain access to their potential child victims. According to Terry and Tallon (2004, p. 24), grooming is "a pre-meditated behaviour intended to manipulate the potential victim into complying with the sexual abuse". This means that the intended sexual abuse is planned well beforehand. Grooming can be done to caregivers as the perpetrator socialises with them in order to gain their trust and access to the child (Lanning, 2010; Terry & Tallon, 2004; Veldhuis & Freyd, 1999). The majority of abusers take their time to prepare before they finally abuse the child. Perpetrators use all sorts of tactics to lure children into sexual acts. Veldhuis and Freyd (1999) explain some of the methods by which offenders approach and initiate sex with children, namely:

1. verbal – shouting at the child to scare him or her;
2. physical intimidation – hitting the child to submit to the perpetrator's needs; and
3. seduction or the use of enticements – using things like sweets, money and presents.

These tactics only work depending on the response of the targeted child. If the child responds positively to the tactic, the abuser will continue to use the tactic. However, if there is resistance by the child, the offender might either change the tactic, force the child into accepting it, or the perpetrator might look for another child. Terry and Tallon (2004), and Veldhuis and Freyd (1999) further suggest that in cases where the child already knows the perpetrator, there is use of 'seduction' (luring someone into having sex) and 'testing' (putting

the child in difficult situations of a sexual nature). The victim normally gets used to the affection he or she is shown by the abuser. The abuser takes advantage of the existing relationship with the victim. He extends his affectionate love through the normal touching of the child, and then slowly moves ahead to touching that would include sexual behaviour. The abuser starts by performing smaller sexual acts with the child until his or her demands increase over time.

Sometimes child sexual abusers take their victims by surprise. This can happen when the perpetrator creates a situation to distract the child and take advantage of the opportunity (Terry & Tallon, 2004). Pryor (1996) propounds that for offenders to successfully groom their preselected targets, the offenders mostly utilise emotional and verbal coercion. In the case of incest cases, offenders have constant contact with the children so they can even negotiate the sexual activities. Some perpetrators play games with the child, for instance tickling then gradually proceeding to fondling the child in a spontaneous manner (Pryor, 1996). Some child sexual abusers systemically introduce the child to sex. They can, for example, start by discussing sex topics, use pornography or exhibit their sexual parts to the child (Terry & Tallon, 2004), or provide the child with attention, affection, kindness or gifts (Lanning, 2010; Veldhuis & Freyd, 1999). All this is done in an effort to groom and engage the child in compliant behaviour for sexual activities with the perpetrator (Lanning, 2010).

1.4 BACKGROUND TO THE SERVICES PROVIDED BY CHILDLINE ZIMBABWE

Childline Zimbabwe is a non-governmental organisation (NGO) that responds to issues regarding children's concerns. Childline Zimbabwe is the cornerstone for children's problems. It is a member of Child Helpline International (CHI), which is an umbrella body supporting Childline Zimbabwe and other Childlines in different countries. The different Childlines in other countries are independent bodies with regard to activities they do. Children come to Childline Zimbabwe for psychosocial and emotional support from counsellors. Childline Zimbabwe plays a crucial role as a neutral body representing children's rights. It runs a helpline which is accessible to clients for 24 hours every day. Delaney (2009) highlights that one of the functions of the Child helpline is to promote the needs of children. This should be done in a holistic manner, giving due consideration to the unique circumstances of each individual child. Counsellors at Childline Zimbabwe promote the rights of children in a child-centred way, empowering the child, and children's active participation is encouraged.

Childline Zimbabwe uses the holistic approach to counselling and helping children who have been sexually abused. This means that organisations such as the police, social welfare, other counselling bodies, hospitals, courts and lawyers work together to attain a common goal,

namely to provide the necessary services needed by the clients. The child is referred from one organisation to another until the case is resolved. The Childline counsellor makes sure that the child passes through all the necessary organisations. In this view, it is highlighted by Delaney (2009, p. 13) that “The nature of the services provided should be dependent upon an assessment of local needs, including services and programmes run by other organisations and the available resources”. The issue of confidentiality needs to be carefully observed as the case moves from one organisation to another.

Below is an explanation of the steps followed by Childline Zimbabwe in response to child sexual abuse. Under normal circumstances, a child would be helped by Childline to pass through:

1. the police;
2. examination by a qualified doctor at Family Support Trust (FST) based at a government hospital;
3. the Department of Social Welfare;
4. the magistrate’s court; and
5. counselling by a Childline counsellor.

From my observations at Childline Zimbabwe, it was clear that the point of departure for some clients is Childline. Others start with the police, the department of social welfare or the hospital. There are few cases where clients start with the magistrate’s court. These steps are not necessarily standardised. Each counsellor intervenes according to his or her own discretion, and which organisation comes first depends on which organisation first receives the case. Childline’s involvement with sexually abused children is thus not organised in chronological order. For effective counselling, all the necessary organisations should be visited through the assistance of Childline Zimbabwe. Due to the lack of clear steps, counsellors end up omitting other necessary procedures and concentrating on one issue, for instance, the arrest of the perpetrator by the police. In such instances, the counsellor at Childline can sometimes do one initial session with the child upon request from the magistrate’s court or the police then fail to do all the necessary follow-up to check whether the child has been fully supported emotionally and psychologically. This study shares light on these steps in more details.

Since Childline Zimbabwe is an NGO, its role is significant in different communities of Zimbabwe. In support of this fact, Maundeni (2009) pinpoints that although NGOs in Botswana play a very important role in improving the well-being of orphans and vulnerable children

(OVC), their efforts are hampered, for instance by the lack of resources. Maundeni (2009) adds that a barrier to effective service delivery is that many children are not aware of their rights. During the researcher's time at Childline, she found that Zimbabwe has only six social workers who are expected to cover cases for the whole country. Botswana (a neighbouring country to Zimbabwe) has similar challenges with consideration to services offered and limited resources. In relation to resources such as transport and social workers/counsellors, Maundeni (2009, p. 4) reported that there are limitations to social workers' ability "to provide adequate counselling, and to conduct or make proper follow-ups and referrals ... an acute shortage of resources has led to poor service delivery". Therefore, like in Zimbabwe, the findings by Maundeni's (2009) study in Botswana has implications for the quality and type of psychosocial support services that vulnerable sexually abused children receive.

Childline Zimbabwe counsellors embark on referrals of child clients to other stakeholders who also provide psychosocial support to their clients. Childline counsellors are guided by psychological theories, child counselling strategies and techniques in their effort to help clients (see Chapter 2 and 3). Briefly stated, it is the counsellor's duty to see that sexually abused children and their caregivers are given specific opportunities to deal with the negative outcomes of child sexual abuse while they are in a supportive environment (Hall, Mathews, & Pearce, 1998). Hence, the counsellor provides a suitable scenario before counselling of the child can commence.

The counselling strategies and techniques that are used enable the counsellor to communicate with the child clients. Whilst counsellors embark on counselling of clients, they face a variety of challenges (see Chapter 5 for a detailed discussion).

1.5 BACKGROUND OF THE STUDY

While working as a newly employed counsellor/social worker at Childline Zimbabwe, the researcher lacked knowledge regarding the exact counselling services Childline provides to its child clients, especially the victims of CSA. The researcher as counsellor/social worker lacked knowledge regarding counselling needs of clients and whether clients were receiving the services they required from Childline Zimbabwe. During her orientation period, the researcher asked her long-serving colleagues what was expected of counsellors but she received mixed responses. The experienced counsellors varied in their approaches to helping sexually abused children and each of them had his or her own way of considering the counselling theories, techniques and strategies. Furthermore, after battling with many unanswered questions about the way the organisation embarked on its services, the researcher was perplexed about how people at Childline still managed to do their jobs successfully in such an

under-resourced environment. During the onset of her employment as a social worker at Childline Zimbabwe, the researcher struggled to do the necessary follow-up of cases due to shortages of transport and numerous cases that needed urgent intervention. Most devastating was one of her first field work/home visits which she did four weeks after the initial report was made to Childline. Upon arrival at the home of the abused child, the researcher was confronted with neighbours who asked her whether she had come to visit the grave of the child. The social worker (in this case, the researcher) had only visited that particular case two weeks after the child had died. No report was made to Childline that the child had died. The researcher was then informed that the child had died due to the injuries sustained during the sexual assault.

Having come into contact with the key stakeholders and receiving mixed perceptions, especially during reflection meetings with Childline staff members and Childline clients, the researcher hence needed clarity on the counselling services, including the standardised counselling procedure for the organisation. She therefore embarked on the research study with the aim of informing Childline on ways to improve their services. It was apparent that there were problems with regard to what Childline purports to offer as compared to what Childline clients actually receive, and thus the problem to be researched was established.

1.6 STATEMENT OF THE RESEARCH PROBLEM

The researcher investigated what Childline Zimbabwe really offers to its clients who are children survivors of child sexual abuse. Information on which psychological approaches and techniques guide Childline Zimbabwe counsellors as they counsel children and their caregivers was investigated.

Childline Zimbabwe's current counselling methods during face-to-face intervention with sexually abused children are described in this study. The Childline Zimbabwe practice guide does not clearly highlight the particular stages to the face-to-face counselling processes since more attention is directed towards telephone counselling. This study is intended to provide a specific counselling process with sexually abused children to which the counsellors may refer during intervention. It was also not clear whether children changed their lives in a positive way after counselling interventions received from Childline Zimbabwe. Therefore, it was important that these issues be addressed for the benefits of the victims of sexual abuse and the counsellors. This was the focal point of the present study.

1.7 RESEARCH QUESTIONS

Van Zijl (2008) asserts that the research question controls the way in which the study is conducted. From the qualitative perspective from which this research was carried out, the following research questions arose:

- To what extent do Childline Zimbabwe's current practices respond to the needs of sexually abused children in Zimbabwe?
- What are the perceptions of Childline Zimbabwe counsellors and their clients about the effects of the counselling services provided?
- How useful are counselling services offered by Childline Zimbabwe to its clients who are children survivors of child sexual abuse?

1.8 AIMS OF THE STUDY

The aims of the present study were threefold:

- to describe the counselling services utilised by the counsellors at Childline Zimbabwe;
- to get a deeper understanding of the different methods of counselling offered to survivors of child sexual abuse by Childline counsellors; that is, the counselling approaches and techniques used, the type and number of follow-ups done per individual child abuse case, and the quality of information recorded on individual case reports by each of the counsellors; and
- to explore the level of client satisfaction for counselling services received from Childline social workers/counsellors, as this was based on the imminent changes in clients' lives after the onset of counselling.

In view of the research problem, the research questions and the aims of the research study, the researcher intended to provide information based on the research results.

1.9 RATIONALE/SIGNIFICANCE OF THE STUDY

Although Childline has a guide that provides information on how counsellors should address survivors of child sexual abuse via the telephone, counsellors do not have a theoretical framework that guides them during face-to-face intervention with their clients. From the study results, it became clear that counsellors would be informed of which stages of counselling are necessary for counselling sexually abused children. Childline Zimbabwe counsellors do not have detailed programmes where their work is documented. As a recommendation, and

especially for newly appointed staff, it will be ideal to know what the organisation is exactly doing and to which extent they are helping children who are survivors of child sexual abuse and their caregivers. This study therefore, addressed the limitations in Childline counselling services. The research report describes the theories, counselling techniques and strategies and the type of help that should be given to the clients. In this report, information on which areas to improve is provided.

Moreover, this study adds value to the field of counselling psychology. It helps bring positive changes to the clients affected by sexual abuse. The results of the present study are also beneficial to Childline Zimbabwe since a critical evaluation of the implementation of counselling services at Childline Zimbabwe also provides important and valuable information for improving the counselling services at Childline Zimbabwe. Counselling psychologists, the counsellors of other organisations that embark on counselling or deal with sexual abuse cases, stakeholders, police, the magistrate's courts, the health institutions, counselling departments at universities, the children themselves and their caregivers would also benefit from the results of the study. The results can be used to predict and change the behaviour of both the counsellors and the clients.

1.10 THE RESEARCH DESIGN

The study adopted a qualitative, case study approach as the research design. Using this approach, data were collected by means of mixed methods where both qualitative and quantitative methods were utilised to enable an in-depth description of the services of Childline Zimbabwe. The case study approach was situated in a descriptive research design which features elements of interpretative designs in exploring the services rendered by Childline Zimbabwe. Analysis of data was done by using interpretive approaches and grounded theory was used as a research method during the analysis stage (as described by Patton, 2002; Terre Blanche, Durrheim & Painter, 2007; Willig, 2001). The interpretive approach focuses on understanding data from the viewpoints of how people involved in the study interpret their lives (as described by Terre Blanche *et al.*, 2007). The experiences of the research participants were taken into consideration while interpretation of their lived experiences informed the results of this study.

1.11 THE OUTLINE OF THE STUDY

This study is divided into six chapters that are organised as follows:

Chapter 1: Child sexual abuse: An introduction – This chapter serves as a general introduction to child sexual abuse. It also provides a background to the counselling approaches used for children who are survivors of child sexual abuse in Zimbabwe. The background to the research problem, the research questions, aims and significance of the study and a brief outline of the research design are also explained.

Chapter 2: Child sexual abuse: Theoretical perspectives – The focus is on different theoretical perspectives that explain child sexual abuse. The types, causes, and effects of CSA on the lives of children are discussed.

Chapter 3: Counselling sexually abused children – This chapter is allotted to the discussion of counselling therapies used for sexually abused children, the counselling process and its stages. Also presented are the major counselling techniques that are helpful in the counselling of children suffering the effects of CSA, the ethical standards and the counsellors' roles in counselling.

Chapter 4: Research methodology – This chapter is devoted to the discussion of the research methods. All the research related aspects such as qualitative, quantitative and grounded theory, research criteria, sampling procedure, data collection methods, data analysis, data interpretation and research context are discussed in detail. Also in this chapter, reliability and validity of the study together with the ethical considerations adhered to in this study are discussed.

Chapter 5: Results – The results of the present study are presented, analysed, interpreted and discussed in this chapter.

Chapter 6: Recommendations and conclusions – Based on the critical examination of the research results, this chapter is concerned with the formulation of recommendations aimed at improving the counselling services provided to children who are survivors of CSA and their families, and conclusions emanating from the study. Limitations of the study and recommendations for future research are indicated and discussed.

1.12 CONCLUSION

This chapter discussed the general background to child sexual abuse, globally and with particular reference to child sexual abuse in Zimbabwe. The background to the study and an overview to child sexual abuse and the services provided by Childline Zimbabwe were briefly explained. The important stakeholders with whom Childline Zimbabwe works have also been stated in brief. Information on children's vulnerabilities has been explained, also the way

children are groomed for sexual abuse by their abusers. In addition, key terms have been defined. Chapter 2 discusses the psychological theories that counsellors use during their interventions with child clients as well as the types, causes and effects of child sexual abuse.

CHAPTER 2

THEORIES, TYPES, CAUSES AND EFFECTS OF CHILD SEXUAL ABUSE

2.1 INTRODUCTION

Child sexual abuse (CSA) is a problem that goes beyond the effects directly experienced by the victims and the causal behaviours of the perpetrators. As Burgess *et al.* (1978) simply state, child sexual assault represents a crisis for the offender, the victim and the families involved. The issue of CSA affects the whole community due to its devastating effects on children, caregivers, social networks and the law enforcement agents. Any effective approaches focusing on addressing the CSA problem should take into account the multifaceted causes of the problem and the needs of those affected by CSA (Eckenrode, 2004).

In comparison with the past, nowadays adults, adolescents, and children themselves talk freely about CSA. The problem affects people from all walks of life. As Ward, Polaschek, and Beech (2006) expound, the ultimate aim for theorists is to construct a global theory that integrates theories from the different levels into a unified explanation of sexual offending. Through this, various researchers and practitioners have developed a number of frameworks to address the CSA issue as shown below.

This chapter focuses on three issues related to child sexual abuse. Firstly, it discusses the different theoretical approaches to child sexual abuse. Secondly, it explores the various types of sexual abuse perpetrated on children and lastly, it looks at different effects of child sexual abuse.

2.2 THEORETICAL APPROACHES OF CHILD SEXUAL ABUSE

A number of theoretical approaches (and models) have been developed that explain how CSA in general occurs. These approaches and theories can also be used to guide counselling of sexually abused children. Although there are a lot of specialist explanations to explain the aetiology and the maintenance of child sexual abuse based on biological, psychological and sociological theories, Bickley and Beech (2001) expound by saying that due to the breadth and complexity of this problem, there is not one theory that adequately manages to explain what really motivates people to have sexual relations with children and the sustaining factors

that cause the continuation of such deviant behaviour. It is nevertheless vital for therapists to understand the aetiology and maintenance of sexual abuse in order to implement appropriate intervention strategies for all types of sexual abuse (Terry & Tallon, 2004). The following section explores some of these approaches.

2.2.1 Biological approach

Biological theorists give precedence to organic explanations of human behaviour (Terry & Tallon, 2004). According to Berlin and Krout (1994), biology can influence the development of sexual interests. Just like other normal appetites or drives such as hunger, sleep, thirst and avoidance of pain, the need for sex can also cause a person to experience discomfort if the need or craving is not fulfilled. Biological regulatory systems exist that may cause an individual to experience desires that can satisfy the sex need, and such an individual is compelled to act in order to diminish his/her discomfort (Berlin & Krout, 1994). Following this view, in paedophiles, the need to satisfy the craving for sex is expressed through seeking sexual gratification with children. Although sexual actions can be modified through early life experiences, sexual desire itself is apparently not learned behaviour and it is rooted in biology. Males are, for instance, not taught how to get an erection (Berlin & Krout, 1994). This means that biological theorists look at physiological factors such as hormone levels and chromosomal make-up having effects on human deviant sexual behaviour. It is believed that sexual arousal, orgasm and ejaculation together with sexuality regulation, aggression, cognition and personality are promoted by male sex hormones called androgens (Rosler & Witztum, 2000; Terry & Tallon, 2004). In addition, Craig and Giotakos (2011) assert that offenders who had violent crimes had high testosterone levels.

Krueger and Kaplan (2001) report that there is a positive association between men with biological abnormalities such as having an extra X or Y chromosome, and their unconventional sexual activity and fantasy. Hence, deviant sexual activity, such as paraphilia, is greatly associated with the degree of genetic loading (Krueger & Kaplan, 2001). Theorists addressing paedophilia normally check for abnormal hormonal and androgenic levels in the brain. In situations where these are abnormal, males engage in abnormal sexual activity, for instance sexual assault on children (Terry & Tallon, 2004). Since there is a correlation between testosterone levels and sex drive, this theory does not explain what happens in females who sexually abuse children (Terry & Tallon, 2004). Berlin and Krout (1994) discuss a possibility of a biological condition, such as Klinefelter syndrome, predisposing a male towards sexually abusive behaviour, and further illustrates that men with Klinefelter syndrome may have sexual orientation problems and at times difficulties with the nature of their erotic desires. Klinefelter syndrome is a genetic disorder that affects males and occurs when a boy

is born with an extra X-chromosome (Men's Health, 2011). According to Barbaree and Marshall (2006), this genetic problem reinforces the possibility that one or more genes can contribute to a male's risk of paedophilia.

Men are believed to have a biologically driven sexual drive that demands release; hence, abuse of children is justified by 'men's virility' or a natural and deeply urgent need to satisfy their sexual appetites (Richter & Dawes, 2008; Townsend & Dawes, 2005). In addition, Ward *et al.* (2006, p. 42) argue that males are predisposed to assault someone sexually "by virtue of their greater sexual drive and strong inclination to engage in impersonal sex whenever an opportunity emerges". Thus Money (1988) and Berlin and Krout (1994) state that excessive prohibition of early sexual expression may put a person at risk of developing paedophilic sexual desires. In this regard, men with sexual disorders often come from homes where any expression of sexuality receives serious repercussions, for instance, where masturbation was not allowed (Townsend & Dawes, 2005). Such incidences are further reported by Townsend and Dawes (2005) where, for instance, a twenty-year-old man was viewed as a paedophile even though his partner was almost eighteen years old, or teenage pregnancy was erroneously defined as an epidemic disease. Hence, children end up having misconceptions with regard to sexual acts that are considered normal and those that are not.

Patterns of sexual arousal are biologically well established in the individual's sexual response pattern by the end of adolescence and 50% of sex offenders trace their sexual offending back to adolescence (Paulauskas, 2013). Paulauskas (2013) further states that adolescence is the onset of paraphilic interests. This means that the urge to abuse a child sexually is more of a biological make-up problem than anything else; children naturally become 'preferred love objects' (Krivacska, 1989).

During counselling of a survivor of child sexual abuse, the counsellor following the biological approach will be in a position to address CSA victims in relation to the factors influencing abuse. The counsellor will be able to help the child deal with his or her feelings of being sexually abused while paying attention to the biological reasons why offenders abuse children. Normal sexual development should be encouraged in children as they mature sexually so as to minimise deviant sexual behaviours in adulthood (Krivacska, 1989).

2.2.2 Cognitive-behavioural approach

This is sometimes called 'cognitive-behavioural therapy' (CBT) and it is used to help the child deal with self-destructive beliefs so as to replace such beliefs with helpful or adaptive beliefs (Geldard & Geldard, 2008). The use of cognitive behaviourism helps to explore how

perpetrators' thoughts affect their behaviour. Generally, when individuals commit offences, they often try to lower their guilt feelings and shame through 'neutralisations'. Pervan and Hunter (2007) explain that sexual offenders are inclined to misrepresent social perceptions in the form of excuses, defences and justifications while rationalising and maintaining their offending behaviour. Scully and Marolla (1984) note that people can commit offences that they know are wrong but they proceed to use various techniques in order to deny such deviance and view themselves as normal. In a way, the offenders remove from themselves any responsibilities, shame or feelings of guilt in terms of their own actions. Rationalisations tend to protect the offenders from self-blame and allow them to validate their behaviours through cognitive defence mechanisms. Most common is the fact that perpetrators tend to blame the victims for their abuse or justify their offences through the victim's actions (Terry & Tallon, 2004). An example comes from the work of Scully and Marolla (1984) who state that the offenders who admitted their offences did this through the use of stereotypes and claimed that women enjoy being raped. Conradie (2001) adds that men with distorted thinking believe that women mean yes when they say no, women like force, and women ask to be sexually abused. In support of these propositions, Geldard and Geldard (2008, p. 128) state, "In situations where sexual abuse has occurred children may often be troubled by their perceived collaboration in the event and blame themselves for the negative outcomes that occur". Children need to be taught that they are not to be blamed for the abuse that happened to them.

Not only child sexual abusers experience cognitive distortions (CDs), but everyone has at times distorted thinking and in most cases, cognitive distortions are harmless (Terry & Tallon, 2004). Minimisation, denial and justification of the offence are the most commonly used neutralisation techniques for explaining CDs. Terry and Tallon (2004) add that it happens quite often that perpetrators lack empathy for the children they abuse. Some studies claim that there is a specific type of CD known as 'sexual entitlement' that causes sexual offending. This type of CD results from the offenders believing that satisfying their own desires is more important than the negative consequences of the child survivor (Hanson, Gizzarelli, & Scott, 1994; Terry & Tallon, 2004).

Terry and Tallon (2004) state that, although sexual offenders do not form a homogeneous group of individuals, they show strikingly similar CDs about their victims, about their offences and about their responsibilities for the offences. In addition, Paulauskas (2013) states that CDs or thinking errors are there for the purposes of denying victims' suffering, allowing the continuation of offending and avoiding painful emotional consequences. Terry and Tallon (2004) further assert that child molesters misread cues from children in several ways, and the better they know the victim, the more likely this is to happen. For example, rapists and child

sexual abusers may view a child who sits on the abuser's lap as seeking sexual contact. Counsellors should be in a position to distinguish between harmless and harmful cognitive distortions and be able to deal with such distortions accordingly.

In most cases, perpetrators actually believe what they are doing is correct. Distorted thinking reinforces the ideas and the behaviour to abuse someone sexually (Conradie, 2001). Some men could have sexual fantasies due to the pornography they have watched. Barbaree and Marshall (2006) argue that life events can lead to the development of high-risk situations. Where there is limited self-regulation, an individual who masturbates in order to drain off the sexual desire and who deals with deviant sexual fantasies would, once in a high-risk situation, lose control and sexually offend. CDs are, however, very important for the maintenance of offending behaviour of CSA since they provide the need of the perpetrators to continue their behaviour without any feelings of guilt and shame.

In short, cognitive behaviourism focuses on the notions that sexual abuse perpetrators minimise or deny their offences. They even deny the damage caused to the victim, the violence used, their responsibility, the planning for the offence (grooming), and the lasting effects resulting from the offence (Terry & Tallon, 2004). The role of a cognitive-behavioural counsellor is to implement interventions such as addressing the mental health problems in children exposed to violence and trauma (as described by Murray, Familiar, Skavenski, Jere, Cohen, Imasiku, Mayeya, Bass, & Bolton 2013). In their study done in Zambia, Murray and others (2013) claim that through the use of cognitive behavioural therapy, the therapists address the multiple negative impacts of stress and trauma in young people and this is done through broad-based psychosocial support services including home-based visits, psychosocial counselling and/or social activities.

2.2.3 Behavioural approach

The behavioural approach posits that sexual deviations are learnt responses that occur as accidental experiences with sexually deviant behaviour (Laws & Marshall, 2003a). For example, deviant sexual interest emanate from repeated masturbation and may lead to sexual fantasies of certain deviant behaviours (Laws & Marshall, 2003a). The social learning theoretical model reported by Krueger and Kaplan (2001) states that sexually deviant interests can be learnt the same way that normative or conventional sexual behaviours and expressions are learnt, for instance, a male child survivor will model the behaviour of his offender. Sexual behaviour can be learnt in various ways, including observation and imitation of others or copying role models engaging in such behaviour. The specific expressions of sexual behaviour are known to be learnt phenomena (Laws & Marshall, 2003a). In this regard,

such learning comes about through cultural factors such as observation, imitating or modelling of direct experience that can occur on a basis of observing other people's behaviour (Krueger & Kaplan, 2001). According to Isom (1998), it is asserted that in social learning theory, individuals – especially children – imitate or copy modelled behaviour which they have observed either personally, in media or in their environment. Furthermore, Ziegler and Hjelle (1992, p. 343) append that children learn by watching and observing either good or bad behaviour; therefore, “during exposure, observers (learners) acquire mainly symbolic representations of the modelled activities which serve as prototypes for both appropriate and inappropriate behaviour”. Hence, sexually abusive behaviour can be learnt in the same manner.

According to Skinner's operant conditioning theory (in Ziegler & Hjelle, 1992, p. 306), “the rate at which operant behaviour is acquired and maintained is a function of a schedule of reinforcement employed”. Skinner (1971, in Rukuni & Maunganidze, 2000, p. 59) believes that “behaviour is shaped and maintained by its consequences”. Therefore, when people are learning to acquire certain behaviours, for instance, abusive sexual behaviour, they continue to reinforce the desired behaviour, thereby maintaining the desired response (Ziegler & Hjelle, 1992).

Barbaree and Marshall (2006) explain the acquisition of deviant sexual behaviour in terms of the need for biological endowment, childhood development, conditioning experiences, socio-cultural influences, family environments, disinhibitory processes and opportunity. In this regard, if an individual has access to these conditions, then he or she can sexually offend. Finkelhor (1984) outlines the four conditions needed for the maintenance of deviant sexual behaviour, namely –

1. to be more congruent with children than with adults;
2. to be sexually aroused by children;
3. to have a blockage in fulfilling their sexual needs with adults; and
4. removal of the socialisation processes that would have normally prevented them from sexual offending.

This means that, while these four factors are present, the offender can continue to abuse children sexually. Laws and Marshall (2003a) state that in 1898 in his reinforcement theory, Thorndike proposed the law of effect, which states that a response which is followed by pleasant consequences will increase in frequency whereas a response followed by unpleasant consequences will have reduced frequency. Since there are so many theories that can explain

the acquisition and maintenance of sexual offending, it is in most cases that individuals have their own perspectives on how sexual offending develops and what it is that maintains it (Laws & Marshall, 2003a).

Behaviourists, according to Berlin and Krout (1994), are more concerned about what can be done to treat paedophilic behaviour. Thus, behaviourists concentrate on extinguishing erotic feelings associated with children and at the same time teaching the individual to become sexually aroused by age-appropriate partners. Terry and Tallon (2004, p. 17) add that “maladaptive behaviour can result from quantitative and qualitative combinations of processes that are intrinsically orderly, strictly determined and normal in origin”. Berlin and Krout (1994) as well as Laws and Marshall (2003a) sum this up by noting that behavioural therapy aims to modify, predict and control people’s sexual behaviours. Laws and Marshall (2003) illustrate that the aim in behaviourism is to eliminate the arousal to deviant sexual stimuli.

Using Kinsey’s (1948) theory of sexology, cited in Laws and Marshall (2003b) explain that sexual behaviour can be classified in a variety of ways, including the individual’s experiences, preferences and behaviours engaged in. This shows that sexual behaviour has taxonomic variables. Most behaviour treatment focuses on homosexuals, particularly emanating from the idea that “psychoanalysis viewed homosexuality as a disorder, a problem, a pathology or a disease that needed treatment” (Mberi & Makore-Rukuni, 2001, p. 27). According to this theory, behaviour treatment concentrates on treating the disorder where properly treated persons would become heterosexuals. Such treatment was known as aversion therapy. According to Laws and Marshall (2003b), the publications exhibiting case studies mainly targeting the treatment of homosexuals, led to the use of aversion therapy to all deviant sexual behaviours including homosexuals, transvestites, fetishists and sexual offenders. In this regard, there is a need to make reliable distinctions among the different types of treatments and the types of offenders (Hanson, Gordon, Harris, Marques, Murphy, Quinsey, & Seto, 2002). However, the use of aversion therapy has never been convincingly demonstrated as producing permanent sexual behaviour changes (Laws & Marshall, 2003b).

Laws and Marshall (2003b, p. 21) state that, through initiatives of offender behaviour treatment approaches,

The future looks bright as we now have evidence that treatment can work, but we must not rest as there remains considerable room for improvement in our effort to reduce reoffending and thereby protect innocent citizens from suffering at the hands of sexual offenders.

Some of the treatment initiatives for offender behaviour involve modification and punishment. Punishment can be in the form of incarceration although it is doubtful whether this would necessarily change the offender's sexual behaviour (Berlin & Krout, 1994). However, in the early years, castration was a way of offender behaviour modification. It was reported by Ortmann (1980) that castration of sexual offenders was first passed as a law in Denmark in 1929 and in that country about 738 offenders were castrated between the years 1929 and 1959. There were also reports of castration of sexual offenders during the same period in other European countries such as Germany and Norway. According to Ortmann (1980), Prentky (1997) and Rosler and Witztum (2000), castration was a powerful mode of intervention since it reduces testosterone levels (discussed under biological approach above) in child sexual offenders. Ortmann (1980) and Prentky (1997) further state that surgical castration was widely used during the years 1929 to 1959 and due to the stigma attached to being castrated, chemical castration was later used to treat sexually aggressive behaviours in child sexual offenders. Rosler and Witztum (2000) point out that surgical castration is not practiced nowadays due to ethical and legal arguments.

2.2.4 Psychodynamic approach

Sigmund Freud is well known for his initiation of the psychodynamic and psychoanalysis approaches. Sigmund Freud asserted that all human behaviours could easily be traced to childhood experiences, for example, childhood sexual assaults by parents and caregivers have an effect on the survivor's sexual behaviour later in life (Elliott, 1998; Freud, 2001; Joyce, 1995). Hence, adult females who were sexually abused as children reported significantly less sexual satisfaction than did the non-abused females (Polusny & Follette, 1995).

Berlin and Krout (1994) highlight that classical psychodynamic theory assumes that all men would ordinarily develop sexual attraction towards adult partners of the opposite sex, but in some cases, this does not occur due to the interference of unhealthy early life experiences with the normal process of psychological maturation. Psychodynamic theory, according to Myer-Hopkins and Laaser (1995), believes CSA results from the offender's unconscious processes of transference and projection, and Freud (2001) adds that resistance is an unconscious process responsible for the individual's urge to sexually offend. Furthermore, Geldard and Geldard (2008) assert that all defence mechanisms identified by Freud are unconscious processes. Other examples of such processes are repression, rationalisation, fantasy and acting out.

According to Craig and Giotakos (2011), psychodynamic theories basically support the view that a variety of emotions of fear and sexual or personal inadequacy together with the possibility of the existence of unrecognised homosexual tendencies interact with aggressiveness and these are directed towards the victim as a substitute for the mother and this result in sexual abuse. Elliott (1998) reports that Freud explained child abuse from two perspectives, namely the death instinct and the transference psychosis. The death instinct posits that all individuals have inborn drives that compel them to have aggression toward the self or others; hence, an individual who was abused as a child is prone to abuse children as an adult (Chiremba & Makore-Rukuni, 2002; Elliott, 1998). The transference psychosis holds that some parents have personality traits that they project onto their children; thus, if an individual had abusive or aggressive parents, such individual will then also have an abusive relationship with his/her own children later in life (Chiremba & Makore-Rukuni, 2002). Transferences are also defined as new editions of the impulses and fantasies which are aroused and made conscious and have a special characteristic for their species (Freud, 2001).

According to Elliott (1998, p. 5), it was stated that psychoanalytic theory outlines seduction theory, which posits that “every neurosis conceals a history of real sexual seduction and actual trauma”. However, Freud (2001, p. 128) points out that he later believed that “sexual impulses operated normally in the youngest children without any need for outside stimulation”. Since it was theorised by Freud (2001) that neurotic symptoms were present in every person, Freud later found it unclear that everyone could sexually abuse his or her child. Thus, Freud saw adult seduction as an etiological factor prompting the development of neurosis (Freud, 2001; Joyce, 1995). It seems child sexual abusers take advantage of the young child during the child’s phallic stage of development and abuse the child (Freud, 2001). Freud (2001) adds that the very young child seeks sexual attention from the loved care-giver so that he/she can release inner sexual tensions which are present in all humans as they develop (Joyce, 1995). Whereas children of pre-school age were used in psychoanalytic treatment, psychosexual development theory was used to explain how a child in the oedipal stage or with electra complex could be wrongly understood for seductiveness by the parent inclined to offend (Elliott, 1998). Liu and Wang (2011) explain that in psychoanalytic theory, the oedipus complex represents the emotions and ideas that are kept in the unconscious mind through the dynamic repression. These cause the boy’s desire to possess his mother sexually. The oedipal stage is the boy’s phallic stage of sexual identity formation while the girl’s analogous experience is the electra complex (Liu & Wang, 2011) where she sexually desires her father, but realises that she does not have a penis and this leads to the development of the penis envy as she wishes to be a boy (McLeod, 2008).

Psychoanalysis posits that, a child sexual abuser is a person who has developed intense conflicts with his or her mother at an early stage of development. This is known as castration anxiety which is also described as penis envy since a male child feels that in women the penis is missing (Freud, 2001). This leads to the Oedipal conflict between a child-parent relationship (Freud, 2001; Schwartz, 2008).

Since the psychoanalytic approach was developed from the medical perspective, the counsellor assumes the expert role while the client is seen as a patient, just like in the doctor-patient relationships: the counsellor diagnoses the client's problem (Makore-Rukuni, 2002b). A psychoanalytic counsellor is expected to establish the client's defence structure, core conflicts and ego strength (Makore-Rukuni, 2002a). In psychoanalysis, the emphasis is always on the therapist's analysis and an interpretation of the client's behaviour (Geldard & Geldard, 2008).

The psychoanalytic theory put focus on incest although there are many other types of CSA. Psychoanalytic theorists therefore developed most of their treatment plans using incest cases. In support of this proposition, Vander Mey (1988) developed an ecological model to psychoanalysis, which incorporates social, cultural and psychological factors that highly contribute to father-daughter incest, and recognises the need for the inclusion of other types of sexual abuse. Incest theories evolved from the psychoanalysis theory, although it is known that psychoanalysis can also be used in the treatment of other CSA cases and not only incest. Incest involves a variety of factors such as the inclusion of other family members rather than only father-daughter incest. Freud (2001) saw the importance of the environment and the role of traumatic intrusion and interference in pathogenesis as factors influencing CSA. The past and a continuity of events also play an important role in explaining CSA using psychoanalytic thoughts. In this regard, Freud (2001) acknowledges that CSA occurs with some frequency. This explains why people who abuse children do not do it as a once-off thing but they continue to do it.

Robins, Gosling, and Craik (1999) as well as Barbaree and Marshall (2006) highlight that not much work has been done in the past with regard to psychoanalytic treatment of CSA although ego psychologists acknowledge the occurrence and consequences of incest. Several theorists agree with the nature of contemporary psychoanalytic theories (Geldard & Geldard, 2008; Ward *et al.*, 2006). Joyce (1995, p. 5) suggests that "contemporaneous with the critique of the rejection of the seduction theory there appeared in the psychoanalytic literature works on the psychoanalytic treatment of child sexual abuse".

Joyce (1995) explains how an adult with the will to abuse, mistakes the child's need for tenderness with the wishes of a sexually mature person. Thus, a child feels helpless and

submits to the needs of the adult. In such cases, the abuser does not feel guilty for his actions and tends to blame the child. Since most of Freud's classical analysis was based on father-daughter incest, there is less work on Freud's analysis of incestuous mothers, and nowadays, there are reports (for instance Barbaree & Marshall, 2006) of children (both boys and girls) sexually abused by parents (therefore mothers and fathers). According to Meiselman (1978), Freud himself was dissatisfied with his own theories of incest, and anthropologists viewed his ideas as 'nothing short of fantastic'. This explains some of the shortfalls of Freud's theories (like the belief that childhood seduction is the ultimate cause of adult neuroses) to the psychoanalytic theory of CSA (Joyce, 1995). Furthermore, Joyce (1995) states that current use of this theory might aid clinicians in understanding the impact of externally imposed trauma on children's developing inner worlds. In this regard, psychoanalytic theory attempts to provide a link between early childhood sexual abuse and failure to develop good relationships with others later in life (Chiremba & Makore-Rukuni, 2002).

In short, psychoanalysis highlights two incest theories. These are:

1. Theory about father-daughter incest is based on the work by Herman (1981) who highlights that, according to Freud, the patriarchal view invokes CSA. According to this view (Herman, 1981, p. 2), "the dynamics of an incestuous family represent a pathological exaggeration of the societal norms of male dominance". The rule of the patriarchal father leads to the belief by women that they should be compliant and submissive, and daughters learn by observation that they should submit and ensure that their mothers can even sacrifice them to the father for sexual purposes (Herman, 1981). Father-daughter incest is explained by Elliott (1998, p. 134) as "a generalized complementary relationship between the sexes, in which the daughter functions not merely as the split-off embodiment of the passive object, but also the missing maternal container into whom the father discharges and expels unmanageable tension". In addition, Gneezy, Leonard, and List (2009, p. 4) report that the patriarchal "Maasai man will refer to his wife and children as 'property'".
2. Primal horde theory, which is also referred as the totem and taboo theory, was developed by Meiselman (1978) after the rejection of Freud's seduction theory. This theory is rooted in a prehistoric acquisition of mankind that follows other moral taboos (Freud, 2001). Freud (2001) adds that psychoanalytic views show that people are tempted to commit incest and due to the barrier against incest, the temptation ends in fantasy and sometimes proceeds to reality. Meiselman (1978) based the totem and taboo theory on the story which asserts that early humans lived in a horde and they were controlled by a violent father who kept all the women for himself while he sent his

sons away to avoid their competition. Meiselman (1978, p. 9) states that the mistreated sons finally teamed up, killed “the father, and ate him in a cannibalistic victory celebration” so that they could have unlimited access to all the women and afterwards, the men regretted what they had done. They realised that there would be worrisome competition for women, and they would destroy the power they had found when they united, so they created incest taboo and stopped any claim for women (Meiselman, 1978).

2.2.5 Systems (family) approach

This approach deals with analysing how the child’s problems fit within the context of the family. McGoldrick and Gerson (1985, p. 4) describe the concept of a system as “a group of people who interact as a functional whole”. More emphasis is placed on recognising processes and interactive patterns within the family. Hence, people and their problems do not exist on their own (CONNECT, 2001). The family is considered to be the primary and the most powerful system to which any person can ever belong (McGoldrick & Gerson, 1985). As a counsellor, one should remember that a family is not a single monolithic entity but it is made up of a group of individuals (Geldard & Geldard, 2008). A family varies from culture to culture (Hanzi, 2006). Nowadays, a family is an ever-changing entity with a variety of family types including those described as nuclear, extended or blended and families with step-parents, single parents and same-sex partners (Kanyowa, 2003). Children from any type of family are vulnerable to CSA and the effects of CSA can equally affect the individual and his or her family. In this regard, Geldard and Geldard (2008) maintain that if a child has emotional problems leading to the exhibition of strange behaviours, these behaviours have an impact on the family environment and all its members. When the child is counselled, it is beneficial to involve the family in the counselling process, that is, integration of individual counselling with family therapy. Pertaining to the CSA scourge, Hing (2010, p. 111) states, “there are emotions that a parent has to deal with, and counselling for the family is always advisable”. Family systems approach therefore assumes that everyone/everything is interconnected, and that intervention can impact the whole system (Myer-Hopkins & Laaser, 1995).

Genograms – the major counselling techniques in family therapy – are best used to show the client and his or her family system, relationship types, emotional involvement with and within family members, and all the significant others in the client’s life are indicated (McGoldrick & Gerson, 1985). A genogram is furthermore a rich source of interpretations about how a clinical problem may be connected to the family context and the evolution of both the client’s problem

and its context over a certain period of time (McGoldrick & Gerson, 1985). Counsellors should therefore try by all means to implement the genogram technique in order to know the possible influences on a child. Below is an example of a simple genogram.

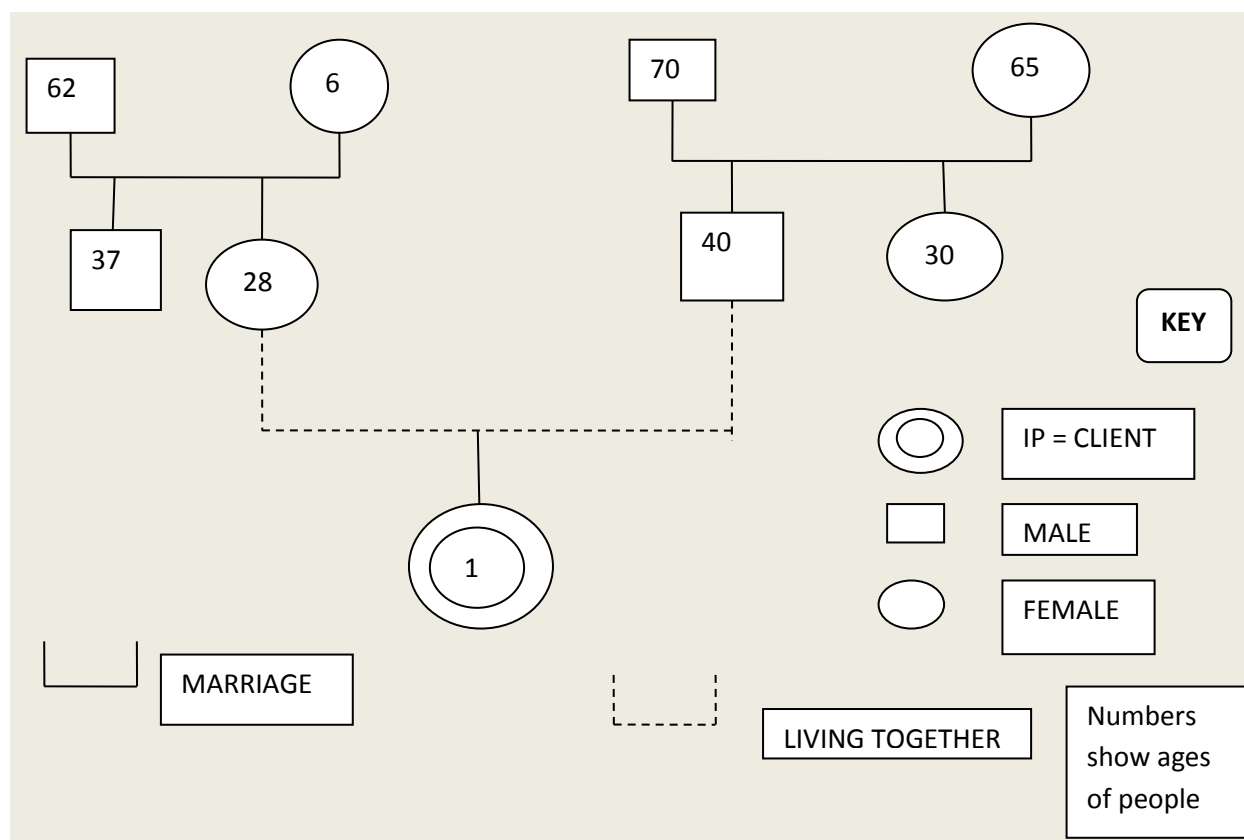


Figure 2.1: A simple genogram adapted from CONNECT (2001) and McGoldrick and Gerson (1985)

The family/systemic perspective involves the understanding of the problem in its context and checking all the levels since different family generations are believed to influence family members (McGoldrick & Gerson, 1985). In this sense, current and historical issues influencing the family are considered. Family members in a closed system tend to react automatically to one another and they do not allow the entrance of events outside the family system. The members of a family system fit together to constitute a functional whole and the behaviour of various family members are complementary (McGoldrick & Gerson, 1985). In a sense, family members with poor relationships are vulnerable to dysfunction, which generally occurs when the stress levels are higher than the system's capacity to deal with it (McGoldrick & Gerson, 1985). The aim of intervention, according to Myer-Hopkins and Laaser (1995) is to find ways of opening up the system. Figure 2.2 below shows the influence of family members on an individual child.

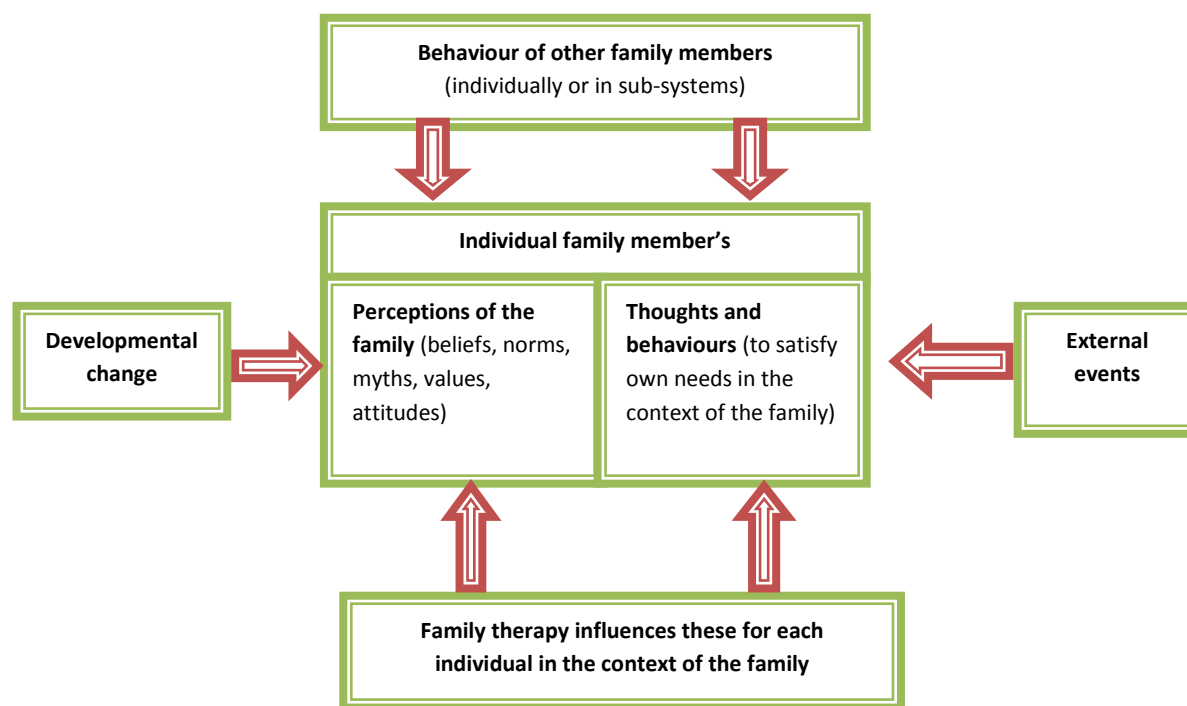


Figure 2.2: Influences on an individual family member's perceptions, thoughts and behaviours (Adopted from Geldard & Geldard, 2008, p. 77)

According to Geldard and Geldard (2008), a child has perceptions about his or her family and these perceptions are based on the family beliefs, norms, myths, values, attitudes and cultural background. For example, a child might perceive incest as a family secret, which should be known only by the family. As counsellors, being aware of such perceptions would help in dealing with such a child and how to address the child during family therapy.

During the counselling of a sexually abused child, a family therapist would invite all family members – including the child – to share their individual perspectives of the family with regard to the CSA issue and to observe and understand their own current thoughts, behaviours and perceptions with regard to their relationships with other members of the family (Geldard & Geldard, 2008). Family members are encouraged to take part and this helps everyone in dealing with the emotions of the sexual abuse.

Rhatigan and O'Leary (2004, p. 1) state that during interventions for sexually abused children

Three issues are of particular relevance during counselling. The first relates to the child victim at the time of the discovery or disclosure of the abuse, and prior to entry into a family counselling program. The second looks at counselling programmes that emphasise the family dimension and the third one relates to counselling approaches for perpetrators of abuse.

The authors are emphasising the need for the family systems approach to counselling. Although Rhatigan and O'Leary (2004) highlight counselling approaches for perpetrators, Delaney (2009) highlights that Childline Zimbabwe does not aim its services at perpetrators of abuse but refer them to relevant organisations like the police and adult counselling organisations like the Musasa Project and Padare.

In the Zimbabwean culture, the problem of CSA impacts on the whole extended family and the community at large. Children are therefore the responsibility of everyone. If there are CSA issues, family counselling would be used where aunts (*tete* in Shona; *babakazi* in Ndebele) and uncles (*sekuru* in Shona; *malume* in Ndebele) would be approached to deal with such sensitive cases before serious cases would be taken to the kraal head or *sabhuku* (Kanyowa, 2003). This shows how important the family is as a system comprising of interrelated parts that mutually affect each other (Kanyowa, 2003).

The long-term effects of child sexual assault can truly be reduced when the child is part of a caring system in which the sexual assault was disclosed to a strong and supportive family alliance where all family members took the abuse seriously and dealt with the crisis accordingly (Burgess *et al.*, 1978). As a result, families who are able to support the child consistently take the lead in the counselling process since they direct the child to the recovery process where the counsellor consults, intervenes and supports the child and his family (Burgess *et al.*, 1978).

2.2.6 Multifactorial Theories

Ward and Siegert (2002) state that in recent years, multifactorial theories of child sexual abuse were developed. Ward, *et al.* (2006) refer to multifactorial theories as level one. Ward and Siegert (2002) illustrate that the best overlapping and unique elements of broad perspectives or other theories are integrated in an attempt to formulate a comprehensive theoretical framework. Furthermore, multifactorial theories involve the integration of thoughts, cognitions, and feelings; and there is an integration of biological, environmental, social and behavioural aspects in counselling and therapy (Ward, *et al.*, 2006). The aim of this theory knitting is to develop a rich, comprehensive and integrated theory (Ward & Siegert, 2002). The multifactorial theories discussed in this section include integrative models, integrated theories and the eclectic or pre-conditions model. Although these theories are not the same in theoretical literature, in this research the researcher discussed them interchangeably since they are closely related and are found under one group.

The eclectic model or pre-conditions model was devised by Finkelhor (1984). This model encompasses or borrows concepts from many other psychological theories. It has been asserted by many researchers that most contemporary counsellors subscribe to this approach where they use different skills and theories for a single case (Barbaree & Marshall, 2006; Geldard & Geldard, 2008; Ward *et al.*, 2006). Hence, there is strong support in literature for the use of multifactorial theories and/or approaches.

According to Finkelhor (1984), there are four separate underlying factors that explain not only why offenders abuse, but also why the abuse continues. These factors are:

1. **Emotional congruence** – which explains the relationship between the adult abuser's emotional needs and the child's characteristics. An example might refer to an abuser who develops low self-esteem when communicating with other adults. Such a person would find comfort in having social relations with children leading to sexual abuse of children.
2. **Sexual arousal** – this is explained in terms of the social learning theory described by Isom (1998) in section 2.2.3 above. This theory proposes that a child's sexual abuser was abused when he or she was a child. Later in life, through conditioning and imprinting, the abuser then finds children sexually stimulating and arousing.
3. **Blockage** – refers to the abuser's inability to have his or her sexual and emotional needs met in adulthood. There are two types of blockages. Developmental blockage occurs when an individual is psychologically prevented from moving into the adult sexual stage of development. Situational blockage deals with individuals who have apparent sexual interests but are blocked from normal sexual expression owing to the loss of a relationship.
4. **Disinhibition** – explains which factors the perpetrator uses to molest a child. Factors contributing to the lowering of inhibitions include personality factors, substance abuse, stress and mental problems. It is normally a combination of these factors that cause a child to be sexually molested. The relief that is associated with sexual offending is reinforcing because it provides an emotional and physical response to coping in a way in which the offenders feel they have control.

During integrative approaches to counselling, counsellors are directive or non-directive, interpretive or non-interpretive (Hough, 1998). These four issues are contentious among counsellors who work with children. Most counsellors thus take a polarised position during integrative therapeutic approaches. In this regard, Geldard and Geldard (2008, p. 42) illustrate that such counsellors “tend to use the approach of their choice within all of their counselling

sessions”. Apparently, valuable work can be done in many different ways and that the counsellor’s individual counselling style needs to be one which appeals to him/her as well (Geldard & Geldard, 2008). Using multifactorial theories or an integrative counselling approach, it is believed that levels of flexibility are needed in order to fulfil the needs of each individual client child, since no two child sexual abuse cases are identical (Burgess *et al.*, 1978). Figure 2.3 below illustrates how a counsellor using the integrative approach can use counselling styles from different approaches.

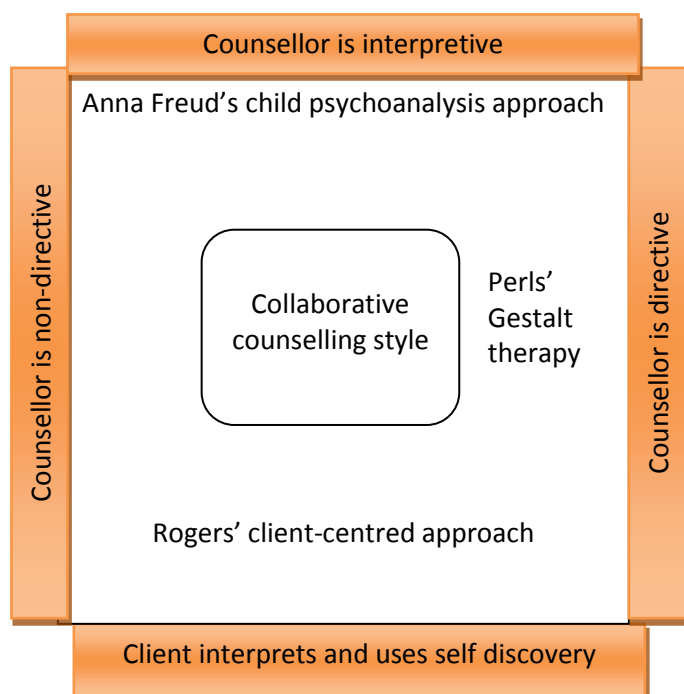


Figure 2.3: Different counselling approaches (adapted from Geldard & Geldard, 2008, p. 42)

The use of integrated counselling approaches adds value to the counsellors’ work as Terry and Tallon (2004) further propound that a combination of genetic and psychodynamic factors (early childhood experiences and level of psychosexual development) interacts with cognitive factors for offending behaviour to occur. Therefore, together with the use of other theories, a counsellor explores the biological, psychodynamic, cognitive and behavioural theories during counselling of child victims of CSA. These theories can therefore “complement each other, and together, rather than apart, build a road to more effective treatment strategies for victims of child sexual abuse” (Joyce, 1995, p. 15). Integrative theories are etiologically rich because of their explicit or implicit inclusion of cognitive, behavioural, volitional and affective factors (Ward *et al.*, 2006). However, the authors comment that therapists should take note when

using the multifactorial theories; they should not adopt a 'one-size-fits-all' approach to all their CSA cases.

The integrative approach has advanced further and is supported by the unified model developed by Ward *et al.* (2006), and the sequentially planned integrative counselling for children (SPICC) model developed by Geldard and Geldard (2008). Although the SPICC model is very similar to the integrated or eclectic approaches, the concepts of the SPICC model have been developed further so that they specifically relate to the counselling of children. Particular theoretical models of counselling, theoretical concepts and practical strategies that are sequentially organised are drawn from prominent psychotherapeutic approaches that include, amongst a variety of well-established theories, psychodynamic, cognitive-behavioural and behavioural therapies (Geldard & Geldard, 2008). According to Geldard and Geldard (2008), the SPICC model was developed to help children during therapy to move around the spiral of change occurring within the child. Table 2.1 below shows the processes in the spiral of therapeutic change and Table 2.2 shows the phases of the SPICC model to counselling.

Table 2.1: The processes of SPICC in the spiral of therapeutic change

Stages in the counselling process	Processes required as described by the spiral of therapeutic change
Disclosing information with regard to specific troubling issues	The child joins with the counsellor. The child begins to tell his/her story.
Focusing experientially on one's experience; trying to articulate the experience in words	The child continues to tell his/her story. The child's awareness of issues increases. The child gets in touch with emotions and may experience some catharsis (emotional release). The child deals with deflection and resistance.
Making changes in thinking and shifts in perception	The child develops a different perspective or view of him/herself. The child deals with self-destructive beliefs. The child looks at options and choices.
Engaging in behavioural experimentation; new experiences which then feed back into the cycle	The child rehearses new behaviours; he/she experiments with, and evaluates these new behaviours.

Adopted from Geldard and Geldard (2008, p. 66)

Table 2.2: Phases of the SPICC model

Phase	Processes required as described in the spiral of therapeutic change	Therapeutic approach used in the SPICC model	Method of producing change and desired outcome
Phase 1	The child joins with the counsellor. The child begins to tell his/her story.	Client-centred psychotherapy	Sharing the story helps the child to begin feeling better.
Phase 2	The child continues to tell his/her story. The child's awareness of issues increases. The child gets in touch with emotions and may experience some catharsis. The child deals with deflection and resistance.	Gestalt therapy	Raised awareness enables the child to clearly identify issues, get in touch with emotions and release strong emotions.
Phase 3	The child develops a different perspective or view of him/herself.	Narrative therapy	Reconstructing and thickening the child's preferred story enhances his/her self-perception.
Phase 4	The child deals with self-destructive beliefs. The child looks at options and choices.	Cognitive-behaviour therapy	Challenging unhelpful thoughts and thinking processes produces behaviour change.
Phase 5	The child rehearses new behaviours; he/she experiments with, and evaluates these new behaviours.	Behaviour therapy	Experiencing new behaviours and their consequences reinforces adaptive behaviours.

Adopted from Geldard and Geldard (2008, p. 67)

The use of the SPICC model in the counselling of child survivors of CSA provides brief and cost-effective counselling services with positive outcomes for the majority of child clients. In addition, it is highlighted in Geldard and Geldard (2008) that the integrative SPICC model is complete since it addresses emotional issues, restructures the client's cognitive processes

and helps in achieving behavioural change. It is recommended that the child's family or significant others be involved during the phases of the SPICC model (Geldard & Geldard, 2008).

Ward *et al.* (2006) advised on moving toward a unified theory of sexual offending. This theory integrates and puts together various theories and sexual knowledge in relation to sexual offending. The theory also shows the relationship between human nature and human functioning. According to Ward *et al.* (2006), there are three main systems that interact in a dynamic way for sexual offending to occur. These are biological inheritance, ecological niche and the three psychological functioning systems. Ward *et al.* (2006, p. 332) add, "these three sets of causal factors combine to generate the clinical problems evident in offenders, and their sexually abusive actions". Geldard and Geldard (2008) summarise this by saying that the integrative model makes use of ideas from a variety of differing therapeutic approaches. This can easily be varied to suit the needs of an individual child. Figure 2.4 below is a diagram to represent the unified theory of sexual offending.

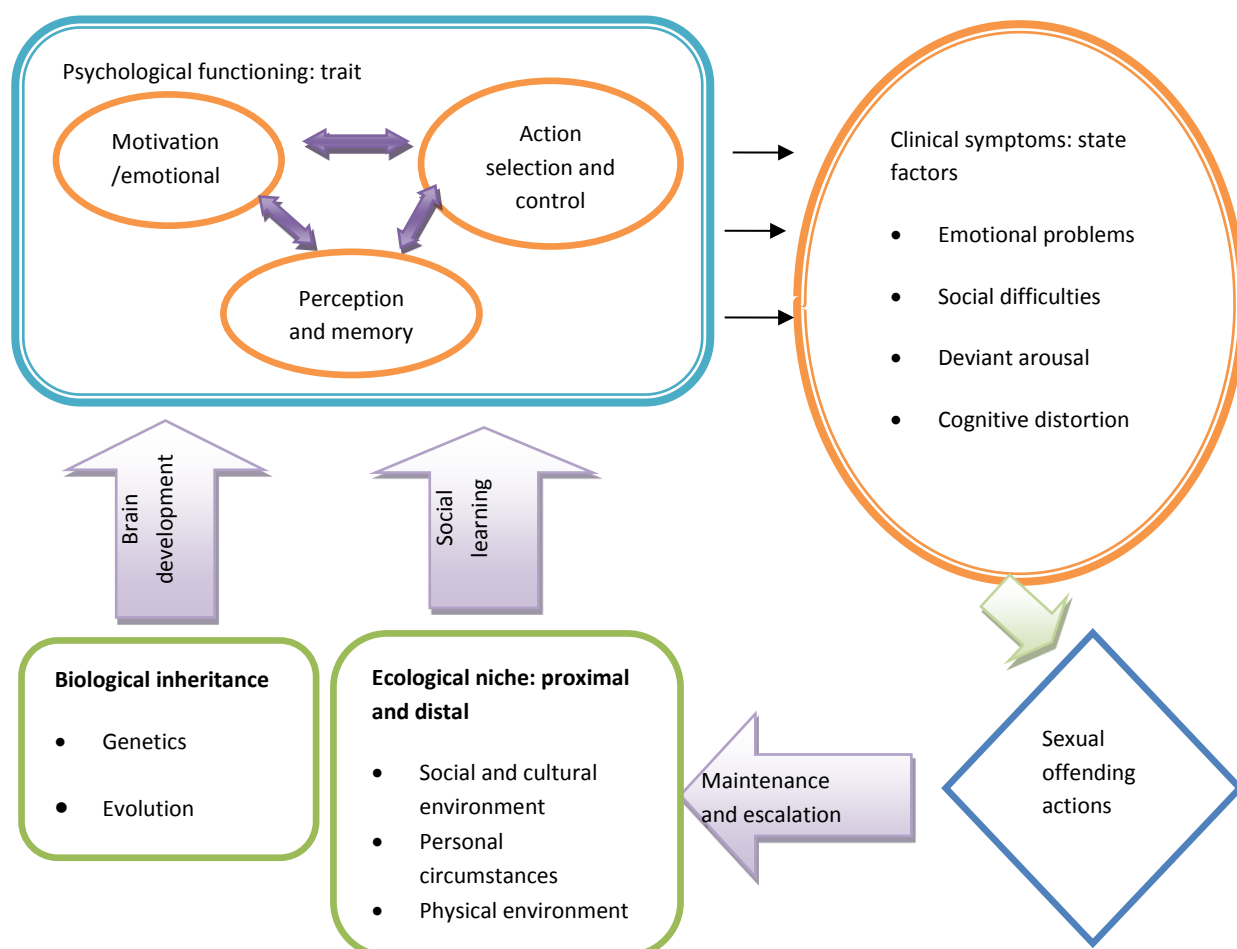


Figure 2.4: A unified theory of sexual offending. Adopted from Ward *et al.* (2006, p. 333)

A counsellor with knowledge of the multifactorial approaches to counselling will be able to address the needs of the child through investigating the factors that led to the abuse. Although Finkelhor (1984) suggests only four conditions forming the integrated approach, nowadays with the use of contemporary theorists such as Ward *et al.* (2006) and Geldard and Geldard (2008), there are many theories that can be combined to form the multifactorial approaches to counselling. The multifactorial approaches help counsellors to borrow ideas from other schools of thought. Hence, counsellors are not limited to the use of one theoretical approach to counselling.

2.3 TYPES OF CHILD SEXUAL ABUSE

Children experience sexual abuse at different ages and in many different ways. The following discussion focuses on the common types of child sexual abuse.

2.3.1 Rape

According to Madu (2001), rape is defined in terms of forcing sexual intercourse or any other sexual activity on someone else. Rape is in most cases forced on a victim and it is a form of coercion. Rape of a child is the actual or attempted vaginal penetrative sex with a girl child by an adult male, or when an adult female engages in actual or attempted vaginal penetrative sex with a boy child. In a sense, a person commits rape of a child when the person has sexual intercourse with a child (Anonymous, 2003). In this regard, Burgess *et al.* (1978, p. 61) propound that “in rape, the child is forced to have non-consenting sexual activity under duress, threat, or intimidation. Victims experience the rape as a life-threatening situation”. As illustrated by Craig and Giotakos (2011), feminist theory views rape as a pseudo-sexual act induced by the socio-political domination of men. According to this view, the belief is that rape is a form of violence experienced by women due to the gender roles; however, nowadays, there are also reports of males experiencing rape as explained by Hartill (2009) and the UNICEF (2012) report.

According to Rape, Abuse and Incest National Network [RAINN] (2009), **Object rape** is another offence perpetrated against a child. Object rape, also called **digital penetration** occurs when “a person causes the penetration or touching however slight, of the genital or anal opening of a child by any foreign object with the intention of arousing or gratifying the sexual desire of any person” (Anonymous, 2003, p. 5). Examples of objects or instruments used during object rape include, among others, sticks, fingers, candles or cutlery. For example, Kattakayam (2012) reports that a 19-year-old man forcefully took an 80-year-old

woman into bushes and inserted a wooden stick into her private parts and blocked her cries with his hand, leaving her bloodied and unconscious.

2.3.2 Incest

According to Brakarsh (2006, p. 4), incest occurs “when a person intentionally has sex with another person who is a blood relative or related by marriage or adoption”. This means that incest involves sexual relations with one’s relative, for example, a mother, father, uncle, brother or sister. Makhubu (2005, p. 55) states, “Child sexual abuse within a family or an extended family system shows that one or several of the boundaries within the family are distorted.” This means that when a parent takes the child as a sexual partner, he or she removes the child from the child’s sub-system to the parent’s sub-system and the child takes over adult responsibilities. In traditional Zimbabwean culture, incest was an acceptable norm in some ethnic groups. For example, Chiremba and Makore-Rukuni (2002) explain that in the royal families, incest was promoted among the family members as a way to curse evil spirits, but incest in other families would call for punishment.

Burgess *et al.* (1978) affirm that knowing that a child has been sexually assaulted by a family member is mostly an upsetting event for a family. For the family to report the case to the suitable authorities like the police, there are many considerations, for example the relationship between family members and the victim and perpetrator, the physical trauma for the victim, the ages of the people involved, and the opinions and views of the community regarding sexual contacts between family members (Burgess *et al.*, 1978).

If the child reports sexual abuse within the family, there is a tendency by family members to deny the sexual abuse in order to protect the abuser and to preserve family dynamics (Hing, 2010). The experience of many incest victims is most disturbing since such children find that home, instead of being a safe place, becomes a maze where they are lost and afraid, with monsters ready to pounce (Cattanach, 2008). In most instances, the child is silenced by the abuser not to disclose the abuse; therefore, “the child, trusting the abuser, is sworn to silence or threatened with violence including death” (Chiremba & Makore-Rukuni, 2002, p. 46). According to Chiremba and Makore-Rukuni (2002), the family dysfunction approach to sexual abuse assumes that all family members are equally responsible for incest, so sexual abuse of a child in the family serves to maintain family pathology and therefore should be kept secret. In this regard, Chiremba and Makore-Rukuni (2002) argue that there is no scientific proof that the whole family is equally responsible for the occurrence of incest. Hence, the family dysfunctional approach tends to ignore the perpetrator of incest, while other family members are left with guilt feelings, which allow them to maintain a destructive denial of own

responsibility. In addition, Ward *et al.* (2006, p. 170) emphasise that incest according to the family dysfunction approach is abnormal behaviour and “the source of the blame was pinpointed as the mother, which conveniently drew attention away from the responsibility and gender of the perpetrator”. Victim blaming is still a problem in most countries, including Zimbabwe; hence, the survivors of incest may be afraid that people will accuse them of having done something wrong that caused the incest to happen (RAINN, 2009). As a result of the forced secrecy evoked upon children by their ‘trusted’ abusers, Cattanach (2008) and Hing (2010) illustrate that the child survivor’s fear is the most probable reason for the nondisclosure of CSA cases. Children who cannot be silenced about their abuse, end up telling someone outside the family, especially trusted persons like teachers, doctors, counsellors and the police (Hing, 2010). In this regard, Fouché and Joubert (2009) add that disclosure occurs as an incidental discovery by someone, during familial conflicts or during child empowering programmes by the community outreach agencies. In this case, Fouché and Joubert (2009) report that suspicion or the alleged sexual abuse by others leads to an official report being laid with the police and only when a docket is opened, a statement will be sought from the child. This means that there are very few voluntary disclosures of CSA by victims.

Nevertheless, incest cases, where the perpetrator is a parent, are particularly damaging since they disrupt the child’s primary support system which is the family (RAINN, 2009). Ways of addressing incest differ for those organizations that provide services for survivors. Most service providers, including Childline Zimbabwe and the Zimbabwean Department of Social Welfare lobby for the removal of the sexually abused child to a place of safety (POS) and sometimes the parent might be jailed. The child may have feelings of loss of family or he/she might think that the family chose to support the perpetrator (Makhubu, 2005). The child might feel isolated from family and other social support systems if he/she is put in a place of safety. Makhubu (2005) further asserts that the removal of the child from the incestuous home might be traumatic since the child might have attained skills on coping with the situation or the child might feel that he/she did something wrong, hence the removal. It is suggested in this regard that removal of the sexually abused child from his/her home is not the best option but intervention options should be sought in the context where the abuse occurred instead (Makhubu, 2005). For example, one way is to refer the family for systems/family counselling where both the child and the perpetrator are helped instead of focusing on only the child, a service offered by the Zimbabwe Institute of Family Therapy (CONNECT, 2001).

2.3.3 Sodomy and indecent assault

Sodomy is the actual or attempted anal penetrative sex with a boy or girl by an adult male. A woman can also have a boy’s penis inserted in her anus (Brakarsh, 2006). Sodomy can

happen due to a number of factors, such as sexual pleasure, rebelling against one's own personality and for ritual purposes. In Bwititi (2011, p. 1), Ruparanganda claims, "some traditional healers advise their clients to engage in sodomy as a way of treating curses or to exorcise some demonic spirits". In fact, all forms of anal penetration are regarded as sodomy. It has recently been noted that more cases of sodomy have been reported than before. Bwititi (2011, p. 1) states that the police said, "... we have noted with concern the increase in the number of sodomy cases. In the past, sodomy cases were rare, but nowadays; hardly a week goes by without a report of a sodomy case". Bwititi (2011) further states that Childline Zimbabwe has recorded an increase in children who report sodomy cases and the perpetrators were family members. Men in the patriarchal societies prefer to conceal sodomy instead of revealing it, as it is associated with shame and guilt. In a school in Zimbabwe, a 19-year-old head boy had sodomised 10 other boys in the school in a short period of time (Court Reporter, 2010). The number of boys receiving counselling due to sodomy has also increased (Bwititi, 2011).

According to Brakarsh (2006), indecent assault involves fondling of a child's sexual parts, such as breasts, buttocks and genitals. Brakarsh (2006) illustrates that anal penetration with a female is considered indecent assault. It was reported in Save the Children Sweden (2005, p. 20) that "indecent assault covers most of the non-consensual sexual assaults or acts involving physical contact that are not currently included in the definition of rape". This means that any physical contact of a sexual nature between the abuser and the victim is considered indecent assault. All the indecent assault acts, for instance being fondled by an uncle, take place without the child's consent and the child is made to believe that such acts are culturally acceptable (Chiremba & Makore-Rukuni, 2002). In traditional Zimbabwean culture, indecent assault was allowed on the basis of culture as it was a way of grooming young girls in preparation for later in their lives when they would get married. At times, the wife could allow her husband to be sexually involved with her young sister so that her husband would not go to another woman (stranger) and the parents of the wife and her young sister would ask for 'damage' to be paid by the husband so that he would be allowed to marry the young girl when she matures (Chiremba & Makore-Rukuni, 2002). However, it was only the members of the extended family, for instance the uncles and brothers in-law who would fondle the sexual parts of their nieces. If it were other people outside the extended family fondling the girl child, it was considered a criminal offence (Chiremba & Makore-Rukuni, 2002).

Today in Zimbabwe and elsewhere, indecent assault is an offence (Sexual Offences Act – Chapter 9:21, Parliament of Zimbabwe, 2001) as children are encouraged to report any contact of a sexual nature by any person, whether it be a relative or not; thus, the traditional fondling of girls is now considered a criminal offence. Sexual abuse may begin with

inappropriate touching, fondling, viewing pornography and/or exposure to sexual acts. This may then lead to sexual intercourse or rape. Indecent assault does not only occur within families, but also in other institutions where young girls are taken advantage of by males in power positions, for instance in churches and schools, or at community gatherings. Hence, “sexual abuse is a power game wherein the child is made to feel powerless by repeated invasion of her body and psyche through the use of force or deceit” (Chiremba & Makore-Rukuni, 2002, p. 68).

2.3.4 Statutory rape and abduction

Statutory rape is defined as unlawful sexual intercourse with any girl under the age of 16 years with her consent (Brakarsh, 2006). Additionally, Fox and Nkosi (2003, p. 3) point out that “sex with a child under the age of 16 is legally defined as statutory rape”. This means that any sexual activity with a child below the age of 16 whether consensual or not is regarded as statutory rape. Children have limited knowledge and cannot consent to sex with adults even if the child and the adult join willingly in the sexual activity (Fox & Nkosi, 2003; Grubin, 1998). Most sexual abusers believe that there is nothing wrong with their actions since the girl has agreed to it, hence when discussing their offending, child sexual offenders make statements like “but she enjoyed it” (Ward *et al.*, 2006). There is a need to raise awareness on the age of consent and for people to know that any child of 16 years and below is not able to consent to sexual acts. Makhubu (2005) reports that children sometimes give apparent consent to sexual activity and that children may like the feeling of being touched and sexually aroused but they are not aware of the consequences such as sexually transmitted infections, pregnancy, future guilt and distress.

Statutory rape happens in situations where the perpetrator is in a power position or the perpetrator has responsibility over the child (Grubin, 1998). Although the child sometimes agrees to the sexual activity, abusers often use physical power and threats to force the child to agree to sexual activity (Makhubu, 2005; Richter, Dawes, & Higson-Smith, 2005). Some child victims of statutory rape have ended up being forced by their parents to marry their abusers, especially if the child had fallen pregnant but if the case is reported to law enforcement agencies, the abuser can be charged with breaking the statutory rape laws (Thomas, 2009).

Brakarsh (2006, p. 5) defines child abduction as “intentionally taking a minor against the will of the parents, guardians, or custodians of the minor with the intention of the person or another party marrying or having sexual intercourse with the minor”. Some sexual offenders use the pretence of ‘marriage’ so that they get access to children (Lanning, 2010). This means that the

offender takes advantage of a child's vulnerabilities, thereby abducting her and telling her that he will marry her. Such children often go voluntarily with the offender (Lanning, 2010). The author further states that in some cases, the offender takes the child away or steals the child without returning her to her home because he wants the child all to himself, away from a 'judgmental' society. He then tries by all means to prevent the discovery of his sexual activities with the child. The child is kept alive for a long time. The abductor usually has long-term methods of controlling the child, for example physical controls such as a sound-proof room, guards for the child, or a very far away location (Lanning, 2010). In this regard, the child is abducted or kidnapped for the purposes of sexually abusing the child. Sometimes the adult male can abduct a girl child without the consent from the child but the guardian has consented to such abduction (Brakarsh, 2006). Traditionally in Zimbabwe, parents married out their young children (girls) so that they could get *lobola* (the bride prize/dowry paid by the husband to the girl's biological parents and/or their relatives). This is a form of abduction since the child is forcefully taken away from her guardians. As a result, children drop out of school to fulfil their new roles of being married. An example of this type of abduction is reported by Thomas (2009). Forced marriages are carried out by men who capture a young woman through physical force and take her to the home of the intended groom where she would be psychologically and physically coerced to consent to marry. Thomas (2009) adds that in some cases, the young woman is raped on arrival at the abductor's house so that she will be too ashamed to return to her parents.

2.3.5 Child pornography

Child pornography is defined as "any means of depicting or promoting sexual abuse of a child, including print and/or audio, centred on sex acts or the genital organs of children" (Anonymous, 2010, p. 1). Offenders view and make use of various sexually explicit visual materials of a minor such as photographs, slides or movies (Lanning, 2010). Child pornography is also linked to paedophiles (Lanning, 2010). Paedophiles usually collect and store child pornographic materials. FBI agent Ken Lanning propounds that "collecting pornographic materials does not mean that they merely view pornography but they save it and it comes to define, fuel, and validate their most cherished sexual fantasies" (Lanning, 2010, p. 79). Offenders who use child pornography find pictures of naked children erotic (Berlin & Krout, 1994). In a sense, pornography also has much greater effects on children just like other sexual abuses (California Coalition against Child Sexual Assault [Calcasa], 2008) since children are made to watch materials they would not normally want to view.

2.3.6 Exhibitionism, voyeurism, oral sex and forced masturbation

Exhibitionism is another form of child sexual abuse in which an adult gets sexual gratification without any physical contact but through visual contact with a child (Burgess *et al.*, 1978) as the adult only displays or exposes his/her genitals to a child. A child may also be forced to undress for the offender to get sexual satisfaction. Lanning (2010, p. 44) refers to exhibitionist sex offenders as “flashers” because they quickly expose their sexual parts to children in order to gain sexual gratification. For example, some women undress in front of windows to expose or display their bodies to strangers (Encyclopedia of Mental Disorders, 2013).

Voyeurism involves having a child to pose for or watch sexual activities. Thus, a person is guilty of voyeurism because of “viewing any portion of a child’s body regarding which the child has a reasonable expectation of privacy, whether or not that portion of the body is covered with clothing” (Anonymous, 2003, p. 10). In some cases, voyeurs make use of equipment that is concealed to videotape, record, film or photograph the body of the child secretly. Voyeuristic activities involve “window-peepers” (Lanning, 2010, p. 44) who look at a child’s body through a window and sometimes using binoculars for the purpose of sexual gratification.

Oral sex is another form of sexual abuse. It involves the use of the mouth to the sexual parts of a child, or the mouth of a child to the sexual parts of the perpetrator (Barriere, 2008; Brakarsh, 2006). Chomba (2012, p. 2) adds that “oral sex can also be in the form of felatio which involves penile satisfaction by licking or sucking with the mouth and tongue”. The offender may also ask the child to suck or lick his or her sexual parts, i.e. the penis, anus, vagina or breasts, or the offender may suck or lick these parts of the child. Makhubu (2005) regards forced masturbation as another way of molesting a child sexually. The offender could ask a child to rub or hold his/her sexual organs causing him/her to masturbate and gain sexual gratification. Some offenders fantasise about children while they masturbate (Berlin & Krout, 1994).

According to Lanning (2010), masturbation is an example of paraphilia (a psychosexual disorder) and not of a sex crime. Some paraphiliac people become sexual offenders when they engage in or act out their fantasies illegally, for example with non-consenting partners, including underage partners.

The abovementioned types of child sexual abuse are however, influenced by a number of factors that predispose children to sexual abuse. These factors are discussed in the following section.

2.4 FACTORS CONTRIBUTING TO CHILD SEXUAL ABUSE

A number of factors that contribute to child sexual abuse have been identified. Child sexual crimes are caused by a multitude of interacting distal and proximal developmental, social, biological and situational factors (Ward *et al.*, 2006) and all these influences should converge at one time and in the correct context for offence to occur (Townsend & Dawes, 2005).

2.4.1 Social factors

2.4.1.1 Unemployment and poverty

According to researchers (Hing, 2010; Save the Children Sweden, 2005; Townsend & Dawes, 2005), there is a general global link between unemployment, poverty and child sexual abuse. Poverty and unemployment cause families to live in overcrowded housing which enhance temptation and provide opportunities for incest (Meiselman, 1978). Unemployment is a well-known social problem that causes stress and anxiety to parents who cannot meet the needs of their families (Hing, 2010). When parents are unemployed, there is often poverty in the family since it is in most cases difficult for them to provide for the basic needs of the family. Feeding for their children is often a problem. Basic needs such as food, water, education, clothing and housing are not met. Townsend and Dawes (2005) propound that many children lacking these basic necessities are vulnerable to being abused, and many of them are found to be paying rent and school fees, buying food for their siblings, school uniforms and books with money provided by their abusers. It is, however, proposed in Save the Children Sweden (2005) that although poverty itself does not cause CSA per se, the hardships that are associated with poverty can be a great source of stress that could lead to frustration and disempowerment. In situations where the man, husband/father is unemployed, he (the man) is unable to fulfil the traditional role of providing for his family. In such cases, poverty will increase the chances of exploitation, and children from such family, where the father is not a breadwinner, are likely to be involved in child labour and sex work in return for food, money and material goods.

Poverty can also increase the vulnerability of women who are economically dependent on their husbands for survival and unable to leave their abusive husbands (Save the Children Sweden, 2005). While there are many other causes of CSA, organisations like ACCESS (Alliance for Children's Entitlement to Social Security, 2003) argue that alleviating poverty alone would go a long way in curbing the economic and social problems affecting children in Southern Africa.

2.4.1.2 *The acceptance of violence in society*

According to Save the Children Sweden (2005), the violent nature of patriarchal societies has impacted on CSA. Barbaree and Marshall (2006), Townsend and Dawes (2005) and Ward *et al.* (2006) all say that societies known to have high levels of interpersonal violence, male domination and unfavourable attitudes toward females and children have high rates of sexual crimes. In Zimbabwe, the political violence has been deeply entrenched in the lives of people, both young and old. Where people are subjected to violence, there are tendencies of people not to respect the rule of law, and children's rights are also hampered. During the dark political violence period in Zimbabwe, Childline Zimbabwe received many reports of CSA as shown by Mutandwa (2012) who reports that Childline Zimbabwe had received an increased number of child sexual abuse reports. For instance, Chikwanha (2013) reported that in 2010, Childline Zimbabwe received 277 093 calls, and the number almost doubled in 2011 with 514 625 calls and in 2012, 661 326 calls were received. These calls included different cases of child abuse including sexual abuse. Heiberg (2001, p. 20) adds, "The political set-up and the role played by those in authority and power make sexual exploitation possible". The Zimbabwe Women's Coalition (Hufstader, 2006) initiated a domestic violence bill and pushed it through Zimbabwe's parliament by late 2006. The bill became law in 2006 and is called the Domestic Violence Act [Chapter 5:16] Act 14/2006 with clear laws against domestic violence (Hufstader, 2006). Among other pressing problems affecting women and children in Zimbabwe, the Domestic Violence Act [Chapter 5:16] outlaws abuse based on cultural practices that oppress women, for example forced virginity testing, forced marriages, child marriages and pledging women and/or girls as a way of appeasing spirits or paying debts. The Act also empowers police officers to arrest alleged perpetrators of domestic violence (Domestic Violence Act [Chapter 5:16] Act 14/2006; Hufstader, 2006).

In the past, domestic violence, including wife and child battering, was considered acceptable domestic issues and therefore others (including the police) were not supposed to interfere (Hufstader, 2006). If violence (especially in patriarchal communities) becomes accepted in a normal and legitimate way in society (Save the Children Sweden, 2005), such society is bound to experience all sorts of crimes, including child sexual abuse. As Loffell (2005, p. 250) expounds, the phenomenon of child sexual abuse is seen to occur within a "culture of violence".

2.4.1.3 *Social and geographical isolation*

Some families or ethnic groups tend to live in certain areas where families of survivors are characterised as chaotic, aggressive and substance abusers; who live in closed systems that

are uncommunicative and socially isolated – all factors that silence child survivors of sexual abuse (Alaggia, 2010), for example, people who live in a national park, a farm or an island where they are very far from other villages or towns. They live in that area for all of their lives. Hence rituals such as marriage, rites of passage and other life processes are exercised with group members. Family members therefore go to those closest to them for sexual gratification (Hing, 2010). Although intermarriages can cause some genetic defects in children born from such marriages, for instance the Doma people in Zimbabwe, whose long isolation and extensive in-breeding has resulted in the prevalence of the genetic disease called electroductyly (split-hand/split-foot malformation) (Peel & Peel, 2013). According to Peel and Peel (2013, p. 1) electroductyly is “a genetic defect in which the middle three toes are missing and the outer two toes are turned inward, giving the appearance of ostrich feet”. Some communities such as the Australian Aborigines practice intermarriages as a way of survival (Meiselman, 1978). Socialisation is very limited due to geographical isolation. Children from such people are vulnerable to CSA since there is no possibility that an outsider can observe the abuse and report it (Hing, 2010).

2.4.1.4 *Unequal gender relations*

A big gap has been created between males and females in the name of culture and Mutandwa (2012) reports that a 14-year-old girl who was impregnated by her brother-in-law was forced by her parents and village head to marry her perpetrator. Mutandwa (2012) adds that this case shows the influence of culture, which allowed the perpetrator to view the girl as his wife. Kambarami (2006, p. 9) asserts, “The patriarchal nature of our society has shaped and perpetuated gender inequality to the extent of allowing male domination and female subordination.” Men and women view this inequality as normal since it is the way they were nurtured and socialised. Mutandwa (2012) posits that the economic, cultural and religious factors in patriarchal societies like Zimbabwe influence the majority of women to accept settlement of domestic issues at family level. Furthermore, Hlupo and Tsikira (2012) postulate that, although women movements are fighting for gender equality and equity, this trend is not the same across the globe as some women are still enduring the wrath of patriarchy. Hence, most women accept and appreciate their subordinate positions to their male counterparts (Hlupo & Tsikira, 2012). Women have no power or control over their own sexuality and this is largely challenged by liberal, radical and Marxist feminist theories. The work of such feminists has shown that men tend to monopolise positions of influence and decision-making both in the family and in the wider society and this is done at the detriment of women (Hlupo & Tsikira, 2012).

According to the Shona and Ndebele cultures in Zimbabwe, the socialisation process differentiates from a tender age, the girl child from the boy child, as boys grow up as superior beings and girls learn to be obedient and submissive to males (Kambarami, 2006). In another report, Save the Children Sweden (2005) reports that socialisation creates gender roles in which boys are taught to be in control and sexually assertive, while girls are expected to be nurturing and passive. Hence, “gender roles reinforce the system of patriarchy, and disempower women and children” (Save the Children Sweden, 2005, p. 41). Both males and females can be sexual offenders (Burgess & Grant, 1988). Some CSA theories, such as the social construction theory, show that men and women act according to the expression of masculinity and femininity concepts which they adopt from their contexts and environments (Chikovore, 2004) and women are seen as victims and men as perpetrators of sexual abuse. There is a need for education and re-socialisation in the family institution and other institutions so that men, women, boys and girls understand the need for equality in gender relations. This is supported by Hlupo and Tsikira (2012) who find it a pity that sensitisation workshops and training are centred on people who are already well informed without involving those on the periphery of the least developed districts. Counsellors should therefore assist female clients to understand how culture has managed to keep them in the submissive traditional roles (Rukuni & Maunganidze, 2001). In this regard, Hlupo and Tsikira (2012) urge civic groups with related scope of operations to decentralise to all remote areas to address the plight of women and girls in societies where abuse is sanctioned by society.

2.4.2 Individual factors

Certain individual factors predispose children to sexual abuse. The following section discusses these factors.

2.4.2.1 Substance abuse and mental retardation

In most cases, people who abuse children would be under the influence of substance abuse, such as drugs or alcohol (Save the Children Sweden, 2005). Simon *et al.* (1992) assert that people who commit crimes are involved with drugs and alcohol abuse and that such people are likely to engage in criminal behaviour, including child molestation. Berlin and Krout (1994, p. 6) add that sexual behaviour as a result of alcohol abuse can be enacted on a child due to the fact that “the alcoholic’s behaviour may be a reflection of diminished judgment secondary to intoxication.” In addition, Heiberg (2001) states that, the increase in sexual abuse and exploitation is related to the widespread use of alcohol and drugs. The environment in which children live can influence their chances of being sexually exploited. For example, children who live in brothels have no proper accommodation as they end up roaming around the

brothel at night where there are high risks of being abused or they sleep in the same tiny rooms as their mothers who might have clients (Heiberg, 2001).

Sometimes child sexual abusers are mentally challenged and tend to commit sexual crimes due to the state of their minds (Terry & Tallon, 2004). In addition, sex crimes are sometimes committed by persons who have psychotic or mental illnesses, and such illnesses may contribute to the sexual offense (Gordon & Grubin, 2004). Duva, Silverstein, and Spiga (2011) posit that people with psychotic disorders have been shown to be more impulsive than those without psychotic disorders. To this fact, Miller (2013, p. 2) highlights that “Generalized hypersexuality, substance use, psychosis or other severe mental disorder, some brain syndromes, or revenge against an adult partner are other causes and motives for sex with children”. Berlin and Krout (1994, p. 6) echo this issue and state that “a mentally retarded individual may become involved sexually with a child because of the lack of availability of adult partners, and a lack of capacity to fully appreciate and understand the wrongful nature of his actions”.

2.4.2.2 Disability

Physically challenged children are more at risk of sexual abuse than those without obvious disabilities. Disability includes mental challenges, visual impairment, physical handicap and hearing impairment. Abusers take advantage of such children since they have in most cases problems representing themselves when it comes to reporting the case (Pennstate Children’s Hospital, 2010). The condition of such children limits them in terms of their mobility or ability to be regarded as ‘normal’ beings and through the immobilising and perceptual handicaps, an offender takes advantage and gain access to the young victim by taking advantage of his or her handicap (Burgess *et al.*, 1978). Burgess *et al.* (1978) further assert that children with a physical or psychological handicap may be especially vulnerable to sexual molestation. They may, for instance, be exploited as the offender believes that the child will not know what is happening or that the abusive behaviour is inappropriate and the child may not be able to defend him/herself or escape from the abuse (Goldman, Salus, Wolcott, & Kennedy, 2003).

2.4.2.3 Age and stage of development

At a specific development stages, children are susceptible to sexual abuse. For example, babies and infants fall prey to sexual abuse due to their small physical size (Goldman *et al.*, 2003). Mullen and Fleming (1998) assert that the possibility for a child to be sexually abused might be increased by characteristics such as physical attractiveness, a lovable temperament or physical maturity and child molesters selectively target pretty and trusting children. In

addition, Mullen and Fleming (1998) state that early puberty or sexual maturation, for instance in girls, increases their chances of being sexually abused since they have developed secondary sex characteristics (such as breasts), which make the girl look more mature than she actually is. Therefore, abusers take advantage to involve a child sexually due to the child's hormonal changes as she starts puberty. In support of this, a report by Grubin (1998) states that in 1997 in England and Wales, girls between the ages of 10 and 15 were at the highest risk of all the females who were reportedly raped with a rate of 59 cases per 100 000 girls. In Zimbabwe, in a study conducted to investigate the sexual activity of children, the majority of children who were sexually active were between the ages 11 and 15 (UNICEF, 2001).

Some people who sexually abuse children were themselves sexually abused as children (Ward *et al.*, 2006). They then seek to re-enact such behaviour when they are older. As stated by Berlin and Krout (1994), many men with paedophilic erotic urges were sexually involved with adults when they themselves were children and therefore when treating a paedophile, a therapist is in effect treating a former CSA victim.

2.4.2.4 Children born out of extra marital affairs

Children born outside of a formalised marriage are not always considered to be worthy of protection and nurturance as compared to those born in a home where their biological parents had married before the birth (Richter & Dawes 2008). Such children are more vulnerable to sexual exploitation since they have limited protection (Goldman *et al.*, 2003). For instance, in Zimbabwe, some men have two wives. The wife formalised by marriage usually stays in the rural home, while the other one (informally called a 'small house') stays in town where the man works. Lalor (2005) reports that sub-Saharan African societies are male-dominated and have a social structure which prioritises the needs and wants of males over those of females. This is best explained as the "uncontrollability of male sexual urges and physical force in sexual relations" (Lalor, 2005, p. 12). Male dominance and the urgency for male sexual relief have been reported in Zimbabwe and for both Kikuyu men and women in Kenya. Men hence view satisfaction of sexual needs with various partners as normal, something which usually leads to the tradition of polygamy. Lalor (2004, p. 20) further highlights that "men are also viewed by women as morally weak and lacking in self-control in relation to sex". Lalor (2004, p. 21) found that the sexual abuse of children may be facilitated by the widespread belief and cultural acceptance of male dominance and the use of physical force in sexual relations.

Although children (because of their vulnerability and their traditional position in the family) are viewed as victims of CSA in many cultures, they should also be seen as individuals who can

contribute to the finding of solutions to the problems affecting them (Save the Children Sweden, 2005).

2.4.3 Family factors

There are a number of factors within the family setting that may expose a child to sexual abuse. These factors are discussed in the sections below.

2.4.3.1 Overcrowding

Overcrowding in the family leads to a lack of privacy. In addition, Save the Children Sweden (2005, p. 17) states –

The home is one of the most common settings in which child sexual abuse occurs, and this complicates the possibility of disclosure. In addition to the fear of not being believed or feeling ashamed or guilty, children that are abused in their own homes may also fear the loss of needed resources where the abuser is the breadwinner.

Children living in such conditions are vulnerable to sexual abuse both inside and outside the home (Goldman *et al.*, 2003). Therefore parents have problems in terms of being in full control of children who may be exposed to violence and abuse in their neighbourhoods (Richter & Dawes, 2008). Hence, children spend most of their time outside the overcrowded homes, going to places where they are prone to sexual offenders, for example in Zimbabwe, children are placed at risk of sexual abuse because of crowded homes where children are pushed into the streets (Heiberg, 2001).

2.4.3.2 Step-children

Abusers can easily get access to these children since they do not have both parents providing all the support (Goldman *et al.*, 2003), love and care that children need. Since all children are dependent on adults (Hing, 2010), the children feel powerless to come forward to report the abuse since they know that their entire belief system may be destroyed; therefore, the abused child especially an older child could often cover up for the perpetrator out of a sense of keeping the problem 'within the family' (Flournoy, 1996; Smith, 1994). In such a situation, abusive step-fathers (normally the breadwinner) can trick step-children by providing other materials they do not readily get from their mother. In America, according to Flournoy (1996), in the programmes aimed at the primary prevention of incest, it was proposed that the step-fathers needed special consideration since families affected by incest were mostly families where a step-father was present. Hence, Hing (2010, p. 85) reports, "the incidence of

stepfather-stepdaughter incest is far higher than between a daughter and her biological father”.

2.4.3.3 Marital problems

Marital problems can lead to divorce of parents, thereby exposing children and making them vulnerable to CSA since the family finds itself in stressful situations that might exacerbate certain characteristics of family members, such as hostility or anxiety and these may aggravate the levels of family conflict and maltreatment (Goldman *et al.*, 2003). Parents who do not understand each other for some reason put their children at risk of various types of abuse (Kanyowa, 2003). For instance, when the mother is pregnant or if she is sick, she may not want to be sexually involved with her husband. The father may then advance to his own daughters (Hing, 2010). Children with parents who have problems on the sexual side of their relationship are therefore vulnerable to sexual abuse and poor marital relationships have been associated with incest (Flournoy, 1996). Furthermore, some parents experiencing problems with their partners may start having out-of-wedlock partners. Children born from these illegitimate relationships have an increased probability of teen-sexual activity (Rector, 2012). As found by various researchers (Beitchman, Zucker, Hood, DaCosta, & Cassavia, 1992; Mullen & Fleming, 1998), many cases of child sexual abuse occur in children from socially deprived and disorganised family backgrounds. Marital dysfunction leading to the separation of parents, divorce and domestic violence is associated with higher chances of children being sexually abused within or outside the family (Mullen & Fleming, 1998).

2.4.3.4 Second marriages

Second marriages may increase children's vulnerability to CSA when their parents get new spouses after the death or divorce of one parent. Children may be prematurely exposed to sexual abuse due to their difficult circumstances at home. Goldman *et al.* (2003) report that in their study in America, out of 156 child survivors of sexual abuse, 27% of the abused children lived with their stepfathers. At times, some fathers in polygamous societies may marry a second wife. Children from such families end up losing trust and respect for their father because of his behaviour. In such situations, where children have to cope with the challenges of losing one parent in the case of death or divorce, they are again confronted with having to deal with a step-parent. Because of this upheaval in the family, Hing (2010) propounds that second marriages place children at risk, and such children are vulnerable to advances and sexual abuse by their step-parents or outsiders. In addition, Flournoy (1996) claims that step-fathers do not marry for the purpose of gaining access to their wives' daughters; but it is

believed that their inhibitions toward incest are weaker. Pertaining to such marriages, it was stated in 1 Corinthians 7:7-11 in the Holy Bible (n.d., p. 299) that:

For I would that all men were even as I myself. But every man hath his proper gift of God, one after this manner, and another after that. I say therefore to the unmarried and widows, it is good for them if they abide even as I. But if they cannot contain, let them marry: for it is better to marry than to burn. And unto the married I command, yet not I, but the Lord, Let not the wife depart from her husband. But and if she departs, let her remain unmarried, or be reconciled to her husband: and let not the husband put away his wife.

In Zimbabwe, there are various small Protestant churches and religious sects that believe in numerous marriages or polygamous marriages, and many young girls have been forcefully given out in marriage to old men and these men end up having many wives. Kambarami (2006) adds that young girls who are still in primary school are given or married out to older members of the Apostolic Sect, and such arranged marriages are believed to be due to prophetic revelations. Many people in Zimbabwe believe in spirit mediums, witch-doctors and 'mapositori' (prophets/faith healers) that are believed to have supernatural powers or to be the apostolic messengers from God. There are many reports of CSA cases reported to Childline Zimbabwe as children are married due to their belief in the work of the faith healers. However, Hough (1998) suggests that counsellors should follow a non-judgmental approach in terms of other people's values, views and beliefs, but should be neutral and accept and help the child in addressing the CSA problem.

2.4.3.5 Divorce

Children whose parents have divorced tend to be more vulnerable to abuse than those whose parents live together. Thus, according to Menard *et al.* (2004), even though abuse is not found throughout the whole community it is more likely to be found in disturbed and disrupted families. When children have to live with one parent, they are more vulnerable and have limited care. Children also spend time moving from one parent to the other. In this regard, Richter *et al.* (2005) found that children from incomplete families or broken homes are often more vulnerable to abuse than children from stable home environments. Incomplete families have a tendency of raising children who have more freedom due to limited parental control (Hing, 2010). In addition, children who live without parental supervision or protection are often at an increased risk of sexual exploitation (Save the Children Sweden, 2005).

Divorce seems to be a genuine tragedy in most societies as it generally leaves the marriage partners embittered and disillusioned. Goldman *et al.* (2003) add that children from single-parent families are more likely to be victims of physical and sexual abuse than children who live with both biological parents. For the children, divorce takes away the love and security of a healthy family. If their parents are divorced, it will be difficult for children to find good role models for their own future marriages. Therefore re-marriages are not considered as the best

option since many people in Zimbabwe believe in the Biblical idea of a marriage that lasts for life. Hlupo and Tsikira (2012, p. 3) assert that “women are encouraged to remain in marriage against all odds” and men are protected by culture with the freedom to marry, divorce and re-marry. In this regard, women suffer various types of abuse such as physical assault but they remain in matrimony. Different Christian denominations view remarriages differently. In this regard, Shafer (1999) reports that in the year 2000, Pope John Paul II’s view that many according to the Catholic Church, Catholics who are divorced and remarried are unworthy to receive Eucharist (the consecrated bread and wine received by worshippers at a church service).

In addition to familial factors that contribute to child sexual abuse, there are a number of factors in some cultures that influence child sexual abuse. The following section discusses such factors.

2.4.4 Cultural factors

Hanzi (2006, p. 23) defines culture as “the integrated pattern of human knowledge, belief and behaviour, which is dependent upon the capacity of human society to learn and transmit knowledge about their values, ideas and beliefs to succeeding generations”. Rukuni and Maunganidze (2001) consider the symbolic relevance of culture in the traditional artefacts worn by some Africans as a way of preserving their culture. In Zimbabwe, people recognise their culture in the form of traditional rites in dress and rituals. Permanent symbols such as markings (or *nyora*) are cuttings that are done on a girl’s body (Rukuni & Maunganidze, 2001) are meant to beautify the girl.

2.4.4.1 Early traditional marriages

Some of the cultural and traditional perspectives in Zimbabwe seem to condone child sexual abuse (Chiremba & Makore-Rukuni, 2002). Early traditional marriages happen when a young girl is given in marriage to the husband of her deceased aunt or sister (called *chimutsamapfihwa* in the Shona culture), or the girl is given away as a second wife to her aunt’s husband when the aunt is getting old and can no longer bear children. The young girl learns to be submissive, and she is virtually dominated by her much older husband and she experiences brutality, sadistic and humiliating continuous sexual abuse (Makhubu, 2005). In cases of such traditional marriages, the community does not realise the trauma caused to a child having to face adult roles of marriage. Hence, Hlupo and Tsikira (2012) argue that the repercussions of forced early traditional marriages are too ghastly to contemplate on the part of the girl child as caregivers focus on securing their future.

In Zimbabwe, a system in the Shona culture called *kuzvarira* involves a girl child being seen as a family asset or resource during food shortages. Hlupo and Tsikira (2012, p. 4) state that “girls as young as twelve have been married off as third, fourth or even fifth wife to polygamous men who are old enough to be their grandfathers”. She is consequently given in marriage at a very young age to ensure that the family does not starve. Such a child ceases to be a child very early and prematurely becomes an adult (Hanzi, 2006). Sometimes an adult male pays dowry (or *lobola*) to the girl’s father well in advance in the promise that he would marry the girl when she reaches maturity. Hanzi (2006) points out that in most cases, the girl would be kept by her family and would normally be given away to her husband when she matures. As Hanzi (2006) points out, some girls drop out of school due to pregnancy caused by her ‘husband’. This implies that as she matures she experiences all sorts of sexual involvement with her arranged husband. Greed for the bridal dowry (*lobola* in Ndebele, or *rowora* in Shona) also leads to child sexual abuse. In Zimbabwe, the payment of *lobola* serves the purpose of a valid traditional marriage (Hanzi, 2006). Hlupo and Tsikira (2012) add that young girls were married off to wealthy individuals as a way of cushioning their families out of poverty.

2.4.4.2 Sibale

The cultural practice of *sibale* (in Ndebele) or *chiramu* (in Shona) makes it difficult for children to differentiate between practices that exploit them sexually and those that do not (Brakarsh 2006). Hlupo and Tsikira (2012, p. 2) define *sibale* or *chiramu* as “culturally sanctioned sexually suggestive play between brothers-in-law and sisters in-law”. This practice involves older men from the extended family, for instance, the grandfathers, uncles and brothers-in-law who are tasked by the family to give sexual education to the young girls. Currently, this practice is considered as a type of CSA since in Zimbabwe the Sexual Offences Act (2001) prohibits any immoral or indecent act with or upon a young person under the age of 16. Hlupo and Tsikira (2012) recommend that concerned stakeholders such as the Ministry of Health, the Ministry of Education, Sports and Culture, communities and civic pressure groups empower the girl child to have the freedom to make choices regardless of religious and cultural pressures.

2.4.4.3 Ritual sexual abuse

Some families use children (especially girls) to perform certain rituals of a sexual nature. Makhubu (2005, p. 50) defines ritual abuse as “... the involvement of children in physical, psychological or sexual abuse associated with repeated activities ‘ritual’ which purport to relate to contexts of a religious, magical or supernatural kind”. Makhubu (2005) further states

that ritual sexual abuse occurs when a child is used in the name of customary purposes as a sex object or sacrifice during a sadistic or satanic ceremony.

In the Zimbabwean Shona culture, the practice of *ngozi* involves a custom of “giving a girl child as payment to the offended family to ward off the spirits of the family which they have offended” (Brakarsh, 2006, p. 6). The following is a case example to illustrate what *ngozi* is:

Zed Moyo (not real name) killed his wife Mary Zulu (not real name). The Moyo family would give a young girl child to the Zulu family as payment, a way to acknowledge and reconcile with the Zulu family. Thus, the young girl from the Moyo family will be used for many rituals of a sexual nature while she stays and belongs to the Zulu family.

Another Zimbabwean ritual is the *chinamwari* practice. This is commonly practiced by the Chewa, Nyanja, Tonga, Shangaan and Venda people. *Chinamwari* is an initiation process during which a girl is mentored into womanhood (Chimuka, 2011). The girls are taught techniques for pleasing their future husbands sexually (Brakarsh, 2006). According to Chimuka (2011), girls from the age of 10 are taken into *Chinamwari* camps for up to a period of three months for training by elderly women. It is reported that most girls that have undergone the training drop out of school so that they can use their newly acquired expertise in sexual issues (Chimuka, 2011). Most of such girls end up in early marriages or even prostitution and as sex workers.

2.4.4.4 Child sex rings

Child sex rings also contribute to sexual abuse of children. This involves an arrangement in which an adult male is sexually involved with several underage victims (Burgess & Grant, 1988; Conradie, 2001). Children are rewarded if they bring in new victims and the man can use the girls as his wives and reluctant girls can be persuaded by the other girls having fun to join the sex ring (Conradie, 2001). Paedophiles organise the sex rings and children are sexually molested while they are in that group (Rogers, 1991). The main purpose of these organised sex rings is for ready access to children for sexual purposes, control of the children, maintaining the isolation and secrecy of the sexual activities (Burgess & Grant, 1988). Sometimes, as explained by Burgess and Grant (1988) and Rogers (1991), the sex offenders have a profit motive where these sex rings progress into syndicated sex rings, which are discussed below. Children are seduced or bribed by the offender to become part of the ring. In most cases, the children know each other and are aware of the sexual involvement with the offender and this is known as a solo ring (Conradie, 2001). This makes it easy for offenders to

lure the children into the ring who, in the process, can provide the children with social, psychological and monetary awards (Conradie, 2001).

Sometimes there can be many offenders ('transitional rings') using the many children for sexual gratification needs (Rogers, 1991). Transitional rings usually involve pubescent children (Burgess & Grant, 1988; Conradie, 2001). In most cases, victims are adolescents; especially boys, and these victims may be abducted children, runaways and those suffering the effects of domestic violence (Rogers, 1991). At times, there is a well-organised recruitment of children into the sex rings ('syndicated sex rings'). Production of pornography, delivery of sexual services to the children and networking with customers are done by the syndicate (Conradie, 2001). Burgess and Grant (1988) and Conradie (2001) add that the syndicate makes use of paedophiles, professional distributors and parental figures when recruiting children for the sex ring.

2.4.4.5 Excessive discipline and respect for adults

Excessive discipline and respect for adults also contribute to child sexual abuse. When respect for adults is overstressed within the family or society, the child feels that whatever the adult does or asks for should be agreed to otherwise refusal will be regarded as disrespectful. According to Van Niekerk (2005), in South Africa, child sexual abuse has been caused by the imbalance of power between children and their abusers and the universal norm of respect of children for adults. In Zimbabwe, it is culturally not acceptable that a child discusses sexual matters with parents (Chimuka, 2011). This consequently leads to non-disclosure of sexual abuse in the family due to fear of how the parents would react (Brakarsh, 2006; Killian & Brakarsh, 2005).

There is also a culture of non-interference to family disputes. In this regard, the society considers incest as a domestic issue and therefore as something which should be dealt with within the family (Brakarsh, 2006). Moreover, in societies ruled by chiefs or kings, parents can allow their girl children to dance for the chief or king while they are naked, as a way of respecting and appreciating the chieftdom or kingdom. This practice comprises exhibition, which is a type of sexual abuse (Zululand EcoAdventures, 2011). In Zimbabwe, chiefs in the Chiredzi area where the majority of Tshangani and Ndau people live allow initiation ceremonies, including virginity testing where girls are encouraged to preserve their virginity. When they are discovered to have had sex, the girls are subjected to violence by the family (Chikovore, 2004).

It is therefore evident, that exposure to any factor that may contribute to child sexual abuse is likely to affect the child in more ways than one. The effects of such exposure are devastating to a child. The following section discusses these effects.

2.5 THE EFFECTS OF CHILD SEXUAL ABUSE

There are various effects of child sexual abuse and indicators of sexual abuse vary from one child to another. Child sexual abuse can therefore have psychological, emotional, physical, behavioural and social consequences, which are in most cases interrelated (Lamont, 2010). Whitehall (2011) and Finkelhor and Brown (1985) posit that the more severe the abuse experienced by the child is, the more severe the resulting behaviours and effects will be.

2.5.1 Psychological effects of child sexual abuse

Some common psychological effects of sexual abuse have been reported in studies as described in the following sentences. These effects include among others, low self-esteem (Barriere, 2008; Trinity College Dublin, 2003), depression and suicidal tendencies (Pennstate Children's Hospital, 2010). Symptoms such as withdrawal or nightmares about the abuse have also been reported by sexually abused children (Brakarsh, 2006; Trinity College Dublin, 2003). Other symptoms include high levels of guilty and repressed anger (Finkelhor & Browne, 1985; Killian & Brakarsh, 2005; Trinity College Dublin, 2003). In addition, Hughes (2001, p. 1) mentions "having unexplained periods of panic, which may be flashbacks from the abuse" as symptoms of child sexual abuse. Furthermore, post-traumatic stress disorder symptoms such as re-experiencing of the abuse through dreams, inappropriate play, substance abuse, betrayal and powerlessness have been reported in studies on child sexual abuse (Finkelhor & Browne, 1985; Killian & Brakarsh, 2005; Madu, 2001). Esere, Idowu, Durosaro, and Omotosho (2009) say that women endure sexual abuse in the family because they are unable to escape and are under threat of greater harm if they report the abuse. Regehr and Glancy (1997) say that many survivors of incest seek psychological treatment from a variety of practitioners in an effort to find an answer to reducing their distress. Due to the need for incest survivors to higher their lowered self-esteem, Regehr and Glancy (1997, p. 6) add that "many incest survivors have turned to self-help books as a means of finding solace".

According to Burgess *et al.* (1978), a lot of anxiety caused by the sexual contact between adults and children is focused on the psychological effects on the child victim. Whereas physical injury is evident and recovery is visible, psychological or emotional trauma is not

always immediately obvious and has long-term consequences (Burgess *et al.*, 1978). CSA issues should therefore be treated with care.

2.5.2 Emotional effects of child sexual abuse

Sexually abused children may suffer from a number of emotional losses. These include, among others, children being scared of any person for fear of being abused again. Furthermore, sexually abused children tend to show signs of loneliness and separate themselves from others (Barriere, 2008). While other children look sad, some children may look extremely excited. This might be a coping mechanism whereby they try to hide their inner feelings of hurt. Sexually abused children lose confidence in themselves and others, they feel betrayed by their caregivers, they feel guilty of what happened to them and they have feelings of loss and grief (Brakarsh, 2006; Finkelhor & Brown, 1985; Hing, 2010; Killian & Brakarsh, 2005).

As Van Niekerk (2005) and Krivacska (1989) point out, after the disclosure of the abuse, many negative effects are caused by the reactions of adults, particularly the parents and the criminal justice system. The emotional feelings that the child suffers therefore emerge only after the disclosure of the case and such feelings depend on how adults respond to the child's proclaimed sexual abuse. The child's insight (especially an older child) into what will happen after disclosure of CSA may encourage non-disclosure (Killian & Brakarsh, 2005; Krivacska, 1989).

2.5.3 Physical effects of child sexual abuse

Normally, caregivers are the first people to notice physical changes in children who have been sexually abused. Symptoms such as bodily damage – for example swelling, diseases, and infections have been reported in children who have been sexually abused (Brakarsh, 2006). Moreover, other studies on child sexual abuse have reported common symptoms such as crying, bleeding, pain, bruises and wounds (Finkelhor & Browne, 1985; Madu, 2001).

Sexually abused children can develop health problems. They are more at risk of surgery such as the reconstruction of the vulva and the anus, especially in the case of very serious coercive rape cases. This normally includes injuries to the perineum (the skin between the vagina and anus), genital abnormalities (Hing, 2010; Pennstate Children's Hospital, 2010) injuries to the anal area that makes it painful to walk or sit (Pennstate Children's Hospital, 2010), and STIs such as syphilis, gonorrhoea, HIV/AIDS (Hing, 2010) and genital warts where a surgery process called electrocautery is used to remove the warts (Healthwise Staff, 2010). However,

there are also other signs of sexual abuse that can only be detected by a doctor on physical examination, such as injury to the internal sexual parts (Pennstate Children's Hospital, 2010).

2.5.4 Behavioural effects of child sexual abuse

Children show different behavioural indicators of sexual abuse. The strongest indicator that a child has been sexually abused is inappropriate, sexualised behaviour, inappropriate sexual knowledge, sexual interest and sexual acting out by that child (American Psychological Association, 2013; Brakarsh, 2006). Hing (2010) adds that children who are sexually abused can try to escape their situation by running away from home, giving rise to them becoming prostitutes or causing them to steal money for survival purposes. The American Psychological Association (2013) posits that children and adolescents who have been sexually abused can suffer a range of behavioural problems, from mild to severe, in both the short and the long term. Some of the behavioural indicators are changes in eating habits, bed-wetting, obscene language, withdrawal from previously favourite activities, like going to school, and defiant behaviour are among the vast number of acting-out behaviours (American Psychological Association, 2013; Barriere, 2008).

Sexually abused children tend to regress to behaviours that are too young for the stage of development which they already have achieved (Hughes, 2001). Depending on the child's developmental stage and the circumstances of the sexual abuse, a child may experience regressive behaviours such as thumb-sucking and sleep disturbances (American Psychological Association, 2013). In addition, sexually abused children panic when people come too close to them (Psych Central, 2012). Moreover, some abused children engage in self-harming behaviours such as suicide. Injury and self-mutilations have also been reported in many studies (Brakarsh, 2006; Hughes, 2001; Killian & Brakarsh, 2005; Polusny & Follette, 1995; Trinity College Dublin, 2003). Such children also tend to hurt themselves intentionally or to abuse their bodies (Psych Central, 2012).

2.5.5 Social effects of child sexual abuse

Stigmatisation and other social problems have been noted in sexually abused children (Finkelhor & Browne, 1985; Madu, 2001). Such children tend to separate themselves from others and are inclined to feel lonely. Sexually abused children also lose out on their childhood since they do not want to play with the other children (Barriere, 2008).

Since the majority of reported CSA cases are resolved through the criminal justice system, this increases the chances of more stress placed upon the child and his or her family leading

to more social consequences of the disclosure (Krivacska, 1989). In this regard, it has been reported recently by Moushey and Dvorchak (2012) that those children who are courageous enough to come forward are victimised in court as they face intense questioning when they tell their story under oath to a jury. Hence, Krivacska (1989, p. 5) describes some comments by parents whom he asked how they would respond when a neighbourhood child had been sexually abused. One parent stated, "I would never allow my child to play with that kid again." This shows how child victims of CSA can be socially isolated and be further blamed, something which can lead to less reporting of CSA. Krivacska (1989) further reports that, through the various options and a multidisciplinary way of responding to CSA, reporting is becoming less of a double-edged sword. This means that those affected by CSA should be encouraged to report and should also be granted the support they need.

According to American Academy of Child and Adolescent Psychiatry (2008), some children who are sexually abused have problems relating to others except on sexual terms. This means such children cannot have any other relationships with other people as they can relate only for sexual reasons. In support of this, Widom (1995, p. 5) states, "Among children who were sexually abused, the odds are 27.7 times higher than for the control group of being arrested for prostitution as an adult." Hence, Hing (2010) highlights that some sexually abused children become sexual abusers or prostitutes or develop other serious problems when they reach adulthood.

In the long run, survivors of child sexual abuse may have problems in relationships or sexual difficulties with their partners (Trinity College Dublin, 2003). Some victims of child sexual abuse may report little or no psychological distress but such children may be afraid to show their true emotions or they may be denying their feelings as a way to cope with new situations in life after the sexual abuse (American Psychological Association, 2013). This is the time when they decide to disclose their childhood sexual abuse experiences to someone and seek counselling, for instance, when they get married, have children of their own, or move to a new place (Trinity College Dublin, 2003).

2.6 CONCLUSION

The theories discussed in this chapter differ in their exclusive focus on the offender's behaviour and treatment and their emphasis on the etiological factors contributing to CSA. It is however important to note that there is no preferred approach to counselling children since each counsellor would intervene in his or her own individual way using his or her own preferred model to suit individual CSA cases (Geldard & Geldard, 2008). Therapists therefore help sexually abused children using a variety of theoretical approaches. Some of the major

theories were discussed in this chapter, and they also explain how child sexual abuse occurs. Various types of child sexual abuse have been discussed. Counsellors should consider that counselling strategies depend on the individual child's needs taking into consideration the type of CSA has been experienced by the child. The causes of CSA differ from one child's case to another. During therapy, therapists should take note of what caused the sexual abuse to take place. It is up to the experienced counsellor to assess the client's problem and to employ the necessary intervention with reference to the specific individual needs. Each case is unique and should be treated in its own special way and in consideration of the child's age, gender, developmental stage and vulnerability.

As has been explained in this chapter how children show various effects of CSA, which can be mild, debilitating or life-threatening. The effects of CSA discussed in this study were not grouped according to short- and long-term effects since it has been frequently highlighted in the literature that each child reacts differently to CSA; thus, what is a short-term effect for one child may be experienced as a long-term effect by another child. Issues of disclosure have also been described since many consequences of CSA seem to emerge after disclosure of sexual abuse. It has been illustrated that some of the traditionally accepted practices are now legally considered criminal acts. Chapter 3 describes the counselling of sexually abused children.

CHAPTER 3

COUNSELLING SEXUALLY ABUSED CHILDREN

3.1 INTRODUCTION

The difficult circumstances to which many children are subjected, coupled with their increasing vulnerability to child sexual abuse in Zimbabwe have left vast numbers of children needing specialised counselling services (Urombo, 2000). Children's vulnerabilities are increased because they occupy a subordinate status in society. They are mostly victims of child sexual abuse due to their social, psychological and intellectual positions (Hanzi, 2006). The economic hardships and the effects of HIV/AIDS on most Zimbabwean families can increase the risks of abuse for children (Chiremba & Makore-Rukuni, 2002). In this regard, Campbell, Skovdal, Mupambireyi, and Gregson (2010) report that AIDS-affected children are vulnerable to abuse. As a result, counsellors find themselves having to provide counselling services to many children who are victims of sexual abuse. The terms 'counsellor' and 'therapist' in this study are used interchangeably to refer to the counselling service provider.

Insert 1: The mother sat alone in her garden, watched and counted all the birds that were busy building nests in her only tree that she had planted when her one and only daughter was born seven years ago. She listened to their songs as they did their job. Suddenly something flashed through her mind. She said to herself, "If only I had had someone to talk to when he started touching me." Suddenly her seven-year-old daughter talked behind her. The mother had not seen her coming. The daughter spoke and said, "Mum, is it uncle Chipei? He always touches me as well and I promised him that I will never tell anyone" (Taida, the mother of a Childline Zimbabwe sexually abused child client, Tariso, during a counselling session in May 2009) (Taida, Chipei and Tariso are not their real names).

The above insert shows the consequences of child sexual abuse and how devastating it can be to someone for the rest of his or her life. Hing (2010) says that the abused child is able to retain information of the sexual abuse by means of the senses even if there is limited cognitive and nervous system development at the time of the abuse. In support of this proposition, Hing (2010) states that the child is able to recall this information at a later stage in life. Sexual abuse is one of the most distressing types of child abuse and it affects the well-being of all societies. As counsellors, we are faced with challenges and trigger issues each day. We have to think, plan and act differently in terms of every different case we handle. This chapter addresses the therapy for children, counselling strategies, stages of counselling and

techniques to use with sexually abused children, qualities and attributes of counsellors, ethics in counselling and issues of confidentiality. Also discussed are the counsellor's roles. Full details of Childline Zimbabwe's treatment team and community involvement are provided later in this chapter.

3.2 THERAPY FOR SEXUALLY ABUSED CHILDREN

Many different counselling interventions are used for child clients. Each counsellor and his or her particular client determine the process to be followed. Counselling intervention is a special relationship between a client and a counsellor, and it focuses on improving skills in the domains of importance to the client, for example self-esteem (Jacobs, Bleeker, & Constantino, 2003). Early symptomatic change in therapy may play a causal role in the development of the therapeutic relationship with improvement strengthening the client's bond with the therapist (Klein, Schwartz, Santiago, Vivian, & Vocisano, 2003). The child client's involvement in the establishment of treatment goals and in feeling a positive bond with the therapist are two key factors in the development of an effective therapeutic relationship since this would reflect the agreement between the therapist and the client on how to achieve the goals of treatment (Klein *et al.*, 2003). Jacobs *et al.* (2003) further illustrate that when working with children and adolescents, therapists need to be aware that the self-perception of these young clients undergoes significant changes as therapy is taking place. When the child views the therapeutic relationship to be good, there are high chances of successful therapeutic change (Klein *et al.*, 2003).

Geldard and Geldard (2008) point out that a therapeutic process uses counselling approaches and skills in conjunction with other strategies such as play and group therapy. An integrated child therapeutic process comprises various specific processes that interact through the facilitation of a skilled counsellor. The process of child therapy is explained by means of the diagram below.

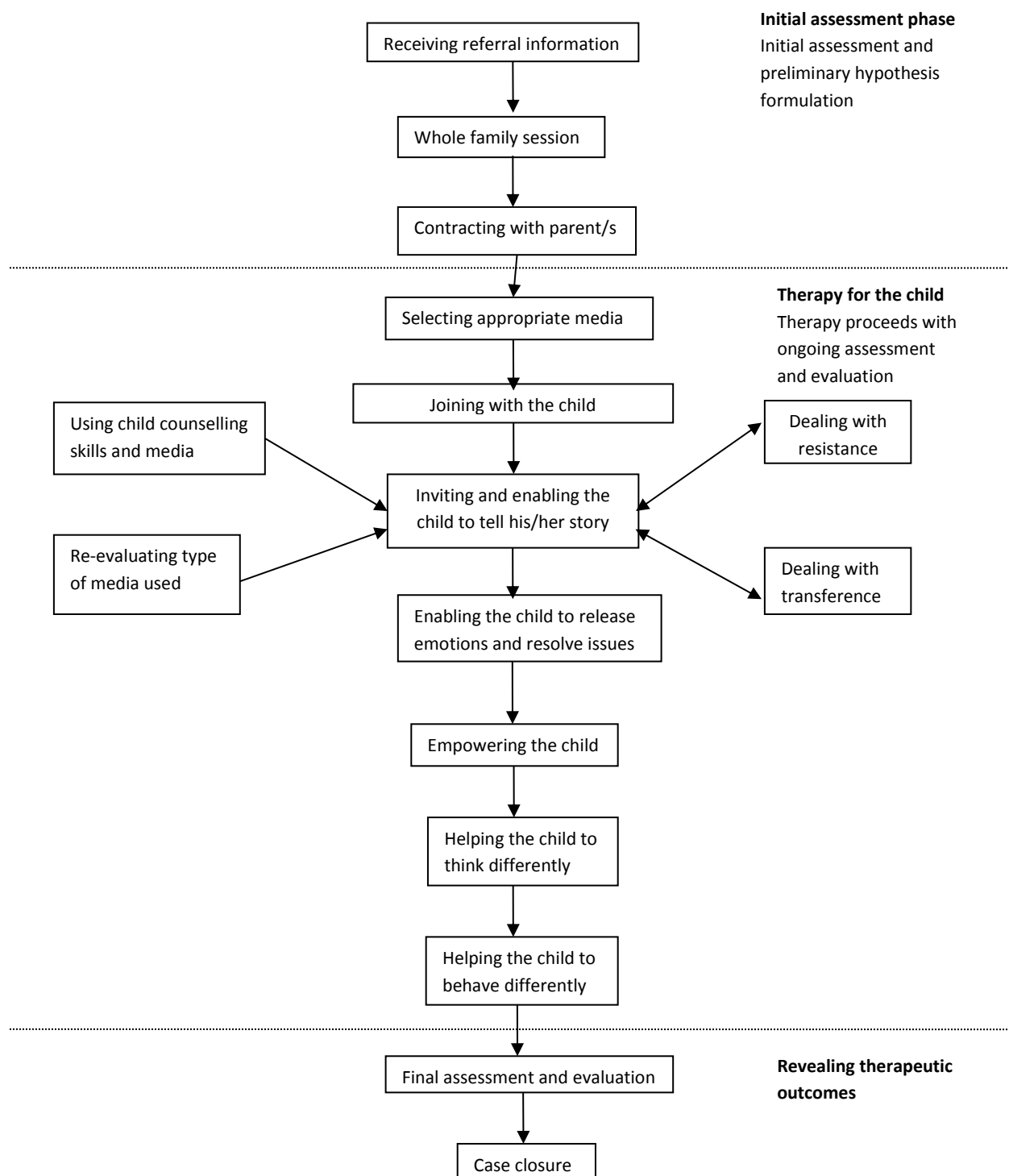


Figure 3.1: The process of child therapy (adopted from Geldard & Geldard, 2008, p. 46)

Since children and their cases all differ from each other, the therapist can adopt all or some of these stages for counselling child victims of CSA. Not all the processes or the order shown in Figure 3.1 above are applicable for each child's CSA case. The counsellor assesses the client and his or her problem in order to see which step/s should be involved. Some steps may be

repeated and some may be omitted while other steps can occur concurrently (Geldard & Geldard, 2008).

The child therapeutic process shows that counselling intervention passes through various phases. The three major phases are: the initial assessment phase, therapy for the child and the review of therapeutic outcomes (Geldard & Geldard, 2008) as discussed below.

3.2.1 Initial assessment phase

This involves the preparation time for child therapy. During this phase, information about the child and his/her problems is gathered. It is during this time that the counsellor meets the child and his/her significant others, for instance, parents, caregivers or teachers. The counsellor takes the client's initial history and the reasons for the client to come into therapy (Bartson, Smith & Corcoran, 2011).

3.2.2 Therapy for the child

The second phase involves the therapist planning the intervention strategies, including the media to be used in terms of the child client's age, gender, personality and type of emotional problem. 'Media' is described as mass entertainment influences or materials used for play (Kalliala, 2006) or a variety of engaging strategies required for children's play such as puppets, clay or other forms of art (Latif, 2001). It is during this phase that the therapist establishes rapport with the child. The child is allowed to tell his/her story. The counsellor helps the child to work through the resolution of the main issues. By considering the importance of client behaviour during counselling and therapy, the counsellor/therapist ascertains ways in which the client responds to the interventions and assesses the ways in which the client changes over the course of the therapy process (Hill, 2001). Wall, Amendt, Kleckner, and duRee Bryant (1989) describe the therapy process as that in which the therapist uses therapeutic compliments by means of a statement of praise or affirmation being made to the client. Furthermore, Wall *et al.* (1989) explain that the compliment creates conditions for successful therapy by increasing the therapist's manoeuvrability and empowering the client to move toward a desirable therapeutic change.

3.2.3 Review of therapeutic outcomes

During this last phase, the final assessment and evaluation for the help given to the child are done. The child client and his/her caregivers are involved in the final phase so that assessment and evaluation of all counselling sessions can be completed. The counsellor

checks the value of the work covered and recommends other interventions where necessary. Wall *et al.* (1989) suggest that the final stage of the therapy process should be marked with change in the client's behaviour; with the client having pride in what he/she has been able to accomplish. Hence, the termination stage solidifies the beginning and middle stages (Wall *et al.*, 1989) so that the depth of the behavioural association to the therapeutic process is intensified. It is during this final stage that the counsellor's assessment is used to confirm that further work is no longer required (Latif, 2001).

3.3 COUNSELLING THERAPIES FOR SEXUALLY ABUSED CHILDREN

Child sexual abuse in southern Africa has become a main issue of public consciousness and its effects affect children's physical and emotional well-being as well as their development, their sense of self and their right to health and happiness (Richter *et al.*, 2005). This means that the demand for therapy has also increased, and it is the duty of health professionals, such as counsellors, social workers and psychologists, to provide this therapy. Below is the discussion of some counselling therapies and strategies that counsellors use while helping their child clients.

3.3.1 Gestalt therapy

According to Wagner-Moore (2004), the processes underlying Gestalt formation as described by Perls constitute experience/contact, metabolism or a cycle. Makhubu (2005) explains that Gestalt therapy deals with the child client's total existence as integration, but does not analyse the individual symptoms. The Gestalt concept is therefore understood as a totality that has a unified whole (Perls, 1973). Hough (1998) describes Gestalt in terms of four concepts, namely pattern, shape, form or configuration. Furthermore, Geldard and Geldard (2008, p. 115) report that Gestalt therapists "believe that the body, emotions, and thoughts are inter-related and inter-dependent". In addition, Makhubu (2005) postulates that the main aim for Gestalt therapy is to help children reach maturity, be self-aware and be responsible for their own lives. Gestalt therapy uses the term 'contact' to explain the exchange between the individual and his/her environment (Perls, 1973; Wagner-Moore, 2004), hence, Makhubu (2005) states that the use of Gestalt therapy assists the child to be in charge and be able to advance from environmental support to self-support.

Makhubu (2005) further proposes that, through Gestalt therapeutic intervention, the child may possess the capability to become a self-regulating being by achieving a sense of unity and integrating it into his/her life. The individual's mandate to self-regulation is called homeostasis. Gestalt formations within the individual provide meaning to what is happening to the individual,

both from within and externally. In this regard, Geldard and Geldard (2008, p. 35) state that when working with children, Fritz Perls “gave the client immediate feedback about non-verbal behaviour as it was observed during the counselling process. This drew the client’s attention either to feelings that were being suppressed or to resistance.” Perls invited the child client to get in touch with and to describe his or her bodily sensations, and then linked these to own emotional feelings and thoughts (Perls, 1973). In this process, the child is viewed in the here and now. Furthermore, Perls (1973, p. 121) states, what we are trying to do in “Gestalt therapy is to understand the word ‘now,’ the present, the awareness and see what happens in the now.”

Contact (or ego) boundaries are Gestalt theoretical components to which Perls (1973) refers to as a place where psychological events take place. According to Perls (1973), people experience and meet these boundaries through their thoughts, actions, behaviour and emotions. Barlow (1981) describes contact boundaries as those that distinguish the self from others. There are developmental, family, social and cultural boundaries (Geldard & Geldard, 2008), which are permeable to allow a link between a person and his/her environment. During counselling, the counsellor addresses the linkage of these four boundaries to the child’s behaviour. Perls (1973) and Wagner-Moore (2004) explain that the way in which a person functions in his environment shows what happens at the contact boundary. It is at these boundaries that psychological events such as thoughts, actions, behaviour and emotions take place (Barlow, 1981). If there is erosion of the child’s ego boundaries, for instance sexual abuse, the child feels disempowered and becomes anxious (Geldard & Geldard, 2008; Wagner-Moore, 2004). Within the ego-boundaries, there are feelings of unity and cooperation and this is a Gestalt concept of holism which explains that man is a unified organism (Perls, 1973).

To ensure that effective Gestalt counselling occurs, counsellors should consider the client child as a whole, taking into account what is happening to the child in the context within which that child lives. The child should therefore not be separated from his/her environmental influences.

3.3.2 Group therapy

According to Grotzky, Camerer, and Damiano (2000, p. 1), “Sexual assault is a trauma that affects the entire family as well as the community of the person assaulted.” CSA is a social problem so all society members should take part in the fight against it. Due to the exponential increase of CSA reports, therapists have considered the use of group therapy models since the children discover that they are not alone but other children have also encountered sexual

abuse. This discovery can be empowering to the children since group intervention is effective in helping children with social, emotional and behavioural difficulties (Shechtman & Leichtentritt, 2010). In any group, there are issues of trust, power and control (Nelson-Jones, 2000); children can therefore freely open up and talk to their peers in the group. Since CSA damages a child's self-esteem, groups can be especially useful in addressing self-esteem issues. Poor self-esteem is often caused by the child's failure to form positive interactions with peers. The intended outcome of group therapy is mostly to enable the child to identify with others in the group (Geldard & Geldard, 2008). Shechtman and Leichtentritt (2010) add that bonding with the therapist and with the group is a good predictor of the counselling process and its outcomes. In this regard, the more a group member believes that he/she belongs in the group, he/she feels that the group is a resource to rely on, and experiences the group as a source of comfort and support, the greater the member's sense of trust (Marmarosh, 2013).

Group members are often grouped according to gender (Women Organized Against Rape [WOAR], 2013). Srsic and Rice (2012) suggest that gender differences and gender-responsive programmes are potentially effective when used in groups such as girls with emotional and behavioural disorders (EBD). Boys need two counsellors: one male and one female; two female counsellors are ideal to run the girls group (Morrison, 2004). In a study done with a group of five African-American girls with EBD, the two facilitators were both Caucasian females (Srsic & Rice, 2012). The reason for sensitivity in the selection of gender of facilitators lies in the insecurity of the sexually abused boy/girl child clients. According to Grotzky *et al.* (2000), for effective group therapy, the gender of facilitators plays a role in the counselling of abused children as children can prefer a certain gender for purposes of bonding or attachment, role models or boundary setting. Gender of facilitators can sometimes negatively influence some children's disclosure of sexual abuse since they can experience transference when they take the past negative effects of the abuse and transfer them onto the counsellor (Grotzky *et al.*, 2000). This can interfere with children's participation in the group. Given that it is generally reported that the majority of sexual abusers are males and more girls are abused than boys, girls generally feel secure discussing sensitive issues with female counsellors while boys' feelings are varied depending on individual children. Safety issues are defined in the beginning of the group formation, and children in the group are helped in ways of achieving mastery over their emotions, thoughts and body (Morrison, 2004). Walker (2004, p. 6) reports that "It is to be expected that working with powerful experiences of trauma creates powerful counter-transferential responses in the practitioner [counsellor]." Hence in working with abused clients, there is need to facilitate a safe environment that allows exploration of feelings in accordance with the idea that potentially disturbing sexualised or negative counter-transferences can arise (Walker, 2004).

On the one hand, a child sitting in a class where there are other sexually abused children quickly develops a feeling of trust, connectedness and being accepted. Shechtman and Leichtentritt (2010, p. 12) support this proposition where they express that “bonding with group members not only appears to offer a buffer against anxiety, but in light of the high impact of gains of anxiety on reduced aggression and on social competence.” Bonding may also have positive effects on the outcomes of group counselling. Just knowing that other children have also been sexually abused is already part of the treatment. On the other hand, when a girl child is the only one who has been sexually abused, she feels lonely. In group therapy, however, a child is able to see a child’s peers who have experienced the same problem of sexual abuse. Seeing the peers being comfortable and happy to be in that group might reduce his/her fears and anxiety (Duffany & Panos, 2009). Children can undergo both individual and group therapy and these can be administered consecutively. All parents or caregivers of sexually abused children should receive their own group therapy (Grotzky *et al.*, 2000), as those who do would greatly enhance and accelerate their children’s recovery by giving them love and support.

Working in groups facilitates interaction and discussion of various individual problems. For instance, Angie, a 13 year-old girl quoted in Grotzky *et al.* (2000, p. 165) wrote in a letter in 1996: “Then I met a bunch of other girls who had been touched and we talked about what happened and realized it wasn’t our fault”.

A related form of group therapy is a support group which is also led by social workers. For example, professional social workers at Africaid, a community-based organisation in Zimbabwe, through its Zvandiri (‘the way I am’) programme run support groups for children and adolescents affected by HIV/AIDS (Africaid, 2013). According to Africaid (2013), the Zvandiri programme provides community-based prevention, treatment, care and support for children. Like the Zvandiri support groups providing constant fora in the lives of children where they can share, learn, feel loved and supported and have fun each month (Africaid, 2013), in support groups for survivors of CSA, children occasionally meet and talk with the help of a support group leader guiding the group.

According to Connors (1994), the therapist therefore uses Bennett Braun’s (1988) BASK (behaviour, affect, sensation, knowledge) model of dissociation. Connors (1994) explains that an individual’s behaviour, affect, sensation and knowledge capacities act in concert with one another but in dissociated functioning where any of the four spheres may be isolated from the other spheres. Using the BASK model, the therapist teaches children how their thoughts, feelings and bodily sensations relate to their actions and behaviours. Children learn to make their own BASK books where they reflect on their own:

1. **behaviours** – how they are doing;
2. **affections** – how they feel emotionally;
3. **sensations** – what they are feeling in their bodies; and
4. **knowledge** – what they know about their situation (Grotzky *et al.*, 2000).

3.3.2.1 Qualities and attributes of group therapists

Group therapy facilitators have a role to help children understand their situations, and to explain and confront the core issues of sexual abuse. According to Geldard and Geldard (2008) and Grotzky *et al.* (2000), for effective group therapy, therapists need to possess some counselling skills and attributes. Ryan, Safran, Doran, and Muran (2011) describe good therapists as being mindful when they work with clients. Mindfulness is considered as a multi-dimensional construct consisting of four separate factors as described by Ryan *et al.* (2011). These factors are observing, describing, acting with awareness and accepting or allowing without judgment. Furthermore, Heinonen, Lindfors, Laaksonen, and Knekt (2012) describe the therapist's professional and personal characteristics as predictors of outcomes of psychotherapy. In this regard, Heinonen *et al.* (2012) suggest that the predictors of therapeutic work consist of the therapist's healing involvement and stressful involvement. On one hand, the healing involvement involves the therapist's investment in his/her work, affirmative manner with clients, sense of skilfulness and efficacy, and constructive coping (Heinonen *et al.*, 2012). On the other hand, the stressful involvement shows how the therapist addresses difficulties, feelings of anxiety or boredom, and coping by avoidance of issues (Heinonen *et al.*, 2012). Therapists are therefore expected to be genial (warm, open and optimistic), forceful (of intense and task-oriented temperament and having an assertive interpersonal manner) and reclusive of aloofness, skepticism, privateness, and subtleness (Heinonen *et al.*, 2012). Besides these therapist qualities discussed above, the following qualities and skills based on the work of Grotzky *et al.* (2000) and Geldard and Geldard (2008) have also been highlighted:

- being enthusiastic about the group;
- ascertaining confidentiality of therapy sessions within group members;
- with many children in therapy, therapists are bound to be triggered by the overwhelming sexual abuse issues; occasional debriefing with other therapists is therefore pivotal so as to be able to facilitate a group process while attending to the needs of individual children; and

- showing sensitivity to types of abuse, age of children, gender of children and their perpetrators – depending on group members, it might be better to re-group children according to gender, age or type of sexual abuse.

In addition to the above qualities, counsellors/therapists need certain attributes. Oaklander (2001) states that children readily respond to the therapist's stance for which a relationship is generally manifested fairly quickly; therefore, finding creative, nonthreatening ways to reach child clients reflects the therapist's personality. The counsellor's individual personality will therefore influence what the counsellor brings into the counsellor-child relationship. Heinonen *et al.* (2012, p. 11) assert that "active, engaging, and extroverted therapists showed a faster symptom reduction in short-term therapy ... and more cautious, non-intrusive therapists predicted greater benefits in long-term therapy ...". Counsellors are all different and they use their own strengths and personal attributes to enhance their work. Geldard and Geldard (2008, p. 17) point out that "... there are some basic attributes and behaviours which are desirable in the counsellor if an appropriate child-counsellor relationship is to be achieved. There are also some roles which the counsellor must play". According to Geldard and Geldard (2008), a counsellor must be

- congruent – involves being integrated, grounded, genuine, consistent and stable in order to develop and maintain trust;
- in touch with his/her own inner child – getting in touch with that part of the self which fits with the child's world, so that the counsellor is "able to join with the child successfully, to understand the child's feelings and perceptions, and to provide opportunities for the child to experience them fully" (p. 18);
- accepting – being non-judgmental, encouraging, not showing approval or disapproval; and
- emotionally detached – so as not to be emotionally involved in the child's issues. "Instead of giving either sympathy or affirmation, the counsellor should validate the child's experience" (p. 20). Simply said, the counsellor should not take over and own the child's problems.

3.3.3 Play therapy

Play is the child's natural medium of self-expression (Axline, 1993). During play, children use various media, toys, symbols and games when they play out their feelings. According to Cattanach (2008, p. 35), "It is by playing and only in playing that the individual child is able to

be creative and to use the whole personality and it is only in being creative that the individual discovers the self". Misurell, Springer and Tryon (2011) describe play therapy as therapy that uses developmentally appropriate games which provide a mechanism for child treatment to be provided in a fun and engaging manner. Play is also a spontaneous process. Children's play often represents life processes, for instance, a girl dresses her dolls the same way her mother would dress the baby, or building blocks and other toys are used to construct a house. The child is given an opportunity to play out his/her feelings and problems like the way an adult would talk out his/her problems.

The play therapy process for the abused child is defined by Cattanach (2008, p. 81) as "An exploration through play which helps the child make sense of her experiences in a way which is appropriate to her developmental level". The form and content of this exploration are largely determined by the child (Cattanach, 2008) as he/she makes use of games, toys and other mediums in expressing emotions, thoughts, wishes and needs. Instead of a child verbally communicating his/her feelings, the media in the play therapy room serve as his/her words while play acts as his/her language. In play therapy, a child is considered to have feelings that he/she cannot describe in words, while play is something easy for the child to handle adequately. At times, the child can also capture his/her feelings in a graphic way. The child determines how and what constitutes the play and they are routinely given access to structured tools if they wish (Hill, 2006), for example, art and drawing materials.

The counsellor does not need to interrogate children to maximise play therapy, but only provides the space for children to play (Hill, 2006). Geldard and Geldard (2008) pinpoint that play is an effective way to bring about change in children, and the child's strengths are expressed through playing. Since most children are usually reluctant to go to the play therapy room with a stranger (counsellor), Hill (2006) suggests that it is vital to involve parents in the introductory play therapy sessions in order to settle the child with the objective of moving towards individual play therapy. With the help of the therapist, the child is helped to express him/herself fully so that she can release feelings of anxiety, disappointment, fear, aggression, insecurity and confusion and can make sense of her experiences (Cattanach, 2008). It should however be noted that some children can briefly play about their abuse but then use the play therapy sessions with the guidance of the therapist to develop a sense of self-esteem and identity which then fully empowers the child (Cattanach, 2008).

3.3.3.1 *Play therapy strategies*

According to Axline (1993), play therapy can take place in two ways: directive play therapy, whereby the therapist is responsible for guiding the child and interpreting what the child plays

out, and non-directive play therapy, which deals with the therapist leaving the responsibility and direction to the child.

- ***Directive play therapy strategy***

Here, the therapist leads the play therapy process while the child follows. During play, the therapist guides and directs the child on what to do, where this is done, which play materials to use, and how to use the materials. The play therapist is responsible for interpreting the child's play interactions. The therapist is directive as the therapy progresses in order to build the skills (Lennon & Barbato, 2001). The therapist asks questions while the child answers and/or the therapist answers the child's questions. The therapist can also advise the client and can probe by asking further questions (Ziegler & Hjelle, 1992). Directive play therapy thus views probing the child to say more as an important technique. Becvar and Becvar (2006) believe that all therapists' behaviour in therapy is directive and they state that directives in therapy serve three purposes, namely:

1. facilitating change and making things happen;
2. involving the therapist in the therapy process by keeping him/her figuratively speaking; and
3. offering a stimulus and reactions that inform the therapist about the client's environment.

Becvar and Becvar (2006) illustrate that directives can be paradoxical in the sense that the therapist prescribes and maintains control by anticipating the client's responses to therapy, or operant directives can be given by the therapist when he/she gives suggestions to clients.

- ***Non-directive play therapy strategy***

Non-directive play therapy is a theory rather than just a counselling technique. It is in itself a healing process (Cattanach, 2008). Non-directive play therapy can also be called self-directive therapy where the client directs and is in charge of the therapy process and the counsellor is humble in his/her role. A counsellor following non-directive play therapy asks no probing questions (unless the child initiates a discussion about an issue that is worrying him/her) and gives no criticisms or suggestions (Axline, 1993). In non-directive play therapy, clients are considered able to find their own solutions to their problems and the counsellor uses active listening and reflecting on the child's statements (Geldard & Geldard, 2008). According to Hill (2006, p. 2), during non-directive play therapy, "children are assured that they will be able to

control the content of play sessions and that the therapist's job is to pay attention to how they are feeling".

For withdrawn and nervous children, play therapists noted changes in the children's ability to speak up and the children demonstrated increased levels of confidence within the play-based evaluations (Jager, 2012). These changes seem to be the inner self-attempting to reveal a full realisation of the self-concept (Axline, 1993). During non-directive play therapy; the child strives to reach complete self-actualisation whereby he or she is allowed to foster "toward maturity, independence, and self-direction" (Axline, 1993, p. 10). During therapeutic contact, the goal of a counsellor following non-directive play therapy is offering favourable conditions for the child to grow.

Counsellors should consider the differences between directive and non-directive play therapy and to combine play therapy with the best counselling methods in consideration of the child's age and concerns. According to Misurell *et al.* (2011, p. 3), "over the years, a number of individual, group, and family interventions utilizing various theoretical orientations (cognitive-behavioral, psychodynamic, client-centered, and play therapy) have been developed for treating symptomatology associated with CSA". Since many theories have been developed through the use of play therapy with children, it can be noted that the use of play therapy is a dynamic practice and has proven to have helped many eclectic psychologists/counsellors involved in the counselling of children suffering the effects of CSA.

3.3.3.2 Stages in the play therapy process

Cattanach (2008) suggests three stages that play therapy counsellors can follow while working with abused children. Figure 3.2 below shows these stages.

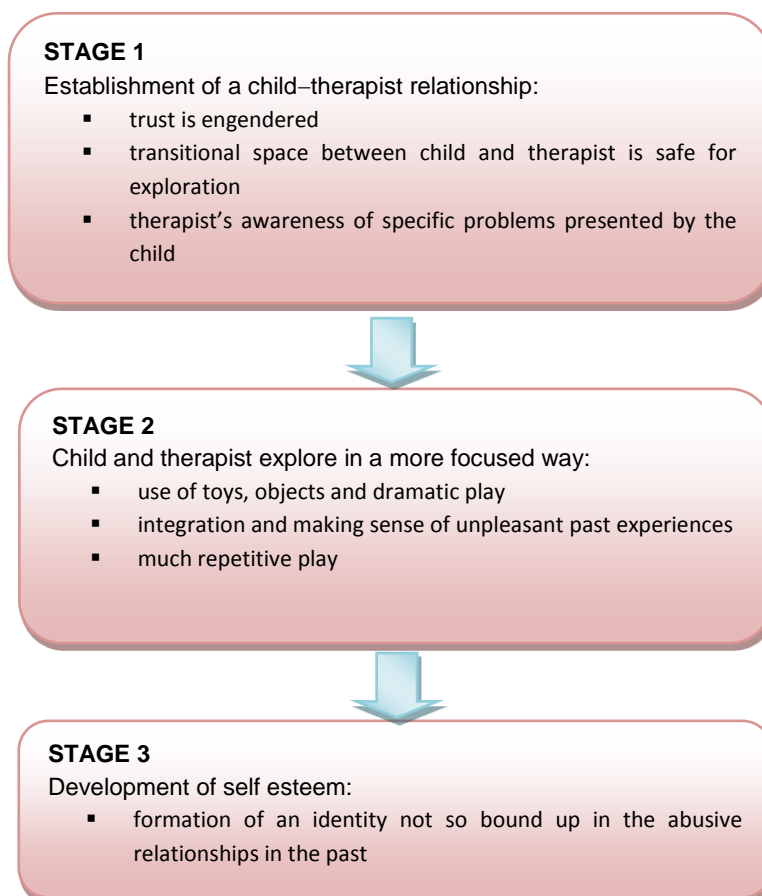


Figure 3.2: Stages in the play therapy process

During counselling of sexually abused children, play therapists tend to use play for children of all ages (infants, children and adolescents). This is supported by Bratton, Ray, Rhine and Jones (2005, p. 1) who report that, “play therapy appeared equally effective across, age, gender, and presenting issue.” Analysis of results reported in Bratton *et al.* (2005) revealed that neither age nor gender of participants were significant predictors of treatment outcome; suggesting that play therapy is equally effective for boys and girls of all ages.

Piaget (1972, p. 148) asserts that “play is an activity for pleasure”. Play therapy is an excellent opportunity to begin the development of effective social interaction and social interest (Cattanach, 2008; Suprina & Chang, 2005). Moreover, the counsellor-client interactions should be aimed at empowering the CSA survivors (McGregor, Gautam, Glover, & Jülich, 2013). A good emotional contact with the client and the counsellor is established through showing empathy and having time to listen to the client’s needs, expectations, worries and providing them with all the necessary information they are entitled to (Hilden, Sildenius, Langhoff-Ross, Wijma, & Schei, 2003). Play therapy is best suited when used in combination with other counselling approaches such as psychoanalytic, behavioural, or eclectic/integrated

approaches. It can also be used with children in different settings, either individual, family or in group counselling although the type of media would differ for different ages and in different settings (Geldard & Geldard, 2008).

Through play, the infant acquires new skills and strategies that contribute to the formation of the self and object representations (Valentino, Cicchetti, Toth, & Rogosch, 2006). Piaget (1972) postulates that children make friends, become assertive, acquire new skills and access coping mechanisms of others who are experiencing similar challenges while they play together. Piaget (1972) adds that games with rules are ludic activities of the children who become socialised when they play such games with others. As the child grows older, his social circle expands, and their social relationships are formed.

The client should be made aware that growth is a process of change and that it is relative and dynamic. Behavioural responses happen due to children's imitation of caregivers, and this reflects the development of new social skills (Valentino *et al.*, 2006). In the case of sexually abused children, there is a good possibility that such abuse could lead to more severe consequences for the child's development (Valentino *et al.*, 2006). For example, such children might be sexually abused again and they might become sexual offenders later in life (Axline, 1993). During play therapy, the counsellor pays attention and focuses on the client's behavioural responses and to his/her social skills. Depending on different situations, the child can be humble or proud, courageous or afraid, dominant or submissive, curious or satisfied, eager or indifferent, loving or hateful, fighting or peaceful, delightfully happy or despairingly sad (Axline, 1993). According to this view, "play therapy is widely used to treat children's emotional and behavioural problems because of its responsiveness to their unique and varied developmental needs" (Bratton *et al.*, 2005, p. 1). These different reactions, feelings, thoughts and experiences can be directly or symbolically acted out through the use of play materials (Axline, 1993; Bratton *et al.*, 2005) while the child is in play therapy.

Sexually abusing a child is something that goes against the child's need for positive self-esteem (Axline, 1993). Furthermore, Asgeirsdottir, Gudjonsson, Sigurdsson and Sigfusdottir (2010) argue that self-esteem is a strong negative predictor of depressed mood and anger for sexually abused children. Adults should play a role in fulfilling the child's need for love, belongingness, safety and security. The rate at which positive change occurs depends on the reorganisation of the child's accumulated experiences, attitudes, thoughts and feelings to bring about insight (Axline, 1993).

3.3.3.3 *Play therapy room and its materials*

A good counselling room enables counsellors to engage their clients easily. Childline Zimbabwe has a small counselling room set aside to engage clients in counselling sessions. Based on the availability of money and space, Childline Zimbabwe should furnish a special play therapy room. Counsellors need a variety of play therapy materials and resources that could help their interventions and delivery of services to their clients (Cattanach, 2008). When choosing the materials to put in the play room, safety needs should be considered. Equipment or toys which can easily break may result in many children being anxious (Geldard & Geldard, 2008) as most children do not normally want to be held responsible for breaking things. The play materials should be in full view of the child so that he or she can choose his or her own medium for expression. The counsellor should check on the materials constantly, removing broken or spoilt materials, and keeping the play therapy room clean and in order after every counselling session. Moreover, Cattanach (2008) suggests that all children have excellent memories about the toys they have played with, and removal of some old or broken toys can be meaningful to some children. Counsellors should therefore not remove toys without consultation with their clients (Cattanach, 2008). Simple toys and physiological models and dolls should be available (Brakarsh, 2006). Anatomically correct dolls should be fitted with removable clothes and they should represent every possible family figure. These dolls help especially young children to demonstrate how the abuse took place. They are also used during play therapy as well as during the court hearing for the case. As Grimm (2013, p. 9) claims, "a child witness should be permitted in the discretion of the court to use anatomically correct dolls and drawings during his testimony".

Geldard and Geldard (2008) illustrate that play therapy can be used for children of all ages as long as the media suits the individual child's needs in relation to the child's developmental age. Axline (1993), Brakarsh (2006), Cattanach (2008) and Geldard and Geldard (2008) go on to give suggestions for a play therapy room and its materials as explained above.

3.3.4 *Symbolic representation*

Carl Jung used the symbolic representation of a collective unconscious, which is particularly relevant in counselling children when using play therapy where the use of the sand tray, clay and art are emphasised (Geldard & Geldard, 2008). Jung uses the term collective because it is the part of the psyche or the unconscious that is not individual but it is universal and constitutes a common psychic substrate of a suprapersonal nature which is identical and present in all humans (Jung, 1969; Lindenfeld, 2009). Eisold (2002, p. 18) adds that people may use Jung's concept of unconscious communication to explain the "unknown and the

unknowable” and that people learn about their collective behaviour by keeping their minds open to the meaningfulness of events they cannot explain. Jung (1969) developed Freud’s idea of the unconscious, and reported that the unconscious is personal and it rests upon a deeper layer called a collective unconscious. The collective unconscious exists where symbols, which are common in all human beings are manifested (Lindenfeld, 2009). Jung (1969, p. 5) claims that there are “symbolic figures in the primitive view of the world [and these] could easily be applied to the unconscious contents”. There are also symbolic images by “which the archetypes of the collective unconscious become manifest in consciousness and projected onto objects” (Lindenfeld, 2009, 9). Eisold (2002) argues that Jung’s phenomenon of symbols had the quality of universals; that did not arise directly from individual experience but were linked to the assumption of the collective mind.

Jung posits that humans have four basic psychological functions, namely thinking, feeling, sensing and intuiting (Jung, 1969; Ziegler & Hjelle, 1992). With these basic functions, Jung grouped thinking and feeling as rational functions and sensing and intuiting as irrational functions (Ziegler & Hjelle, 1992). The therapist should therefore focus on what the child thinks or feels and which sensations and intuitions the child has, and these are often shown while the child plays. During play, the child utilises both the rational and irrational functions in dealing with life circumstances, hence, “From Jung’s perspective, the later years of life are when people become focused on self-realization through pursuing creative activities” (Ziegler & Hjelle, 1992, p. 176). It is based on this idea that play therapy counsellors aim to help sexually abused children become self-aware so that they are not too much affected later in life by the psychological trauma caused by the abuse. Jung called the symbolic representations showing the unified wholeness of the self ‘magic circles’ or ‘mandalas’ (Ziegler & Hjelle, 1992). Because of this belief, Jung used symbolic representation in the form of relevant media in his work with children (Geldard & Geldard, 2008). Cattanach (2008, p. 36) explains the importance of play, and reports, “The creative activity of imagination frees man from his bondage to the ‘nothing but’ and raises him to the status of one who plays. Man is completely human only when he is at play”. Play is used by child clients to be able to value themselves and develop the capacity to be creative (Cattanach, 2008). This is done in a way that helps therapists to assist the victims of CSA.

3.3.5 Cognitive-behavioural play therapy (CBPT)

Knell (1995) describes cognitive-behavioural play therapy (CBPT) as therapy that incorporates cognitive and behavioural interventions within a play therapy paradigm. In this type of play therapy, the therapist bases his/her theoretical framework on the cognitive model of emotional disorders. This shows that there is a link of cognition, emotions and behaviour of the client.

The therapist pays close attention to these as the child plays in the play therapy room. The sexually abused child often develops disturbed thinking or behaviour as he/she starts to blame him/herself for the abuse (Passarela, Mendes, & Mari, 2010). According to Knell (1995), cognitions determine how people feel and behave. Passarela *et al.* (2010) suggest that the use of techniques such as gradual exposure enable children to evoke traumatic memories of the sexual abuse. The CBPT therapist therefore employs psycho-education, coping and cognitive restructuring, which may reduce anxiety and PTSD symptoms including body safety skills that teach children to protect themselves from future abuses (Passarela *et al.*, 2010). According to this view, disturbed behaviour is considered to be an expression of faulty cognitions (Cattanach, 2008). Cognitive play therapeutic process would involve an exploration of the disturbed thoughts and the therapist must help the child client to formulate thoughts that would be adapted to the child's situation (Cattanach, 2008).

CBPT helps the therapist in modelling the appropriate problem-solving thinking that aims to improve the child's interpersonal relations (Lennon & Barbato, 2001). According to Knell (1995), in an attempt to match the therapeutic interventions to the child's developmental stage, cognitive behavioural therapists make use of play therapy so that the child develops more adaptive thoughts and behaviours. Cognitive-behavioural therapy showed to be effective in the treatment of symptoms in sexually abused children and adolescents with posttraumatic stress disorder (Passarela *et al.*, 2010). Cognitive behavioural play therapists are directive in their interventions. Hence, they maintain an active and directive role while they recognise the child's developmental level and use play therapy materials to foster communication and understanding (Lennon & Barbato, 2001). In a study done with children with ADHD, Abdollahian, Mokhber, Balaghi, and Moharrari (2013) found that play therapy based on a cognitive-behavioural approach was effective for reducing the symptoms of ADHD. In that regard, children were expending some of their energy in play activity sessions and this reduced their hyperactivity (Abdollahian *et al.*, 2013). Lennon and Barbato (2001, p. 8) add to this that CBPT relies on therapist-directed interventions and focuses on "the developmentally appropriate aspects of play therapy onto a goal-oriented, structured approach". In this regard, the CBPT therapist specifies the goals and objectives of play therapy leading to the evaluations of outcomes in such a way that the child's behavioural, emotional and adjustment problems are directly resolved (Lennon & Barbato, 2001). Abdollahian *et al.* (2013) add that cognitive-behavioural psychologists have also used play therapy to treat children with a variety of disorders.

From the above approaches where play therapy has been utilised and proved to have worked in practice, it is worthwhile to consider eclectic counselling methods whereby play therapy is used as a counselling strategy, and which can be used together with different counselling

perspectives. Counsellors should aim to attain more knowledge of a variety of counselling theories and techniques so that they can be in a position to employ effective play therapy with their child clients. Play therapy is therefore a very important and widely used strategy applied by counsellors while utilising a variety of counselling theories and techniques. Childline Zimbabwe counsellors conduct counselling sessions in the playroom where the child client is allowed to make use of the available play materials.

3.4 COUNSELLING TECHNIQUES

The following discussion focuses on some of the main counselling techniques that are necessary for counsellors during their interventions with sexually abused children.

3.4.1 Allowing the child to explore

Attempts at making it possible for the child to explore aim to facilitate the client's progress through changing feelings, thoughts and behaviour. Hill (2001) explains that exploration occurs when the therapist encourages the client to talk about his/her problems. This is done when the therapist helps the client to hear his/her own thoughts and feelings in a new way (Hill, 2001). The client progresses in the healing process and fulfils his or her human potential. In view of this idea and with regard to play therapy, Knell (1995) asserts that the child's disturbed behaviour is considered to be an expression of irrational thinking; hence, the therapeutic process involves an exploration of these thinking distortions and the therapist helps the child to formulate thoughts that would be adaptive to his/her situation. Therefore exploration involves the interplay of the child's cognitions, emotions, behaviour and physiology (Geldard & Geldard, 2008; Knell, 1995).

3.4.2 The use of silence

According to Bani (2011), positive non-verbal communication shows acceptance and warmth, which is important in fostering self-esteem in children. Silence is a non-verbal reaction that expresses different meanings (Delaney, 2009). Hill (2001, p. 181) refers to silence as "talk-stopping". By allowing silence for both the counsellor and the client helps both of them to form a close relationship in which feelings and thoughts are shared. Silence is used by the client to represent avoidance, or to confront or avoid painful issues, or to cope with his/her emotional situation (Huby, 1997). According to Delaney (2009), silences on the part of the client can serve as an indicator that the client –

1. has difficult talking about his problem;

2. has given a lot of information;
3. has said something very significant;
4. does not know what to say next;
5. might just need a bit more time to think about an answer to the counsellor's question.

In this regard, silence on the part of both the counsellor or the client could indicate empathy, understanding, confusion or misunderstanding. Silence on the part of the counsellor helps him/her to provide unconditional support to the child who has been sexually abused. The client feels that he/she is being listened to and that his/her shared feelings are being regarded unconditionally. The counsellor, however, needs to say something about his/her silence to show that he/she is still listening to the child client (Delaney, 2009). For instance, he/she could say "I am just going to stay quiet for a while so that we can both think about what we are talking about" or "I am listening." Although silences are very useful, it is important that counsellors use them effectively. Too much use of silences hinders their purpose since the child might not know when to start talking again. If a counsellor keeps quiet for longer than one minute, it might be difficult for the child to start talking again (Delaney, 2009). Hough (1998) adds that in order to listen effectively, it is necessary to be silent. The counsellor should keep it in mind that clients need periods of silence in order for them to collect their thoughts, or as ways of experiencing their feelings or emotions, and clients communicate a great deal through the use of silence (Hough, 1998).

3.4.3 The use of positive verbal encouragers

Positive verbal encouragers are sometimes called minimal encouragers. Nelson-Jones (2000, p. 135) refers to the positive verbal encouragers as "small verbal rewards [which] are brief expressions of interest designed to encourage clients to keep talking". These include little words such as "please continue", "uh-hum", "right", and "OK". Positive verbal encouragers can also be in the form of expressions. For example a counsellor may say "I understand" or "I know". These words and expressions provide positive responses to the client's story and contribute to a positive counselling environment. These words according to Latif (2001) occur automatically in conversations as someone predominantly listens rather than to talk. They are used by the counsellor to encourage the child to say more since these responses indicate to the child that he/she is being listened to. Latif (2001) further suggests that counsellors should space their minimal encouragers since frequent use of these leads to intrusion or distraction of the child client. This adds to the fact that positive verbal encouragers must be used with care so that they reflect their therapeutic use. Nelson-Jones (2000) suggests that a counsellor may say these words to reward clients for saying either positive or negative things about

themselves especially negative statements that are made in early sessions and positive statements that are made in later sessions.

3.4.4 Focusing

During the counselling treatment, it is necessary for the counsellor to stay centred on the main issues that show the concerns of the child. A counsellor who can actively listen to his/her client finds it easy to focus on the child's issues. The counsellor hence asks the client to describe his/her problems as he/she sees it; therefore, the counsellor and the client both focus on the problem (Smith, Adam, & Kirkpatrick, 2011). Trained counsellors possess skills that help them to stay focused on the client in the counselling process and his or her immediate environment. Ivey and Ivey (2008) assert that focusing on contact functions helps the child to access suppressed emotions so that the child is given affirmation of his/her actions and behaviours. The counsellor needs to pay attention to the child's social contact since children who experience emotional difficulties usually have impaired contact functioning (Latif, 2001). According to Oaklander (2001), healthy contact involves the use of the senses namely looking, listening, touching, tasting and smelling (usually used during Gestalt therapy). Oaklander (2001) adds that contact can also be done through awareness, learning, healthy expression of emotions, ideas, thoughts, curiosities, wants, needs and resentments. Similarly, Latif (2001) states that focusing occurs through the contact tools namely looking, talking, touching, listening, moving, smelling and tasting.

With the assistance of a counsellor, focusing helps the client in confronting and examining his/her story and personal feelings and this can help to make a breakthrough in the client's understanding of his/her feelings (Ivey & Ivey, 2008). Sometimes, while focusing on a contact function, the counsellor can encourage the child to put his/her feelings into words and so help the child to get in touch with bodily feelings and sensations so that he/she is connected with the emotional feelings being experienced (Latif, 2001).

For instance, the use of appropriate media in counselling helps the child to stay focused. By using media, the child becomes connected with his/her emotions and uses the media to express these emotions. During therapy, the counsellor asks the child about how he/she feels while using the media; hence, the counsellor focuses directly on what the child is feeling (Latif, 2001). Focusing helps to reframe and reconstruct the client's problems, concerns, issues and challenges (Ivey & Ivey, 2008). The counsellor is therefore expected to stay on track with everything happening in the counselling room while paying attention to the child's verbal and non-verbal cues.

3.4.5 Open-ended questions

The use of open-ended questions allows the client to share his/her internal perspective without curtailing his/her options (Nelson-Jones, 2000). Open-ended questions encourage the client to tell the story in his or her own words. Hence, in the initial counselling session, the counsellor wishes to assist the client to say why he/she has come (Nelson-Jones, 2000). Feelings and emotions are expressed freely. If the counsellor uses closed-ended questions, the questions would limit the child from saying more because they attract answers such as “yes” or “no”. Closed-ended questions have a tendency to lead the child to say things that are of interest to the counsellor. Geldard and Geldard (2008, p. 14) add that, with the use of closed-ended questions “there is a danger of asking too many questions, because the child may fear being asked to disclose information which is private and/or too scary to share”. Asking too many questions may also infringe the child’s ego boundaries. In such cases, the child gets used to the counsellor’s questions and will wait to provide answers only rather than the child leading the conversation and talking about issues that are important for the child (Latif, 2001). The counsellor should bear in mind that the goal of questioning is to stimulate the child to talk, and open questions tend to fulfil this goal rather than closed questions (Nelson-Jones, 2003). What follows below are examples of the two types of questions:

- open-ended question: What can you tell me about your family?
- closed-ended question: Do you come from a big family?

3.4.6 Assessment

When all the goals of counselling have been achieved, it is usually time to end the treatment. Killian and Brakarsh (2005) state that the child and the family should be seen for at least three sessions so that a valid assessment could be made and immediate intervention be conducted. Assessment is an important counselling technique that counsellors need to use at the beginning of, during and at the end of a counselling relationship. As Becvar and Becvar (2006) put it, assessment concentrates on the strengths of the relationships between the therapist and the client(s). The therapist therefore focuses on these strengths in order to consider the end to therapy. Some clients become dependent on counsellors although the goal of the type of counselling being discussed here is for children to become empowered (Jager, 2012). Geldard and Geldard (2008) state that it is inevitable that most child clients will develop a caring attachment to their counsellors and therefore it would be a loss for the child when the counselling relationship comes to an end. The counsellor needs to adequately prepare the child for termination. Counsellors are also concerned about the time it takes for the child’s case to be finalised. The legal sector tends to take up to three years or more for sexual abuse

cases to be concluded (Sadan, 2005); hence, counsellors need to terminate such cases at the right moment. According to Geldard and Geldard (2008), some signs of success in therapy that can be revealed through assessment are:

- the child no longer shows obvious CSA indicators such as unreasonable fears, sleeplessness and forgetfulness;
- the child can now show confidence, he or she can participate normally in school or at home;
- the child can express him/herself fully;
- the child is no longer interested in attending more sessions; and
- the child can explain the lessons learnt from therapy.

3.4.7 Termination

The termination of a counselling relationship is regarded by Hough (1998) as ending the relationship between the counsellor and the client when the client becomes autonomous and is able to cope alone. Although termination is a difficult stage, it should be done at the correct time, in other words not too early but also not too late. It can be agreed at the start of the relationship when the relationship will be expected to come to an end. The counsellor should involve the client in the termination process by reviewing the client's progress. Geldard and Geldard (2008) state that termination can sometimes cause children to be ambivalent about leaving the counselling relationship, and the counsellor should involve them in the termination process by allowing them to share their mixed feelings. In summary, five issues as stated in Brakarsh (2006) have to be considered before a counselling relationship can be terminated. These are:

- the client should have a caregiver with whom he/she can discuss the CSA issues;
- the child should feel safe and socialise with significant others and is now less vulnerable;
- the child should be almost at the same level as prior to the abuse, e.g. in school;
- the child is no longer symptomatic, e.g. no longer experiencing panic attacks, bedwetting or sleep problems; and
- family conflicts should be resolved.

3.5 THE COUNSELLOR'S ROLES IN COUNSELLING

Four main themes describe the nature of counselling (Hough, 1998). The counsellors' roles thus follow these themes, namely to fulfil the needs of a helping relationship, to base counselling on the principle of empowerment, to help clients to identify their own resources and lastly, to maintain the confidential aspect of counselling relationships (Hough, 1998). Furthermore, Geldard and Geldard (2008), during therapy, the counsellor (from an integrated psychological approach) should be responsible for:

- facilitating or engaging the child in a therapeutically useful process in a calm and stable way and not interrupting, constraining or influencing the child's natural expression of behaviour;
- encouraging the child client to talk freely;
- interpreting the child client's statements;
- responding to the child client and his/her family's needs for seeking therapy. For this reason, Geldard and Geldard (2008, p. 15) point out that during the joining process, "it is important for the counsellor to know precisely what information the child has received about coming to counselling and to clarify, affirm or correct perceptions about what will happen";
- accepting the child client as he/she is;
- establishing a feeling of permissiveness in a warm and friendly counselling relationship;
- recognising the child's feelings then reflecting those feelings back to the child so that the child can gain insight; and
- respecting the child's ability to solve his/her own problems.

Sexually abused children and their families need immediate professional help and treatment. In this regard, the role of a counsellor is to "... help the child regain his or her sense of self-esteem, cope with feelings of guilt, and begin with the process of overcoming trauma" (American Academy of Child and Adolescent Psychiatry, 2008, p. 2).

Kalliala (2006) reports that practitioners (counsellors) talk to the child clients and listen to their stories, observe their play during play therapy and find out what is known and understood by parents and counsellors about the children's behaviour. As the counsellor engages in all these roles mentioned above, one of the major roles according to Suprina and Chang (2005, p. 258)

is that, "When working with victims of child abuse, the therapist must match the intervention to the psychological and cognitive development of the child."

Cattanach (2008), in consideration of Schaefer's (2011) eclectic prescriptive play therapy (discussed above), states that the goal of the therapist is to construct an individual programme for each child, and this is best done by flexible and skilful therapists who can adapt a particular treatment procedure that suit their own personal style. As a result, the therapist's role will vary according to the particular play therapy approach used.

While the client plays, the counsellor's main duties according to Axline (1993) and Cattanach (2008) are to:

- help the child to use play materials to effectively express him/herself;
- be a play partner, audience and empathic listener for the child when necessary;
- value the child by recording or explaining the child's play;
- refrain from directing what the child says or does during play;
- refrain from hurrying the play therapy session; and
- contain the play so that the child can discharge his/her feelings and make sense of his experiences.

Although play therapy can be used throughout a counselling relationship with a child, it has been found to work well during the initial stages of the relationship. Counsellors should at all times follow ways that are comfortable to them as long as the goals of the child client are met.

Case recording is one of the main administrative tasks of the counsellor, and it is an important aspect that counsellors need to pay attention to. All sessions done with clients should be clearly documented. These documents provide the necessary information about a client, and make it easier to follow up on each child's case. The researcher used case studies to review the intervention strategies utilised by counsellors and follow-ups done per individual client, the intensity of the emotional support and documentation done per case. Case writing also plays a vital role for other counsellors to take over a case when the counsellor is absent or has left the job. Axline (1993) suggests that writing each excerpt helps the counsellor to include the reason for referral and a brief summary of the child's problem.

According to Chigwedere (2004), some of the areas highlighted by written case reports are:

1. significant background information about the client;

2. the client's presenting problems;
3. the number of sessions and date attended;
4. what the counsellor has done;
5. personality and intellectual changes noted in the client within subsequent sessions;
6. the way the overall counselling process is progressing;
7. issues that have been addressed sufficiently by the counsellor; and
8. reflected changes in the client's life and future actions to take.

Hence, writing case reports is crucial in a counsellor's work with clients.

It is the duty of the counsellor to be objective when using referral information since such information paints a picture of the child in his/her environment. To this effect, Oaklander (2001) advises therapists to honour and accept children as the children present themselves. In this regard, the use of the Gestalt concept focussing in the here and now, Oaklander (2001, p. 2) claims that "the therapist will accept the child as he or she presents the self without expectation ... In this way, the relationship between therapist and client flourishes". Using these ideas, it is better for the therapist to start with the child from where he or she is at the time the counselling relationship begins regardless of anything else the therapist hears or reads about the child. In most cases, the child makes contact with a friendly, empathic, congruent and accepting counsellor who takes the child as he or she is at that moment. Through documentation, the counsellor can compare the child's presenting story to the newer version of the problem or to what has initially been reported. Recording of all the important information about the client helps the counsellor to focus on the actual problem of the child. Biographical information about the child client and his/her family background (presented in the form of a genogram described in Chapter 2) is also important data to be recorded on each case report.

3.6 COUNSELLING PROCESS AND STAGES

These are followed by counsellors during their work with child clients. According to Martin, Turcotte, Matte, and Shepard (2013, p. 14), counselling addresses a variety of factors namely "the clients' wellness, relationships, personal growth, career development, mental health, and psychological illness or distress". This is achieved by the counsellor adhering to a counselling process whereby he/she facilitates the client's personal growth, development, and self-understanding, which in turn empowers the client to adopt more constructive life practices.

There are many definitions of counselling provided by various authors. Stokes (1994) defines counselling in the medical context as listening or helping, and as involving the specific counselling skills being used in a non-directive exploration of the patient's problem. Hough (1998, p. 4) affirms the definition of counselling offered by the European Association for Counselling (1996) which is:

Counselling is an interactive learning process contracted between counsellor(s) and client(s), be they individuals, families, groups or institutions, which approaches; in a holistic way, social, cultural, economic and/or emotional issues. Counselling may be concerned with addressing and resolving specific problems, making decisions, coping with crisis, improving relationships, developmental issues, promoting and developing personal awareness, working with feelings, thoughts, perceptions and internal and external conflict. The overall aim is to provide clients with opportunities to work in self defined ways, towards living in more satisfying and resourceful ways as individuals and as members of the broader society.

Bedi *et al.* (2011, p. 3) provide the following definition which is endorsed according to the understanding of counselling psychologists in Canada, namely:

Counselling psychology is a broad specialization within professional psychology concerned with using psychological principles to enhance and promote the positive growth, well-being, and mental health of individuals, families, groups, and the broader community. Counselling psychologists bring a collaborative, developmental, multicultural and wellness perspective to their research and practice. They work with many types of individuals, including those experiencing distress and difficulties associated with life events and transitions, decision-making, work/career/education, family and social relationships, and mental health and physical health concerns. In addition to remediation, counselling psychologists engage in prevention, psycho-education and advocacy. The research and professional domain of counselling psychology overlaps with that of other professionals such as clinical psychology, industrial/organisational psychology, and mental health counselling.

This implies that counselling is an activity that is undertaken by people who are trained in this interactive process, and the relationship between the counsellor and the client is significant and based on equality of partners (Hough, 1998). Hence, "when a person who has experienced child sexual abuse seeks help or enters therapy, they meet with their individual counsellor and agree on how they might work together" (Trinity College Dublin, 2003, p. 1). Delaney (2009) describes the process of counselling as sometimes referring to the process of listening only while at other times it involves counsellors giving advice to their clients. Brakarsh (2006) considers counselling as a special relationship between the client(s) and the counsellor where information over the client's problems is shared and discussed.

Therapy facilitates the expression of many complicated feelings such as guilt, shame, anger, rage and hatred. Therapists work with sexually abused children in an effort to embark on a significant healing journey which is aimed at helping children emerge from victims into survivors (Pistorius, Feinauer, Harper, Stachman, & Miller, 2008). In the case of CSA, the purpose of counselling is to create an environment of trust where the child and family can learn more about their thoughts, their feelings, and their life. The child or family is enabled to take action to achieve their own goals or to solve their own problems. Counselling helps clients to develop a clearer understanding of their concerns. Through the process of counselling, clients can acquire new skills to manage personal issues better. Just sharing problems, thoughts and feelings with a counsellor who is outside the client's personal life can be helpful since the counsellor can offer a different perspective that can help the client to think of solutions to his/her own problems (USQ, 2010).

In most cases, the counselling process or stages to be followed will depend on the individual counsellor, in consideration of the nature of the problem, the age of the client, the risk factors involved and the number of counselling sessions the client had already received. However, counsellors follow a general counselling process during counselling interventions. Below are two counselling processes that guide Childline Zimbabwe counsellors during counselling.

3.6.1 Delaney (2009) counselling process and stages

According to Delaney (2009), there are five stages to counselling that can be adopted for both face-to-face and telephone counselling. These are:

- Rapport building – this is the stage at the beginning of a conversation between the counsellor and the client. The counsellor works to establish a relationship with the client so that it is possible for the client to say more.
- Exploring feelings – the counsellor explores the client's situation and the way he/she feels about that situation. At this stage, the counsellor listens to the child client's story.
- Considering options – the counsellor together with the client considers the possible options to solve the problem or to make the situation bearable for the client.
- Developing a plan – the preferred course of action is further developed and actions for what might be done are identified. The counsellor helps the child client in identifying which information the child might want to tell significant others such as the caregivers or teachers.
- Ending the counselling session (or relationship) – this is the stage when the counselling session (or relationship) comes to an end. A good ending helps in leaving

the client with a positive experience of the counselling session but also the relationship and this lays the foundation for further sessions or relationships if and when necessary.

3.6.2 Family Support Trust (FST) counselling model

The counselling model of the Family Support Trust (FST) developed by Brakarsh (2006) states that a counsellor has to go through the following four stages in order to counsel an individual or the family of a sexually abused child:

3.6.2.1 *Joining*

This involves the first meeting with the child client (and caregivers if available). The counsellor creates a counselling relationship with the client(s) so that trust and confidence are developed on the part of the clients and they feel safe and comfortable. This aids effective communication between the counsellor and the clients. In order to join with the clients, Brakarsh (2006) suggests the following:

- introducing yourself as a counsellor;
- greeting the child; and
- addressing the child's likes, dislikes and fears.

Nelson-Jones (2000) states that good helpers (counsellors) possess good meeting, greeting and seating skills. According to Nelson-Jones (2000, p. 152), some helpers (counsellors) engage their clients in "small talk" when they first meet their clients. This is minimal and it does not give the impression of a social relationship, but it may humanise the meeting and greeting process which are all important aspects of joining. The joining process should always be adjusted to meet the individual child's needs (Latif, 2001). Hence, the main function of the joining process is to help the child client to understand the nature of his/her relationship with the counsellor.

3.6.2.2 *Defining the problem(s)*

This helps the clients to explain the main problem on which they want to focus during counselling. Counsellors should be careful not to focus on their own preconceived ideas about the clients' problem. McGregor, *et al.* (2013) state that given the prevalence of child sexual abuse in a variety of communities, service providers should get as much as possible the

history of the abuse as this would help in focusing on the real problem and guiding the intervention process. Here the counsellor may ask the clients some of the questions below:

- What brings you here today?
- What else have you tried to do to solve this problem?
- How long have you had this problem?
- What would you like to achieve from these meetings?

3.6.2.3 Widening the view of the problem

At this stage, the counsellor enquires about other systems that might be influencing the problem. The counsellor generally looks at the environment within which the child client lives. The counsellor finds out what is going well or wrong by considering –

- the child's home and/or family life;
- the child's school life;
- the caregiver's work, social and marital life;
- the caregiver's physical health life; and
- the child's social and physical health life.

3.6.2.4 Solutions

This addresses which options the family together with the child could devise in order for them to overcome the problem. The counsellor together with the clients revisits the areas they identified as problematic and try to find solutions. At this stage, the counsellor could ask the following questions:

- Which changes would you like to see in your life?
- What could everyone in the family do to help with this problem?
- Which obstacles might prevent you from overcoming the problem?
- What could you do then?

The above discussion indicates the counselling stages followed by counsellors. The need for counsellors to join and formulate counselling relationships with their clients was explained. It is through this initial stage that counsellors explore their clients' feelings. Counsellors should

also check the clients' support systems, to see if these have an influence on the clients' problems. Together with the client, the counsellor then considers available options and devises a solution to the client's problem. After all the necessary interventions are done and favourable outcomes obtained, the counselling relationship can safely be terminated.

3.7 ETHICAL STANDARDS IN COUNSELLING

Urombo (2000) defines ethics in counselling as the guidelines that provide the directions for conduct of counsellors. Counsellors are guided by rules of counselling and they are expected to follow these rules during all counselling relationships with their clients, since many health professions consider intentionally or unintentionally harming a client as a serious offence (Urombo, 2000). Nelson-Jones (2000, p. 287) defines ethics in counselling as, "rules of conduct or systems of moral standards for different situations. They address considerations of right and wrong behaviour".

Childline Zimbabwe, like many other professional organisations has a code of conduct that is followed by all counsellors (Delaney, 2009). It is the duty of all counsellors to abide by the rules stated in this code of conduct. According to Haeny (2014), ethical considerations involve the following principles:

- Beneficence and nonmaleficence – that psychologists (counsellors) should do their best to protect the welfare and rights of their clients and to be aware that others might take advantage of their professional status; and
- Fidelity and responsibility – an ethical obligation indicating that psychologists (counsellors) be aware of their professional and scientific responsibilities to society and communities in which they work, the professional standards of conduct, roles and obligations, appropriate responsibility for their behaviour and be able to manage conflicts of interest that could lead to exploitation or harm to their clients.

The relationship between the child and the counsellor should be non-intrusive where both the counsellor and client respect one another, and counsellors do not impose their own values upon the clients (Nelson-Jones, 2000). Hilden, Sildenafil, Langhoff-Ross, Wijma, and Schei (2003) and McGregor and others (2013) advocate that service providers should be more survivor sensitive and avoid practices that can dispose CSA survivors to trauma, negative experiences, physical and psychological discomfort. McGregor and others (2013) further suggest that service providers should therefore modify their behaviours and procedures in order to minimize such discomforts for the CSA survivors. Geldard and Geldard (2008) say that, in cases where parents or other significant others first disclose the CSA case to the

counsellor and when the child discovers that important information has been given to the counsellor without his/her consent or knowledge, the child may feel threatened, exposed, vulnerable and might be uncertain about how much more information the counsellor may already know. Because of this, there is definitely an erosion of the child's ego boundaries and this leads to the child feeling disempowered (Geldard & Geldard, 2008). The child may therefore be unsure of the counselling relationship and can be anxious about attending therapy.

During intervention, counsellors are bound by ethical codes, which serve to protect both the counsellor and the client. Higginbotham (1995) describes standards and ethics for counselling as those that address the management of confidentiality, avoiding the exploitation of clients, respecting clients' autonomy and the competencies necessary to practice counselling. In this regard, ethics show what people in a counselling relationship must and must not do. Central to this are ethical dilemmas. Nelson-Jones (2000) posits that counsellors will sometimes be faced with ethical dilemmas involving choices between possible alternatives on how best to act. According to Urombo (2000, p. 65), an ethical dilemma is a "situation in which whatever action a counsellor takes results in violation of some standards. The counsellor experiences conflict in determining what course of action to take." The counsellor therefore either violates professional standards or civic expectations. Counsellors are encouraged to possess good ethical decision-making skills when faced with ethical dilemmas (Nelson-Jones, 2000). An example could be a situation where a boy child shares with the counsellor that he has been a victim of sodomy. He confidentially tells the counsellor that he revenged by poisoning the food of his uncle, who was the perpetrator of this sexual abuse, and that no one in the family knew about the cause of the uncle's death the previous year. In this case, the counsellor encounters the ethical dilemma of confidentiality. On the one hand, the counsellor is expected by law to report law breakers while on the other, the client expects the counsellor to keep confidential information privately. Urombo (2000) argues that there is in fact no good or best solution to ethical dilemmas. The following section discusses some of the ethics in the counselling process.

3.7.1 Confidentiality

Confidentiality is an issue that needs a lot of attention during counselling of CSA issues due to the sensitive nature of such cases. Harman (2011) illustrates that confidentiality entails the evidence of anything said, or any admission made, by the client to the counsellor while the counsellor is carrying out professional services for that client. All information, including details of clients, is strictly confidential and may not be disclosed to anyone without the express concern of the person concerned (Delaney, 2009). Cattanach (2008) illustrates that

confidentiality is the most important matter to discuss with the child before play therapy begins. There are limits to confidentiality, and Delaney (2009, p. 69) states that “while confidentiality is considered imperative, considerations should be given to situations where children, particularly being vulnerable, are at risk of significant harm, or experiencing current harm”. In such cases confidentiality is broken to ensure the safety and well-being of the child and his/her right to protection. Nelson-Jones (2000) explains that confidentiality involves the counsellor not divulging private information about the client without the client’s permission and it also involves informing the client of the limits of confidentiality. In addition, Geldard and Geldard (2008) suggest that the counsellor should tell the child client right at the start of the therapeutic process, that what is said during the session will be private and that, when necessary, certain information will only be disclosed to significant others with the child’s permission. At this point, the counsellor should therefore make it clear to the child that the child is free to share any information from the counselling session with their significant others as long as it is the child’s own informed decision. Thus, the counsellor discusses with the child how, when and which information will be shared. This empowers the child and provides him/her with control over ways in which disclosures are shared with other people (Geldard & Geldard, 2008). Hence, counsellors need to allow clients to retain responsibility for their lives (Nelson-Jones, 2000).

3.7.2 Informed consent

Informed consent means that clients have to understand the counselling process and they should willingly agree to it (Urombo, 2000). In this regard, informed consent involves the right to be informed about what the counselling process would entail and to consent knowingly and without any pressure to the strategies being used during the process (Nelson-Jones, 2000). Some of the important information that clients should be given includes the reason for counselling, the counselling goals, the rules to be obeyed by both the counsellor and the client, the counsellor’s roles, the client’s rights, the process to be followed and confidentiality and its limits (Nelson-Jones, 2000; Urombo, 2000). In relation to the limits of confidentiality, Harman (2011) notes that a counsellor may disclose certain information only if consent to disclosure is given by the client. After all the important information had been given to the client by the counsellor, the client and/or caregiver can then fill in an informed consent form for counselling to start. It should however be noted that, if clients themselves cannot give informed consent to therapy, therapists should discuss the matter with significant others, for instance, parents/caregivers of young children or of mentally handicapped people (Urombo, 2000). Counsellors should always value informed consent by appropriately disclosing all the

relevant information to their clients. This involves among others voluntary participation in counselling discussed below.

3.7.3 Voluntary participation

Counselling is usually a voluntary process where the client is willingly engaged in counselling sessions. In the case of a client who is sent for counselling, the counsellor explains what counselling entails through adherence to the principle of informed consent (see 3.7.2) and this enhances the rights and freedom (of clients) to choose whether or not to take part in counselling as described by Nowell (2012). The role of the counsellor is to inform the client about what is involved in counselling, and the client should feel free to participate or not to participate in counselling (Urombo, 2000).

Furthermore, it is stated that counsellors should discuss with their clients the clients' rights to refuse counselling if they had reasons to do so and the counsellors should clearly explain the implications of that refusal (Urombo, 2000). In order to ensure voluntary participation of clients, counsellors should follow a universal and professionally defined code of conduct and this helps to regulate the relationship between the counsellors and their clients and in situations where clients are treated with respect especially in diverse cultural backgrounds, as described by Nowell (2012). Research from South Africa (Phasha, 2010) and the United States (Haight, 1998) points towards the need for organizations that work with sexually abused children to pay attention to their clients' cultural backgrounds as this would positively help in formulating counselling strategies.

3.8 CHILDLINE ZIMBABWE'S TREATMENT TEAM: THE HOLISTIC APPROACH

Childline Zimbabwe follows a holistic approach and involves other stakeholders (treatment team members) in addressing CSA issues. Childline Zimbabwe follows Delaney's (2009) counselling procedure. Below is an example of the general flow of events for most child sexual abuse cases.

- child's case is received by Childline Zimbabwe;
- involvement of the Department of Social Welfare;
- reporting the case to the police;
- child referred to the government hospital for examination by a Family Support Trust doctor;
- child's case goes to court; and

- movement of the child to a safe place.

The order of these stages for intervention sometimes changes. Where the client would start depends on individual cases.

In helping child victims of CSA, Childline Zimbabwe works together with other important organisations such as the Department of Social Welfare, the hospitals, the police and children's homes. Delaney (2009) refers to such organisations as those that are child-safe. Different organisations intervene differently to the needs of sexually abused children. Each organisation plays a different role in helping sexually abused children. For these organisations to perform their specific and vital roles, there must be clear communication and linkages between professionals from the different agencies (Burgess *et al.*, 1978). Burgess *et al.* added that a troubled family with their sexually abused child seek attention or help from any of the agencies on the treatment team. Childline Zimbabwe uses a holistic approach when dealing with survivors of CSA as they refer clients' cases to other organisations. For Childline social workers to do their work adequately, the child (depending on individual cases) should be seen by all or some of the members of a treatment team, which comprises of the member organisations as shown in Table 3.

Table 3: Childline Zimbabwe treatment team

TEAM MEMBER	ROLES
Childline Zimbabwe counsellor/social worker	<ul style="list-style-type: none"> • provides emotional support • leads the child to pass through all the necessary departments • establishes the family situation of the child • visits to the child's home/school
Government social worker	<ul style="list-style-type: none"> • assesses the intensity of the situation • has the mandate to place a child in a children's home or a place of safety
Police	<ul style="list-style-type: none"> • investigates the case • refers the child to hospital if necessary • ensures the arrest of perpetrators • sends the case to the magistrate's court
Government doctor	<ul style="list-style-type: none"> • examines the child • admits the child to hospital if necessary • treats the child's injuries
Children's home	<ul style="list-style-type: none"> • accommodates the child in a place of safety

	<ul style="list-style-type: none"> • protects the child from further abuse • serves as a caregiver • sends the child to school
Magistrate's court	<ul style="list-style-type: none"> • magistrate provides the ruling of the case • suggests the final punishment for the perpetrator
The family	<ul style="list-style-type: none"> • takes overall responsibility over the child • provides support (including emotional and psycho-social) to the child • gives all the necessary information regarding the child
The communities and their leaders	<ul style="list-style-type: none"> • provide information about sexually abused children in the community • protect children from abuse

Author's own compilation

Monahan and Forgash (2008) and McGregor and others (2013) advise that a team effort that includes the client and all service providers facilitates a relationship that helps in establishing a treatment plan, consistent and close collaboration and sharing of information and concerns. The team's effort provides the client with positive experiences and actively decreases abuse-related associations and better client management (Monahan & Forgash, 2008). According to Pennstate Children's Hospital (2010), the members of a treatment team work together in the monitoring of the child's physical and mental health. The common goal is to reduce the long-term effects of CSA. The earlier sexually abused children get help, the greater their chances of healing from the effects of abuse (S.T.O.R.M TEXAS, 2010). Morrison (1996) refers to the multidisciplinary collaboration in child protection work where effective partnerships both between clients and agencies and between agencies in the child protection field are encouraged. Intervention by collaborating agencies is required at primary, secondary and tertiary levels where procedures for joint working are essential while the outcomes in terms of services and benefits are achieved for abused children and their families (Morrison, 1996). It should, however, be noted that, if a family is badly handled at the entry point into the treatment team system, it may be very difficult to gain access to the client and to deliver the much needed help thereafter (Burgess *et al.*, 1978). Members of the treatment team should always treat clients with care. McGregor and others (2013) suggest that it is important to adopt a practice that all health professionals routinely ask their clients on how they can make interventions more comfortable. In the very end, the main role of the health professionals in working with CSA survivors in a more sensitive manner is "to improve the health outcomes for adult CSA survivors by delivering a positive post-CSA intervention..." (McGregor, *et al.*, 2013, p. 5).

3.8.1 Working with communities

All stakeholders involved in child welfare work in partnership with the aim of promoting the healthy development of children and strengthening their rights (Morrison, 1996). Prevention of child sexual abuse is far better than the cure. According to American Academy of Child and Adolescent Psychiatry (2008), caregivers can prevent or lessen the chances of child sexual abuse by raising awareness of sexual abuse in terms of children. Children can be taught to say “no” and to report sexual abuse issues straight away. They should also be taught the differences between respect and blind obedience to adults. Professional prevention programmes can be introduced in local schools and communities. Childline Zimbabwe combats some of these activities through social workers and the Childline training department when they do outreach programmes in schools and communities.

3.8.2 Advocacy work

Even though there are limited resources, the various stakeholders in Zimbabwe have come together and adopted a multi-sectoral stance in the fight against child sexual abuse. Various organisations such as the department of social welfare, the hospital and the police act as advocates for children as they work together to lobby government and come up with strategies that can help in the prevention of CSA, care for child survivors of CSA and punishment for perpetrators. The collaboration of various stakeholders aims to strengthen the position of various organisations in the struggle against child sexual abuse as they lobby with a united voice on important CSA issues. The South African government has historically relied on civil society/non-governmental organisations (NGOs) to combat problems facing society (Save the Children Sweden, 2005). The situation is the same in Zimbabwe where NGOs have resources to reach out and help societies in need. Childline Zimbabwe is one of the organisations that can go out into communities and provide the much needed psychosocial services to children relating to various problems, including CSA. It is important that each country’s governmental bodies take the responsibility to ensure quality and accessibility of services provided by the NGOs although they have inadequate resources to help the whole population (Save the Children Sweden, 2005). In its work with sexually abused children, Childline Zimbabwe undertakes initiatives involving relevant service providers so that the child sexual abuse cases are dealt with fairly and accurately.

According to Save the Children Sweden (2005, p. 7), “there is no quick fix to the issue of child sexual abuse” and there is a need for active participation in prevention programmes at community level whereby issues to do with change in perceptions, behaviours and norms are addressed. A culture that respects children’s rights should be adopted. Since the problem of

CSA is multi-sectoral, the media should play a big role in sending correct information to people of all walks of life about the challenges due to child sexual abuse faced by communities (Save the Children Sweden, 2005).

3.9 CONCLUSION

Insert 2: “I don’t want you to leave me, I want you to be with me, you are my friend, you are the one who uprooted me from the trouble” (Tadzie, a Childline client survivor of father–daughter incest in 2009).

Tadzie said this to the counsellor after the counsellor had visited her after she had been moved to a place of safety, a children’s home. This citation shows how grateful some clients are after receiving Childline Zimbabwe counselling services. For counsellors to provide adequate counselling interventions to child survivors of CSA, they have to be more survivor-sensitive and follow the phases of child therapy (see 3.2). Child therapy is an all-encompassing process that counsellors employ in order to achieve valuable counselling. Gestalt, play and group therapy are some strategies that are central to the counselling of children of all ages and all types of abuse. Counsellors can, however, only do that if they possess certain qualities and attributes. These attributes make it possible for counsellors to join with the children and form good therapeutic relationships (see 3.3.2.1). Counsellors also make use of various counselling techniques to fulfil certain counsellor roles during a therapeutic process with survivors of CSA. Counselling stages (see 3.6) provide the necessary steps to be followed during counselling service provision for CSA issues from relationship building to termination. Ethical issues (see 3.7) are the basic reference tools for all counsellors since these stipulate the expected behaviour and practice guidelines for counsellors. Counsellors also use a treatment team, which involves various stakeholders who combine their efforts to the fullest with the aim of bringing positive changes in the lives of child clients who have suffered the effects of CSA.

Chapter 3 was devoted to the discussion of the counselling strategies that are helpful in the counselling of children suffering the effects of CSA. The chapter provided the theoretical basis for the analysis of counselling practices at Childline Zimbabwe, which is elaborated on in Chapter 5. The methodology for this analysis is elaborated in Chapter 4. Chapter 4 gives details of the research design, the sample size and characteristics of the research participants as well as the data collection and analysis methods.

CHAPTER 4

RESEARCH METHODOLOGY

4.1 INTRODUCTION

Researchers are guided by their research questions and the aims of the inquiry rather than their preferences for a certain methodology (Coll & Chapman, 2000). It is therefore the objectives of the study that drive researchers in choosing either qualitative, quantitative or mixed methods approaches to research.

Research methodology addresses the research plan in a way that shows how the researcher actually executed the study. An overview of the research design and the methods used in the current research are discussed in this chapter, for instance, the way research participants were selected, the characteristics of the sample, where the research took place, data collection and analysis processes. In this chapter, the researcher describes the qualitative descriptive case study research design adopted for this study, and explains the rationale for using this approach. The goal of the current study was to describe the counselling services provided by Childline Zimbabwe to its clients who are survivors of child sexual abuse. Data were gathered by means of mixed methods approach using semi-structured interviews, participant observations, questionnaires, and document analysis. Grounded theory was used in the analysis stage. The issues of validity and reliability and ethical considerations of the study are explained in the last section of this chapter.

4.2 QUALITATIVE CASE STUDY RESEARCH DESIGN

According to Terre Blanche *et al.* (2007 p. 460), “case studies are defined as ideographic research methods; that is, methods that study individuals as individuals rather than as members of a population”. In addition, Cohen, Manion, and Morrison, (2000, p. 182) state that, “case studies portray ‘what it is like’ to be in a particular situation, to catch the close-up reality and ‘thick description’ of participants’ lived experiences of, thoughts about and feelings for, a situation”. In this case Childline Zimbabwe’s counselling services is being studied. In case study research, the researcher focuses on the participants as actors, and seeks to understand their perceptions of events (as described by Cohen, *et al.*, 2000). The researcher in this research hence focuses on the perceptions of Childline counsellors and the child clients who are CSA survivors. The researcher uses case studies drawing from Denzin and Lincoln (2005)

since they help researchers in adding credibility to their cases through thorough triangulation of the descriptions and interpretations that are done throughout the study period.

This is a qualitative study and the researcher makes use of a case study following the ideas of Denzin and Lincoln (2005, p. 443) where they propose that, “case studies are a common way to do qualitative inquiry”. Following Ziegler and Hjelle’s (1992) recommendations, with the case study method the researcher can focus on in-depth assessment of the counsellors and clients with the objective of learning their needs, way of work and behaviours through the use of various sources such as document analysis, questionnaires, participant observations and semi-structured interviews. Within case study research, there are no specific data collection methods or analysis unique to its methods of enquiry (Denzin & Lincoln, 2005). The case study perspective stresses that researchers choose to study the case by whatever suitable methods that can address the research problem. Here the case study seeks to explore the counselling services of Childline Zimbabwe for CSA survivors. This exploration is done by mixed methods whereby the focus is laid on the qualitative data emerging from the case (as described by Denzin & Lincoln, 2005).

There are many types of case study approaches (Cohen, *et al.*, 2000; Denzin & Lincoln, 2005). The case study approach adopted for this study can best be labelled as a **descriptive** case study that is interpretative in nature and features elements of an evaluative case study. It is a descriptive case study because it seeks to provide narrative accounts of the counselling services done by Childline. Such studies allow respondents to describe and explain approaches and episodes. In addition Ziegler and Hjelle (1992) illustrate that descriptive case studies can provide a rich narrative account of each individual’s thoughts, feelings and actions as a whole in his or her natural setting. The researcher therefore used the case study approach where she examined human experiences through detailed descriptions of the counselling services offered by Childline counsellors and the services received by Childline clients. In this regard, Cohen, *et al.*, (2000) report that the researcher is integrally involved in the case and there is blending of a description of events with the analysis of those events. The researcher also describes all the observations from this study (as suggested by Hing, 2010) and clearly like the way the words were said or written by the participants. Following the way Leedy and Ormrod (2005) summed up descriptive qualitative researches, the researcher described and explained all emergent phenomena and captured it with detailed information .

This study is also **interpretative** in nature. Following Cohen, *et al.* (2000), interpretative case studies help researchers in inductively developing conceptual categories in order to examine initial assumptions. Through the case study following the interpretive tradition of research, Cohen, *et al.* (2000) consider that it is important for events and situations to be allowed to

speak for themselves rather than to be largely interpreted by the researcher. Hence the researcher following a case study situated within an interpretive paradigm attempted to understand how people try to construct meaning in their lives given that people need to make sense in their actions and understand why they say so that they can explain their actions. In support of this idea, Cohen, *et al.* (2000, p. 181) suggest, "There is frequently a resonance between case studies and interpretive methodologies". This approach was chosen because it allowed the researcher to explore the interpreted reality of Childline counsellors and their clients in relation to specific cases of child sexual abuse. In a case study positioned in an interpretive research design, the researcher is committed to comprehending the human phenomena in the contexts they are lived (Terre Blanche *et al.*, 2007). This is what Cohen *et al.*, (2000, p. 183) refer to as "seeing the situation through the eyes of participants". In addition, the researcher can understand the object of study because he/she puts him/herself in the shoes of what is being studied (Mfenqe, 2005). Terre Blanche *et al.* (2007, p. 275) refer to this process as "empathic reliving" or "empathy".

In research, a case study investigation seeks to achieve an understanding of the person's life experiences and behaviour patterns through the use of any available information (Ziegler & Hjelle, 1992). Hence the researcher used mixed methods where different data collection methods were utilised. Denzin and Lincoln (2005) state that the holistic nature of qualitative research looks at the bigger picture and a principled respect for the multiplicity of people's cultural forms where those forms are preserved. Through this respect for multiplicity, the researcher can understand the whole issue being studied (Hing, 2010). In this research, the researcher looked at many aspects that influence the counselling of survivors of child sexual abuse in their totality. This was done by considering all the aspects involved in the operational service delivery by Childline Zimbabwe counsellors, for instance, information obtained from the counsellors, clients, and the documents analysed. According to the suggestions by Ziegler and Hjelle (1992), case studies can be used to identify threads of consistency where the researcher can draw some general conclusions about the way counselling is done at Childline. Finally, (as suggested by Ziegler & Hjelle, 1992) if the goal is to study processes, then the case studies are the strategy of choice. In this sense, the goal of this research is to study the counselling processes by Childline Zimbabwe.

4.3 AIMS OF THE STUDY

The aims of the present study were as follows:

- to describe the counselling services utilised by Childline Zimbabwe counsellors;
- to get a deeper understanding of the different methods of counselling offered to survivors of child sexual abuse by Childline counsellors, namely
 - the counselling approaches and techniques used;
 - the type and number of follow-ups done per individual child abuse case; and
 - the quality of information recorded in individual case reports by each of the counsellors; and
- to explore the level of client satisfaction for counselling services received from Childline social workers/counsellors, as this was based on the imminent changes in clients' lives after the onset of counselling.

4.4 SAMPLE

The sample consisted of two groups of people. These were the five Childline counsellors and the 25 Childline Zimbabwe child clients (from which five children were 7 years and below and they were represented by their caregivers). In total, the research sample consisted of 30 research participants.

The participating counsellors were all females with ages ranging from 30 to 50 years and their mean age was 40.8 years. Among the 25 child clients, there were 22 girls and 3 boys and their ages ranged from 3 years to 16 years and the mean age was 11 years. Both males and females had an equal chance of being selected. Since there were many reports of sexual abuse of girl children and less of boy children, only 3 boys participated in the research as compared to 22 girls.

Below are the graphs and a table showing participants' ages and gender distribution.

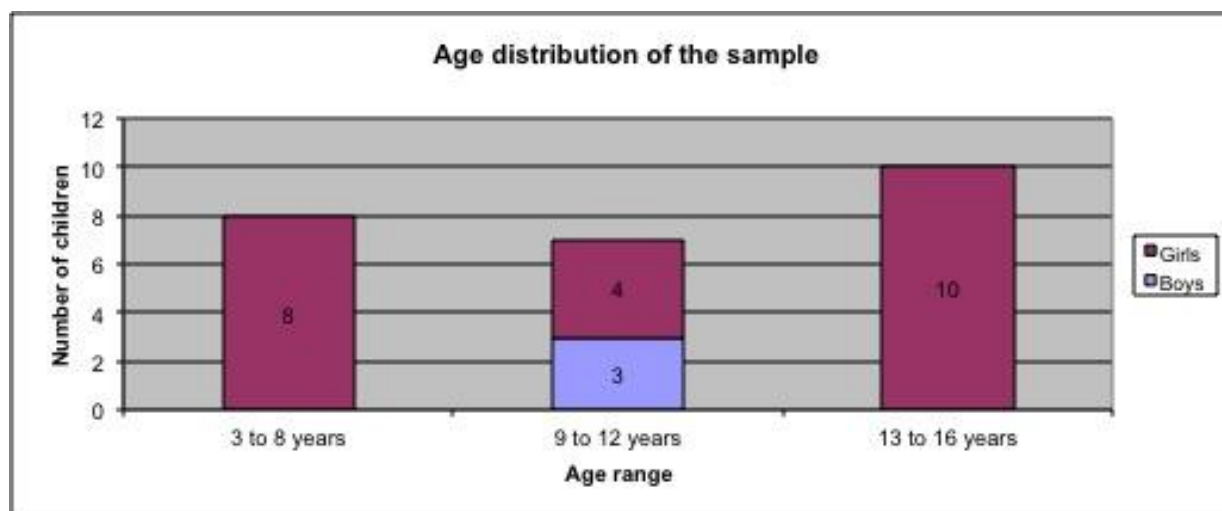


Figure 4:1 Age distribution of the selected child clients

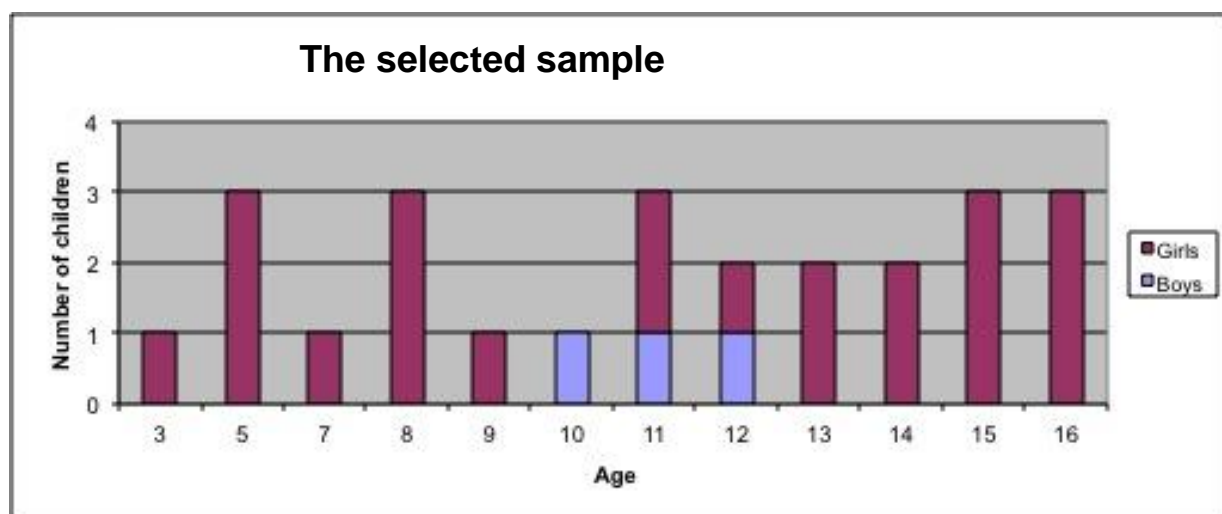


Figure 4.2: The selected sample for child clients

Table 4: Age and gender of counsellors

NAME OF COUNSELLOR	AGE	GENDER
A	50	F
B	48	F
C	45	F
D	31	F
E	30	F

The researcher did not obtain information about the caregivers' ages and gender since more focus was placed upon the child survivors of sexual abuse. Therefore, the researcher focused only on all the children including the five represented by their caregivers.

4.4.1 Sampling criteria

Research participants (counsellors/social workers) who met the following research criteria were selected for the study:

- counsellors/social workers who were permanent employees of Childline Zimbabwe and who had counselling experience with survivors of child sexual abuse;
- counsellors who were members of the Counselling Department for both Bulawayo and Harare regions; and
- counsellors who had been volunteers who conducted telephone counselling before they joined Childline Zimbabwe as social workers or counsellors.

Children who met the following research criteria were selected for the study:

- children between the ages of 0 to 16 years
- children had to be clients of Childline Zimbabwe during the research period
- children should have experienced sexual abuse at some point in their lives
- caregivers who participated during interviews and questionnaires had to be the ones who took care of children of 7 years and below. (By the time children are 8 years of age they are more able to articulate). This is reported by Ferguson *et al.* (1992 cited in Kuhl, 2010, p. 4) who state that "Learning to produce the sounds that will characterize infants as speakers of their 'mother tongue' is equally challenging, and is completely mastered until the age of 8 years."

4.4.2 Sampling procedure

As a way of selecting the sample, three types of sampling were used during the selection of child clients. These are:

- purposive sampling;
- random sampling; and
- non-random sampling.

First of all, the researcher made use of purposive sampling in order to get only CSA cases. According to Terre Blanche *et al.* (2007, p. 139), in purposive sampling "... sampling depends not only on availability and willingness to participate, but that cases that are typical of a population are selected". The researcher obtained all the cases of child sexual abuse that had been handled by each of the five counsellors during the period March to June 2009. This gave a total of 93 cases. From these reported cases, 45 cases were rape, 33 involved incest, 4 child marriages, 5 cases of sodomy, 4 indecent assault cases, 1 pregnancy and 1 case of child play. Random sampling was then used to obtain five cases of sexual abuse from each of the five counsellors, four of the five counsellors (researcher was the fifth counsellor) were from the Harare office and the only one counsellor from the Bulawayo office. The researcher then selected a non-random sample of three of the five cases from each of the five counsellors. These were selected on the basis of their geographical accessibility and their ability to speak English or Shona. This gave a total of 15 cases (child clients) who were interviewed (see Appendix 2) and who were asked to respond to the satisfaction questionnaire (see Appendix 4). In short, a non-probability sample in the form of purposive sampling was used to identify the participating children. A random sample was drawn from these participants. Finally, a non-random sample was used to identify only the participants who were to take part in the semi-structured interviews and questionnaires.

All 25 case reports from the random sample were used to analyse the interventions provided by the counsellors. All five Childline Zimbabwe counsellors from the Bulawayo and Harare offices, excluding the researcher (the 6th counsellor) were interviewed (see Appendix 1) and responded to the questionnaire (see Appendix 3). While selecting the sample, the researcher made every effort to reflect on the diverse demographical nature of the local society in the sample (as recommended by Craddock & Mathias, 2009). Hence, she selected participants who represented both rural and urban communities in Zimbabwe.

4.5 DATA COLLECTION TECHNIQUES – MIXED METHODS APPROACH

Data were collected by means of tape-recording, taking notes during the semi-structured face-to-face interviews, field observations, item satisfaction questionnaires and document analysis. Document analysis comprised of readily available general statistics of all CSA cases at Childline Zimbabwe during the period of March to June 2009 and the case reports from the children clients of Childline counsellors. The researcher combined qualitative and quantitative data collection, analysis and inference techniques for the broad purposes of breadth and depth of understanding and corroborating phenomena as, according to Lopez-Fernandez & Molina-Azorin (2011), such combination promotes triangulation and complementarity. Lopez-Fernandez and Molina-Azorin (2011) point out that triangulation helps with achieving a

convergence of results obtained from the quantitative and qualitative approaches so that such results are more reliable. Data collection was field-based and flexible. The researcher obtained data from the counsellors as well as the child clients (CSA survivors) and/or their caregivers. The data sources that were used are discussed below:

4.5.1 Semi-structured interviews

To gather research data, the researcher conducted face-to-face, semi-structured interviews in which she used open-ended questions. Different interviews were used for Childline Zimbabwe counsellors and for sexually abused children and/or their caregivers (see Appendices 1 and 2 respectively). The questions asked to all counsellors were the same while the set of questions asked to the children and/or their caregivers were also the same. The interview session lasted approximately one hour. Interviews were chosen for this study because interviewing is a natural form of interacting with people. Interviews fit well with the interpretive approaches to research since they give an opportunity to get to know people better. Terre Blanche *et al.* (2007, p. 297) assert that through interviews "... we can really understand how [people] think and feel." Through the use of semi-structured interviews, the researcher was able to create an open and trustworthy environment within which the interviewees could authentically express themselves in order to fully express their feelings and experiences.

Open-ended questions were used during interviews, and participants were free to say what they needed or wanted to say. The researcher captured all the information of the interviews by taking notes. In some cases, the responses were recorded on audiotape. Although the researcher intended to audiotape all the research participants' responses, this was however not fulfilled since some of the research participants (both counsellors and Childline clients) were not in a position to have their sensitive CSA issues recorded on audiotape, despite the researcher's reassurance that all research information was strictly confidential. Only 2 (40%) of the counsellors and 7 (54%) of clients agreed to have the interviews recorded. These recordings were used although they were not all very audible as individual participants spoke with very low voices. Moreover, the researcher had a back-up to rectify this problem by carefully taking comprehensive notes from all the interviews. Statements from each participant were written as they were said; hence, the researcher recorded direct quotations in order to rule out the problem of misinterpreting the participants.

4.5.2 8-item satisfaction scale questionnaire (ISSQ)

The researcher formulated the 8-item satisfaction scale questionnaire in relation to the Checklists, Likert scales and other rating scales that have been used in other studies. For

example, the researcher borrowed ideas from such measurement tools and designed the satisfaction scale that suited the aims of the current study. These ideas were obtained from the formulation of Rating Scales, Ranking and The Card Sort described in Nachmias and Nachmias (1990, p. 215-218); Checklists and Social-Distance Scales in Oppenheim (1979, p. 81-124); Rating Scales in Breakwell, Foot and Gilmour (1993, p. 219-220). The ISSQ in this research were similar to the Likert scale and/or the rating scales for the attitude tests developed and used in the Department of Psychology for the social psychology course PSY482V at the University of South Africa (UNISA) and the course material was compiled by Mynhardt, Appelgryn, Moore, and Nieuwoudt (2008). Although the checklists and scales referred to in this section were aimed at measuring the attitudes of participants on different items, the 8-item satisfaction scales here aimed to explore the participants' satisfaction levels with the counselling aspects of Childline Zimbabwe.

The researcher administered the following 8-item satisfaction scale questionnaires (ISSQs) to each of the participants on the same day soon after the administration of the semi-structured interview:

1. an 8-item satisfaction scale questionnaire for personal quality of counselling services offered by the counsellors (see Appendix 3); and
2. an 8-item satisfaction scale with personal quality of services received by the child clients or caregivers for children under the age of 7 (see Appendix 4).

It took the researcher approximately ten minutes to administer the ISSQ to each participant. The ISSQ scales each consisted of 8 items that were rated on a scale from 1 to 7, where 1 represented the least satisfaction and 7 representing the highest satisfaction. When evaluated qualitatively, the aim of using such a scale was to identify problem areas related to the counselling services and to explore remedial actions suitable to address these problems. The counsellors had to be in a position to show which counselling approaches bring positive changes to their clients while the clients had to indicate clearly which of the services received were satisfactory. The researcher later used this information during the recommendation stage where suggestions were made to counsellors to improve on those items that had produced poor results.

The researcher explained this tool thoroughly to each participant so that they understood its meaning and the way they had to use it. In this research, there were five children who were 7 years and younger. The researcher therefore administered the semi-structured interview and the ISSQ to the five caregivers. The ISSQ was difficult to fill in, even though some of the children above 7 years had a good command of English. Some caregivers were illiterate. The

researcher helped them to fill in the questionnaire by going over each item one by one together with the child client who was 8 years and above or with the caregiver for a child who was 7 years and below until all the questions had been answered. In addition, the researcher was very careful not to lead the clients in the rating process.

4.5.3 Document analysis

This comprised two types of documents, namely case reports and the general statistics of child sexual abuse cases at Childline Zimbabwe.

4.5.3.1 Case reports

The researcher received five case reports from each of the five counsellors, making a total of 25 case reports. On average, one case report consisted of six pages. These were photocopied, and the original copies were given back to the counsellors. The researcher made use of case reports as the research strategy and gathered the qualitative data by means of cross-case analysis. The researcher read through all the cases, comparing and contrasting individual cases and, in the process, the researcher gained new information. The researcher used the case reports since these provided a rich source of case data which supplemented observations, interviews and questionnaires as suggested by Patton (2002). For example, the researcher received information on counselling interventions that could not be observed since the case records revealed information on what had already taken place before the research process began. Records and other documents constitute material culture and are rich for many organisations and their programmes (Patton, 2002). In order for the researcher to gain access to these case reports, she negotiated and discussed the matter with the director, the counselling department manager and all the counsellors of Childline Zimbabwe.

The case reports were compiled by individual counsellors and contained information about the child client, the nature of the case, the counselling sessions and the services provided. They were written for Childline purposes and records of cases. The case reports provided archival data and proved to be valuable in this research since the researcher was able to learn directly from constantly reading them and, as described by Patton (2002, p. 294), case reports can also work “as stimulus for paths of inquiry that can be pursued only through direct observation and interviewing”. The researcher was cautious about the confidentiality of the contents of the case reports since the case reports contained sensitive information about clients’ sexual abuse. As Cohen *et al.* (2000) suggest, the researcher therefore used the case reports to evaluate the recorded information with regard to the services provided by Childline

counsellors to child clients. The information the researcher received from the case reports was, according to Terre Blanche *et al.* (2007), beyond the interactive situation and was needed to guide and facilitate decision-making.

4.5.3.2 General statistics for child sexual abuse cases

The Childline Zimbabwe counselling department manager made the departmental statistics relating to child sexual abuse available to the researcher. The general statistics showed the total number of cases per sexual abuse type as indicated in section 4.4.2. The most vulnerable age group in terms of sexual abuse during the period under discussion was also revealed. Out of the 93 cases reported to Childline Zimbabwe in the four-month period (March to June 2009), there were three children between the ages 0 to 4 years; thirteen children were between 5 and 8 years; thirty were 9 to 12 years; thirty-seven were between 13 and 16 years while 10 children's ages were unknown (Childline Zimbabwe, 2009). According to these statistics, children between the ages 13 to 16 were most vulnerable to sexual abuse.

4.5.4 Participant observations

Research data were also gathered by means of observation. As an active participant in a variety of Childline counselling activities, the researcher was in a position to collect data from personal observations during these activities. The researcher noted some important counselling services offered by counsellors during her integration into the organisation as a social worker/counsellor. (The researcher was physically present in counselling sessions while colleagues were conducting counselling sessions with clients). The researcher also obtained information during departmental meetings, group counselling with colleagues, de-briefing exercises with colleagues and supervisors and counsellor trainings by professional counsellor trainers. Some of the observations were performed during field work as the researcher worked for Childline as a social worker/counsellor. In this regard, Leedy and Ormrod (2005, p. 143) state, "As they collect data, many qualitative researchers also begin jotting notes (sometimes called memos) about their initial interpretations of what they are seeing and hearing". Furthermore, observational research according to LeCompte, Preissle and Tesch (1993) indicates that the researcher observes participants while collecting data on what they are doing, whether or not the researcher and study participants interact in one way or another. The researcher also ensured that specific observations that were relevant to the study were recorded in which all data items were coded in terms of the activity being observed, date, time, place and context of the activity. Three examples of these data sources are presented in appendix 16.

As would be seen in chapter 5 where the results are presented, the researcher presents data gathered by means of all the above-mentioned data collection tools for the counselling services utilised by Childline Zimbabwe. For easy visualisation of the data, tables and graphs are used to present quantitative data and a brief explanation is given under each table or graph. This is followed by the data interpretation and evaluation of the counselling services at Childline Zimbabwe.

4.6 PROCESS OF DATA ANALYSIS

Data analysis followed a number of steps. Raw data gathered from interviews, questionnaires, document analysis, and participant observations were recorded, analysed and interpreted. Cohen *et al.* (2000, p. 282) state,

The great tension in data analysis is between maintaining a sense of the holism of the interview and the tendency for analysis to atomize and fragment the data – to separate them into constituent elements, thereby losing the synergy of the whole, and in interviews often the whole is greater than the sum of the parts.

In addition, Bell (1993 cited in McClintock, 2002, p. 36) states, “A hundred separate pieces of interesting information will mean nothing to a researcher or a reader unless they have been placed into categories; we are constantly looking for similarities, for groupings, patterns and items of particular significance.” Hence the researcher reduced large chunks of data to generate smaller meaningful categories (as suggested by Cohen *et al.*, 2000; Strauss & Corbin, 1998). In this process, the researcher constantly looked for similarities and differences (as suggested by Strauss & Corbin, 1998), for patterns in her data, by counting frequencies of ideas, grouping the data and finding strong relationships among the pieces of data (Cohen *et al.*, 2000).

The researcher used an inductive approach when going through the details and specifics of the data so that important categories, dimensions and interrelationships could be discovered and explained. Themes and ideas were constructed as the study progressed. Grounded theory was used as a theoretical base for data interpretation, as Willig (2001, p. 16) states, “without theory there is nothing to research”. Jeanty and Hibel (2011, p. 6) explain:

Grounded theory is one that is inductively derived from the phenomenon it represents. It is discovered and provisionally verified through systematic data collection and analysis of data pertaining to that phenomenon. Therefore the data collection, analysis and theory stand in reciprocal relationship with each other.

One does not begin with a theory and then prove it. Rather, one starts with an area of study and what is relevant to that area is allowed to emerge.

Hing (2010) adds that an inductive process involves the generation of insights, perceptions and concepts that emerge from the data during the analysis stage. Hence, data was analysed to determine its meaning through the use of inductive reasoning (Leedy & Ormrod, 2005). The researcher drew on Strauss and Corbin (1998, p. 66) who state “doing line-by-line coding through which categories, their properties, and relationships emerge automatically takes [the researcher] beyond description and puts [him/her] into a conceptual mode of analysis.” Although literature helped the researcher to frame her earlier categorisation, the final emerging themes and categories presented and analysed were completely grounded in her data.

The researcher was guided by the constant comparative method which “involves systematically examining and refining variations in emergent and grounded concepts” (Patton, 2002, p. 239). The researcher was doing this through the critical way of working with research data, and for the data which had no predetermined variables, a new category was formed. Categories that were not corresponding with the aims of the study were discarded. For the semi-structured interviews, answers from different participants were grouped together according to common questions.

Numerical data from the item satisfaction scale questionnaires were statistically analysed and item analysis was also done during this stage. The responses from the 8-item satisfactory scale questionnaires were analysed using simple descriptive statistics. This mainly involved the calculation of average response rates for each item of the questionnaire and displaying the results in tables in chapter 5. Since scaled items can be evaluated using standard quantitative methods (Terre Blanche *et al.*, 2007) high scores on the scale indicated positive attitudes while low scores indicated negative attitude. This meant that, where participants indicated higher scores on an item, they were happy with that item and where they indicated low scores, they were less happy with that particular item. The two ISSQs for counsellors and for child clients and/or caregivers were also analysed separately.

Analysis of the documents/records involved contextualising the texts represented by the written documents and this showed how the texts constituted the child sexual abuse issue as an object and the clients and counsellors as subjects (as suggested by Denzin & Lincoln, 2005). Patton (2002, p. 498) argues, “Qualitative researchers are uniquely positioned to study these texts by analysing the practical social contexts of everyday life within which they are constructed and used”. The researcher followed this argument by linking the contents of the

case reports to the sexual abuse of the children in the context where it happened and the way counsellors addressed the issues of the children.

Each case report was analysed in an effort to understand it and to evaluate the services given to the clients formatively. As described by Cohen *et al.* (2000), content analysis reflects the nature of documents being analysed in relation to the purpose of the research. This was the stage where the researcher's three cases of sexual abuse (comprising two girls and one boy who were randomly selected) were used in comparison with the counselling intervention methods of the other five counsellors.

Data obtained from the general departmental statistics of CSA cases, covered the period March to June 2009 (see section 4.4.2 above). This helped the researcher to get a general outline of the total number of cases that Childline Zimbabwe received and addressed within that period of time. The researcher also verified the accuracy of the documents whereby she cross-checked and compared the statistical records with the case log files where all the cases were recorded. All numerical data was statistically analysed.

4.7 RESEARCH CONTEXT

The study was conducted at the Harare and Bulawayo Childline offices in Zimbabwe. There are ten provinces in Zimbabwe. Seven provinces are linked to the Harare office and three are linked to the Bulawayo office. Harare is the capital city of Zimbabwe and houses Childline's head office. Harare is the largest city in Zimbabwe; hence, many cases are received by the Harare Childline office. The Harare office has five counsellors/social workers who provide emotional support to children in difficult circumstances and in Shona-speaking Mashonaland provinces of Zimbabwe.

Bulawayo is the second largest city in Zimbabwe and there is only one counsellor/social worker in the area. The counsellor provides counselling services to the whole Bulawayo and in Ndebele-speaking Matabeleland provinces. The researcher visited the selected child clients in Harare and Bulawayo and the surrounding areas. The researcher met the participants while they were in their natural environments and she created the opportunity for them to speak for themselves in their natural settings. This allowed the researcher therefore to gain a deeper insight into the participants' world view and a deeper understanding of the meaning attached to participants' situations by analysing the different contexts of the participants' situations (as suggested by Craddock & Mathias, 2009). In the case of the child clients and/or caregivers, interviews were conducted in the comfort of their homes or in the school environment for children who were contacted during school hours. According to Nachmias and Nachmias

(1990, p. 329), “The home is considered one of the most private settings [in many cultures] ...” For the counsellors, the interviews and questionnaires were administered at the Childline’s counselling rooms.

In Zimbabwe, there is need to provide information for counsellors/social workers on the effects of CSA on abused children and ways in which these children should be helped to deal with these effects. There is however limited knowledge in many Zimbabwean communities on how to address CSA. Through this study, the current counselling services and their effects in the lives of child survivors of CSA are further explored.

The researcher has also compiled demographic information of all participants who took part in the semi-structured interviews and the 8-item satisfaction scale questionnaires. This was done to obtain an overview of who the participants were and in relation to the nature of the CSA problem in Zimbabwe. Information on demography and the types of child sexual abuse the counsellors have dealt with in the past were obtained directly from the individual counsellors and the form was administered to each participant together with the questionnaire (see Appendices 9A and 9B respectively). In the case of the child clients, the researcher obtained the demographic data and information on the types of sexual abuse they have experienced directly from case reports (see Appendices 10A and 10B respectively).

4.8 RELIABILITY AND VALIDITY

During the research process, the researcher was aware that she was very much involved in all the counselling processes of Childline Zimbabwe since she was one of the counsellors. The researcher was researching counselling services provided by her colleagues. Therefore, she did not view herself as an outside researcher but as part of the system which was being studied. The researcher was aware that this close involvement in the system which was being studied had some implications on the validity of the study. Patton (2002, p. 53) says about this type of involvement, “It is participation in an activity that generates interest, purpose, point of view, value, meaning, and intelligibility, as well as bias.” From this position, the researcher did not select, advise or direct the research participants in what she wanted to hear, since this would have affected the validity and reliability of the research negatively. The researcher involved the participants in an empathic way, as if she heard counselling issues for the first time (as recommended by Patton, 2002), at the same time leaving out her own thoughts, feelings and biases. The researcher accepted and understood the participants’ perceptions without presenting her own ideas (as suggested by Strauss & Corbin, 1998).

In order to establish the validity and reliability of the present study, the following guidelines helped the researcher through the research process:

- **Self-reflection** – the researcher was critically reflective about her own assumptions in counselling. A qualitative analyst is reflective on his/her own perspectives and being self-analytical, politically aware, and has reflexive consciousness (Patton, 2002):
 - constant self-reflection on her role as a researcher within the research process and that which was being researched (as described by Lather, 1986); and
 - self-reflection on the researcher's own motivation to do the research (as described by Lather, 1986). The researcher was open to discussion with participants and other parties involved in the research. The researcher therefore discussed with fellow counsellors, counselling supervisors, department manager and the director of the Childline organisation to negotiate the research process. Important aspects from such meetings and discussions were recorded and saved on the computer and on the memory stick and was frequently retrieved during the research process (see appendix 16).
- Keeping an **audit trail or log book** where the researcher recorded all what happened during the execution of her study. The consistency of data can be verified through the verification of raw data (Golafshani, 2003) and other research processes. Furthermore, the use of an audit trail or a log book allows other people to follow how the researcher conducted the research, and to see how conclusions were reached (Hing, 2010). This enhances the dependability of qualitative research (Golafshani, 2003). Examples of information recorded in the log book are the outcomes of the meetings held at Childline Zimbabwe regarding the research, what transpired when the researcher observed counselling sessions by other counsellors, discussions in departmental meetings, printing and filing email communications with the director, counselling manager or other counsellors. The researcher used information contained in the log book while collecting data. (See appendix 17 for some examples). The log book is also available in hard copy.
- Continuous **consultation** with the researcher's colleagues and supervisors.
- Triangulation made possible through the use of multiple methods utilised in this research.

The researcher used different types of data collection methods and this is called triangulation (as reported by Denzin & Lincoln, 2005). Qualitative researchers focus mainly on multiple methods (as suggested by Denzin & Lincoln, 2005) where researchers attempt to explain

more fully the richness and complexity of human behaviour by studying it from more than one standpoint (Cohen *et al.*, 2000). Triangulation involves the use of multiple measures, including data sources, data collection methods and theories (Lather, 1986; Patton, 2002). The researcher made use of data collection methods such as semi-structured interviews, participant observations, questionnaires and document analysis. Using many methods secured the researcher with an in-depth understanding of the phenomenon being studied (Denzin & Lincoln, 2005). Furthermore, many methods provided the researcher with cross-data consistency and also provided her with diverse ways of looking at the phenomena under study (as suggested by Patton, 2002). The researcher also did a comprehensive literature review, which ensured the credibility of the conclusions drawn and of the research project.

The researcher reports her research in a contextualised manner so that readers can see on which grounds she is basing her conclusions (see research results in chapter 5). Contextualised descriptions enable readers to transfer or extrapolate patterns or findings of the research for possible adaptation into their own or new settings (Patton, 2002). Hence, readers may transfer constructs that may assist them in understanding child counselling practices. The findings of this research are focused on the context of Childline Zimbabwe. The research aimed at describing the interventions used by Childline Zimbabwe while working with sexually abused children. There are several different kinds of validity as described by Cohen *et al.* (2000). The researcher considered internal validity in this research since according to Cohen *et al.* (2000, p. 107), "Internal validity seeks to demonstrate that the explanation of a particular ... set of data which a piece of research provides can actually be sustained by the data." Internal validity also refers to the extent to which causal conclusions were drawn (Terre Blanche *et al.*, 2007) from the emerging data. In that regard, the researcher intended to identify problems regarding service provision by Childline counsellors so that improvements could be applied and thus, the research findings would generally benefit Childline Zimbabwe as an organisation although other organisations working with abused children could also use the findings in their own settings. According to Cohen *et al.* (2000), research should be empowering to all participants and it should involve the researcher and the people being researched. The 8-item satisfaction scale questionnaire (ISSQ) and the semi-structured interview for clients were developed to involve child clients in research. According to this view, involving participants in research also aided validity and reliability of the research.

4.9 ETHICAL CONSIDERATIONS

According to Terre Blanche *et al.* (2007), the majority of ethical guidelines for researchers were developed due to the emergence of abuse to research participants and researchers should be aware of the fact that the dignity and welfare of research participants are much

more worth than the research itself. There are a number of ethical considerations to which the present study adhered. These are discussed below.

4.9.1 Informed consent and voluntary participation

According to Ziegler and Hjelle (1992), informed consent means that subjects should be told in advance about any aspects of the study that might be expected to influence their willingness to participate and that subjects should be allowed to withdraw at any time they want to withdraw. In this regard, the researcher told the participants not to feel obliged to take part in the research process. The researcher informed all participants that their involvement was at all times voluntary, and they received a thorough explanation beforehand of the possible upcoming questions, benefits, rights and consequences (such as time or sensitivity of the topic under study) of taking part in the research project. In support of this, Nachmias and Nachmias (1990) report that informed consent reduces the researcher's legal liability since participants would have voluntarily agreed to participate in the research project. The researcher also assured the participants about their anonymity in the final report.

After the researcher's explanation of the issues of voluntary participation, informed consent and confidentiality (discussed below) and after participants had agreed to take part in the research, the participants were asked to fill in the informed consent form (see Appendix 5 A). The researcher also explained to them the issue of audiotapes and negotiated the use of these tapes. The researcher asked participants who agreed to have the interviews tape-recorded to fill in an extra consent form (see Appendix 5 B). The researcher then provided the guidelines for the interviews and questionnaires.

Since the study explored the quality of counselling services offered by Childline Zimbabwe indirectly from counsellors' records and directly from the semi-structured interviews and questionnaires, the researcher made the counsellors aware that their intervention approaches were being explored and that the study was not judgmental in terms of individual performance. The researcher also made it known to the children that their satisfaction with counselling services received was being explored.

4.9.2 Confidentiality

According to Nachmias and Nachmias (1990), researchers often tell their research participants that the information they provide will be confidentially treated. In the data collection stage, the researcher explained all the issues around confidentiality of research information and she gave the participants clear and accurate information regarding what

confidentiality entails and its limits (see Appendix 6 sections 13 to 17). The researcher explained to all participants that only information that showed harm to an individual or to his or her environment would not be treated confidentially. In such situations, the researcher made the participants aware that such information would be disclosed to the appropriate persons but that the researcher would first discuss the issues to be disclosed with the participant. The researcher also made sure that Childline clients would not know who else was involved in the research; so, all copies of case reports and other documents being used in the research were kept safely. The researcher was furthermore aware of the confidentiality of the counselling department records, and she obtained permission from the director of Childline and the departmental managers to make use of the records. The researcher availed herself of proper safeguards to protect confidentiality and when necessary, information from the documents was quoted cautiously and cited.

4.9.3 Psychological and physical harm

During the execution of this study, the researcher ensured that there was no harm to herself and the participants. This was done by highlighting what the participants and the researcher were allowed and not allowed to do during the interview and questionnaire administration, for example, that no one was allowed to cause any harm to anyone or to property. Terre Blanche *et al.* (2007) encourage researchers to try and identify possible harms or risks to research participants. In order to guard against psychological and physical harm to the research participants, the researcher advised them to take a short break from the interview and/or questionnaire, and to continue when they were ready. The researcher was conscious about the sensitivity of all the information shared during the execution of this study. In this regard, Nachmias and Nachmias (1990, p. 329) state, "The greater the sensitivity of the information, the more safeguards are called for to protect the privacy of the research participants." The researcher explained the vulnerability and nature of feelings of sexual abuse to all participants and assured them that no identifying particulars would be linked to the final report. This helped to avoid psychological harm emanating from the disclosure of participants' information.

4.9.4 Professional codes of conduct

The researcher needed to be professional in the way she implemented the research process. Moreover, the researcher was guided by the professional ethics, as she considered and adhered to the participants' rights and the morally acceptable codes of conduct. (These are shown in Appendix 8). The use of the professional codes of conduct helped the researcher to explain clearly what was allowed and what was not allowed during the execution of her research. It was therefore the mandate of the researcher to act in a professional way so that

she showed integrity during the research process (as reported by Hing, 2010). Following Hing's (2010) suggestion, the researcher presented herself in a morally acceptable way in terms of the general standards of behaviour in Zimbabwe. The researcher therefore followed what Nachmias and Nachmias (1990) suggested, namely that research procedures should be described fully and accurately in research reports, and all evidence should be included regardless of the support it provides for the research hypothesis, and that conclusions should be objective and unbiased. To illustrate the evidence of the phenomenon being discussed, the researcher reports here by using direct quotations of what participants had said or had written (with pseudonyms) as this contained true information.

The researcher's explicit position working as a counsellor/social worker at Childline Zimbabwe had some ethical implications for the process under investigation. The following considerations showing the ethical obligation of honest about the purpose of the study, the dignity, privacy and interests of participants as described by (Cohen *et al.*, 2000) were considered throughout the research process:

- permission was sought from the director of Childline Zimbabwe in order for the researcher to undertake the research; and
- the researcher remained open to discussion with research participants throughout the study in an attempt to highlight to them the aims of the research, how they would contribute to the study and the researcher's motivation to do the research.

The researcher considered her position as a junior counsellor researching the work of other counsellors with vulnerable children and she carefully negotiated with all the stakeholders involved in the study process. The researcher was honest about what would happen to the findings of the research since it involved personal opinions of research participants. The researcher was responsive to the issue of dissemination of information regarding the final report by explaining to the participants that the final research report would be available and kept by the director of Childline Zimbabwe and also in the counselling department, and that it would be used as a learning resource. Hence, information regarding the final research report was compiled and presented to the research participants (see Appendix 7).

4.10 CONCLUSION

This research took the form of a qualitative descriptive case study that aimed to describe the counselling services offered by Childline Zimbabwe to child survivors of child sexual abuse. Data was gathered by means of mixed methods approach. Quantitative methods were mainly used for supplementing the qualitative methods (as suggested by Cohen *et al.*, 2000).

Research data were collected by means of semi-structured interviews, document analysis (case reports and general statistics), item satisfaction scale questionnaires, and participant observations by the researcher. Grounded theory was used during the analysis of data while the interpretive design was used to interpret the data.

The sample consisted of five Childline Zimbabwe female counsellors, 25 case reports of which 15 child client cases were selected for interview and questionnaire administration. Of these 15 cases, five children were 7 years and below and their caregivers represented them for interviews and the questionnaires, while the remaining 10 children were able to answer the questions. The validity and reliability of this research were also explained. Ethical issues including confidentiality, informed consent, professional codes of conduct and the participants' rights were discussed in this chapter. Data were interpreted through inductive reasoning. Chapter 5 below shows the presentation and interpretation of data gathered.

CHAPTER 5

RESULTS

5.1 INTRODUCTION

This chapter presents a report of the results obtained from the qualitative inquiry used in this study. This is done in an effort to show how the researcher explored the research topic under study. The main goal of this study was to get insight into the counselling services offered by Childline Zimbabwe to CSA survivors in order to learn and identify strengths, challenges, factors affecting counselling practice and identify potential points for improving service provision for its clients. Table 5.1 below shows a summary of the cases of child sexual abuse used in this study.

Table 5.1: A summary of all the child sexual abuse cases used in this study

TYPES OF CASES	NUMBER OF CASES
Abduction	2
Incest	11
Rape	6
Sodomy	3
Statutory rape	3
TOTAL NUMBER OF CASES	25

The results are discussed in view of the critical review of the three aims of this study. A number of themes have emerged from the results, and these are discussed with reference to

direct quotations by the research participants during interviews, as illustrated by participants' responses to the questionnaires and as written by counsellors on case reports. The results are also interpreted and authenticated in view of the literature reviewed for this study.

AIM 1: The first aim of the study was to describe the counselling services utilised by Childline Zimbabwe counsellors. The following themes which emerged are therefore based on this aim.

5.2 THEME 1: THE COUNSELLING PROCESS

The results of this study showed Childline Zimbabwe counsellors' criteria for intervention. Firstly, the counselling process followed by counsellors is described.

In their efforts to provide counselling services to their clients, Childline counsellors follow a general format or procedure which is slightly different amongst the individual Childline counsellors. Based on the researcher's observations, the information presented in this section is a common representation of the respondents' responses during the interviews and in the questionnaire done with the counsellors and the analysis of the case reports. As illustrated by the data collected, below is the general intervention process for sexual abuse cases that Childline counsellors follow after receiving cases. This intervention process is formulated on the basis of what Childline Zimbabwe expects the counsellors to do.

1. The counsellor receives the case from the counselling manager
2. The counsellor starts case follow-up
3. Involvement of other stakeholders if necessary (the Department of Social Welfare, the police, Family Support Trust, magistrate's court, place of safety and school)
4. Continuous counselling by Childline Zimbabwe counsellors
5. Link with family and community support systems
6. More follow-up
7. Case termination

The order of the process of intervention sometimes changes depending on individual cases. For instance, sometimes the case is first reported to the police rather than to Childline Zimbabwe. The counsellor uses his/her expertise during the intervention process to take the necessary actions.

The researcher also observed that the organisational culture of Childline does not insist on counsellors following the standardised way of counselling. From the questionnaire, three of

the five counsellors shared the opinion that all counsellors should follow the same process of counselling service provision. As illustrated by Brakarsh (2006) and Delaney (2009), the intervention process is done in an effort to fulfil the main stages of counselling. The four main stages of counselling that have emerged from the data are:

1. establishing a counselling relationship;
2. collecting background information regarding the case;
3. providing psychosocial support; and
4. terminating counselling relationships.

From the results obtained, sixteen of the 25 children's case reports analysed in this study indicate that counsellors did not manage to reach the abused children but many interventions were directed to the significant others. Child survivors of sexual abuse have generally received very limited intervention services. The analysis of the case reports point to the evidence that in 23 of the 25 cases, all five counsellors did the collection of background information but they did not have lasting counselling relationships with their clients to allow them to provide clients with psychosocial support before terminating the counsellor–client relationships.

5.2.1 The counsellors' goals of counselling

The goals of counselling help the counsellor in identifying the client's issues on which to focus (Rukuni & Maunganidze, 2000) and this helps with the structuring of the counselling interventions for each individual child client. Two types of goals have become evident from the analysis of the 25 case reports and the interviews and questionnaires done with all the five counsellors and the 13 child clients. These are the counsellor's goals and the client's goals or the caregiver's goals. The counsellor's goals are formulated in order to address and resolve the child's issues (Geldard & Geldard, 2008). The counsellor would therefore achieve his/her goals while attending to the child client's goals and/or those of the caregiver. The item satisfaction scale showed that four of the five counsellors were satisfied with the way they addressed counselling goals. According to the case reports reviewed, counsellors did not all show how and if they help clients set own goals although goal setting is a pivotal aspect of counselling (Geldard & Geldard, 2008). The counsellors' own goals were evidenced in 24 case reports that showed that counsellors made use of action plans that were written on the case reports. As examples, counsellors wrote on case reports:

Counsellor B:

To counsel the child and educate her on issues of child abuse.

Counsellor E:

I will still make a few more visits to the home since this is the father's wish, and to verify the claims of the father and the child.

In addition, most of the plans of action were fulfilled. For instance, out of 24 case reports with plans of action, counsellors acted on 17 case reports showing intervention plans, while seven case reports showed plans of action that were not accomplished. During interviews, all five counsellors also illustrated that they aimed to fulfil a number of counselling goals. Two counsellors stated:

Counsellor A:

I want to make sure that children have accessed health facilities; I look for satisfaction from clients. I am happy when perpetrators have been sent to jail. If teenagers get counselling, they end up disclosing and change their behaviours.

Counsellor C:

When the child has convicted herself, I aim to convince her that it was not her fault, until she reasons and understands. I also aim to help the child until she gets brave enough to go to court and open up.

Although counsellors pointed out during the interviews that at the end of every session or a counselling relationship, they wish to achieve several goals, there was no clear evidence in the case reports that they achieved the set goals. There were less counselling sessions held with children that would allow for achieving all goals: those of the counsellors, those of the child clients and those of the caregivers. Childline Zimbabwe has stipulated general counselling goals (Delaney, 2009), but during the current research, counsellors presented their own individual counselling goals. Indicated below is a summary of the common goals as stated during interviews and as written on the case reports by the counsellors:

1. Positive behaviour change
2. Client satisfaction
3. Child and caregiver's positive feedback
4. Perpetrator sent to jail

5. Child opening up
6. Ensuring confidentiality of counselling sessions

From the results of the current study, it was learned that counsellors were not very clear about the limits of confidentiality. The limits of confidentiality refer to those issues that are disclosed by the client in confidence with the counsellor but the counsellor could not keep them confidential and could therefore be legally required to disclose them (Becvar & Becvar, 2006) if such issues are meant to cause harm to any person. During the interviews, all five counsellors expressed that they kept counselling sessions confidential and only disclosed some of the information as a way of de-briefing. However, during these interviews, none of the five counsellors could distinguish 'de-briefing', from the 'limits of confidentiality' and 'sharing counselling information'. Furthermore, four of the five counsellors were of the opinion that there is definitely no problem with sharing client information with colleague counsellors in the counselling department for the purposes of de-briefing. The fact that this 'sharing of information' posed challenges for securing confidentiality of counselling information was evidenced by the testimony of one of the interviewed counsellors who expressed her concern over the sharing of information from counselling sessions. Counsellor D reported:

Confidentiality – I don't say it to clients since all of us Childline counsellors, we always share cases with colleagues; thus, violating confidentiality, it is better to de-brief with your supervisor than with your colleagues. People end up sharing everything to do with the case, e.g. the name, age, and physical address of the child. There is need to revisit confidentiality issues as an organisation.

Four of the interviewed counsellors stated that they discussed the issue of confidentiality with their clients so that clients were made aware of what happens to the information they share. However, this could not be supported by the reviewed case reports, which did not contain information that the issue of confidentiality was discussed with the clients. As Mberi and Makore-Rukuni (2001, p. 23) put it, "Children should not have their confidentiality violated." Furthermore, these authors suggest that, if the counsellor has to inform the child's caregivers about anything that came up from the counselling session, he/she should inform the child about the limits of confidentiality and first discuss his/her intentions with the child.

5.2.2 Satisfaction of counsellors by the counselling aspects

An 8-item satisfaction scale questionnaire (ISSQ) for counsellors was administered to determine the extent of counsellors' satisfaction with the services they provided to their

clients. According to the ISSQ, it seemed that counsellors were generally satisfied with the counselling services they provided to Childline clients. Below is a table showing the satisfaction scores for counsellors.

Table 5.2: Average counsellors' satisfaction scores in percentages for each item

	DISSATISFACTION (SCORE 1–3)	AVERAGE (SCORE 4)	SATISFACTION (SCORE 5–7)
1. Counselling approaches for child sexual abuse cases		40	60
2. Joining/relationship building with client	20		80
3. Termination of sessions	40	20	40
4. How you got the case		60	40
5. Referral system	20	20	60
6. Standardised procedure for Childline	40		60
7. Counselling environment		20	80
8. Counselling goals	20		80

The ISSQ show that three of the five counsellors were satisfied with the counselling approaches they were utilizing in helping their clients. On one hand four of the five counsellors were happy with the way they formed relationships with their clients while on the other hand one counsellor presents that the way joining and counsellor-client relationships were not done properly. Termination of counselling relationships was also a cause for concern since two out of the five counsellors were satisfied while two counsellors were not satisfied and one counsellor was not sure if termination was done suitably. Three counsellors were satisfied with the standardised procedure that Childline follows while two counsellors were dissatisfied. Formulation of counselling goals was done satisfactorily according to four out of the five counsellors. The counselling environment was considered to be suitable by four counsellors while one counsellor was not sure whether the counselling environment was pleasant or not.

From this ISSQ, three issues of concern to the counsellors came up, namely

- standardised procedure for counselling (discussed in section 5.2 above);
- termination of counselling relationships (discussed in section 5.2.3 below); and
- reporting of cases (discussed as theme 2 in section 5.3 below).

5.2.3 Termination of counselling relationships

Having discussed the intervention process followed by counsellors, ending counselling relationships was also reported as a vital skill showing how Childline counsellors stop interventions with their clients. From the results of this study, termination has been a challenge for all five counsellors since the analysis of the 25 case reports showed that there was no termination plan indicated on the case reports.

Since none of the counsellors was in a position to engage his/her child clients sufficiently in counselling, none of the counsellors was able to assess and check on the development of the majority of the children's cases throughout the counselling process so that proper termination could be ensured. Since counsellors' access to child clients was limited as indicated by the 16 cases where actual contacts with child clients did not take place, all 25 case reports reviewed for this study also showed that counsellors were not assessing cases in a continuous process whereby it was assessed in the beginning, during the course of counselling and after the implementation of the interventions so that they could determine when termination was necessary. Therefore, three of the five counsellors were not satisfied with the way they terminated counselling relationships with clients, whereas two counsellors were satisfied with the way cases were ended at Childline Zimbabwe. The counsellors' difficulties in failing to terminate their counselling relationships with the clients were evidenced by all five counsellors during interviews acknowledging that they found termination not an easy skill. Counsellor A illustrated:

Termination is a difficult area and difficult to understand its steps.

In the majority of cases, as seen in 23 of the 25 cases, counsellor interventions ended after stage 1 or 2 of the counselling process. None of the 25 cases had any plan showing how counsellors intended to terminate cases. According Geldard and Geldard (2008), responsible counsellors continue to review the therapy process so that they may check whether counselling goals have been achieved, leading to the termination of the counselling relationship. Furthermore, termination has been a key issue since there was no evidence in all the cases referred to collaborating agents that further interventions took place for such cases. In addition, clients were not made aware of the end of the relationship when they were referred. Counsellor D reported:

I terminate when clients can represent themselves, or when a client starts missing sessions, this determines the time that a client does not need the counsellor anymore. Sexual abuse cases might not be terminated for good, leave the door open.

In addition, counsellor E stated:

As long as the child has support systems, friends, family, mentor, if they can relate, it is time to terminate the relationship.

In 19 of the 24 cases that were referred to other members of the treatment team, no further counselling was provided suggesting that the cases were prematurely ended prior to referral. There is therefore no evidence that clients stop needing the counsellor's help after the referral or court hearing.

Although some of the cases were still ongoing at the time of data collection for this study, there was no arrangement between counsellors and their clients in terms of how the issue of termination were to be addressed. From the 25 case reports, 14 had no interventions done in more than a month, while 11 had interventions in the month prior to the onset of the research study, and two cases had been made ready for filing indicating that no further interventions were needed. In one of these two cases, the child had been seen once while in the other case the child had been seen twice.

For termination to occur, Geldard and Geldard (2008) suggest that once the child client has reached the point of 'resolution', counselling will no longer be needed, and the child will move on and function adaptively. Termination has a final influence on the whole counselling process and on the general services provided to child survivors of child sexual abuse. As Geldard and Geldard (2008) acknowledge, the termination process is a difficult one for the counsellor.

5.3 THEME 2: REPORTING OF CASES TO CHILDLINE ZIMBABWE

Counsellors work on cases that would have been reported to Childline Zimbabwe and use the case source as a stepping stone to start counselling intervention. Cases are reported to Childline Zimbabwe in two main ways.

The **drop-in service** allows case informants to walk into Childline offices during working hours (08:00 to 17:00) from Monday to Friday, so that they can report their cases. Clients immediately get counselling services since the drop-in centre is operated by one of the counsellors on duty. If more than one client walk in and the counsellor is in a counselling session, the client(s) wait until the counsellor can help them. Sometimes when available, university students studying to be counsellors and/or social workers come to work on attachment basis at Childline Zimbabwe. In fulfilment of their studies, these students while at Childline Zimbabwe and for a short period of time, work as counsellors/social workers and

they can also help the clients. Drop-in services can also involve reports made to counsellors and other Childline field officers while they are visiting communities.

Helpline refers to a service that allows case informants to phone free of charge. The helpline is open every day for 24 hours. The toll-free numbers are 116, 961, 701111 or 701112. The helpline is operated by Childline-trained volunteers. Case reports from the helpline are forwarded to the counselling department for counsellors/social workers to follow them up and start the intervention process.

In the case of drop-in clients, clients have the advantage that the case would be addressed by a counsellor in the initial stage but for helpline cases, case informants are addressed by volunteers on the phone and these volunteers do not necessarily embark on counselling. Considering that drop-in cases receive initial counsellor interventions, counsellors take up cases that have already received some professional help as compared to helpline cases. This can affect the total amount of work that counsellors do for either helpline or drop-in cases.

In this study, out of the 25 case reports analysed, 12 cases came in through the helpline whereas 13 of the cases came in through the drop-in centre. Out of 13 drop-in cases, six cases involved the child clients themselves in session and seven cases had significant others coming to inform Childline Zimbabwe about the suspected sexual abuse without the child survivor being involved in the interview session. In this sense, the counsellors offered counselling to seven significant people and to six child clients during the initial meeting when the case was reported to Childline. The counselling department kept a file where information regarding all the cases was documented. Also all case reports had numbers that indicated the origin of each case, whether the case originated from the drop-in or from the helpline.

Counsellors have to rely on **case informants** as their main sources of information regarding the children's cases. Callers or drop-in informants to Childline come in six different types. Below is a diagram illustrating the different types of informants who reported the 25 cases that were reviewed in this study:

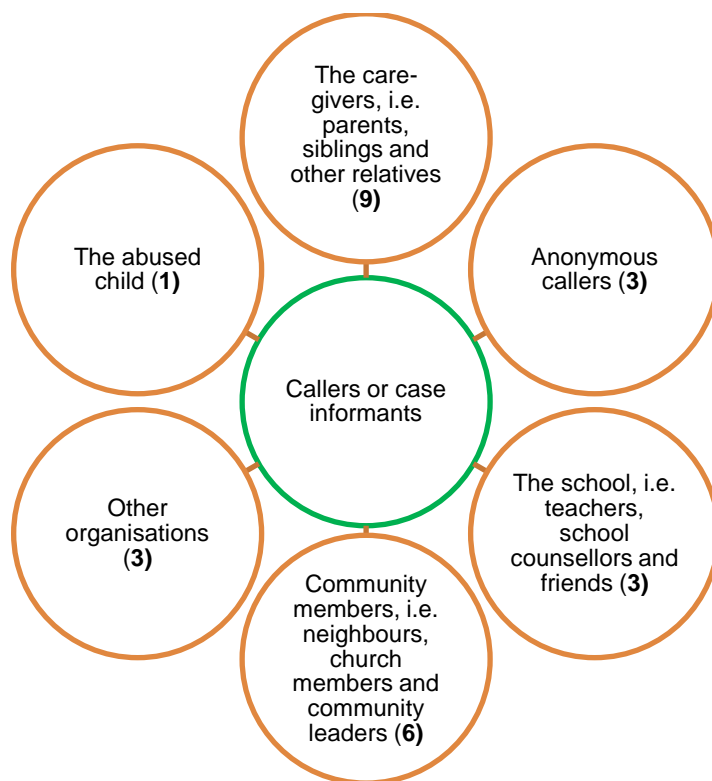


Figure 5.1: The number of cases reported by each type of Childline's case informants (Author's own compilation)

Childline Zimbabwe counsellors rely on these informants in order to get information regarding cases of child sexual abuse. Out of the 25 cases reviewed, nine cases had been reported to Childline Zimbabwe by the caregivers or other relatives of the abused child. The members of the community also reported six cases. Three case informants preferred to stay anonymous. The child's school and other stakeholders working with abused children in Zimbabwe have each contributed three of the reports. Only one case was reported by the abused child. In total, the cases reported by significant others therefore constituted 24 of the 25 cases. Therefore, a number of cases have involved many other people rather than the child clients themselves. It emerged that the reporting by other informants other than the abused child is common practice due to the nature and sensitivity of sexual abuses. It therefore becomes very difficult to provide counselling to the child since in all these cases, counsellors had to concentrate on engaging significant others before they could access the child client.

5.4 THEME 3: REFERRAL OF CASES

Childline Zimbabwe counsellors work together with other stakeholders in addressing children needing different services. For the purposes of this research, all the organisations working together with Childline Zimbabwe in addressing child sexual abuse issues made up the ‘treatment team’ and this was discussed in Chapter 3. As Brakarsh (2006), Burgess *et al.* (1978), and Delaney (2009) illustrate, the use of a treatment team creates a holistic approach to the issue of child sexual abuse.

5.4.1 The treatment team

It has become clear from the results of this study that, in order to address child clients’ cases of sexual abuse, the main option that has been considered and was used by all five counsellors was referral through the use of the treatment team. Childline counsellors reported having done a lot of referral work but providing limited counselling to the child clients. From the 25 case reports, it was noted that when counsellors received the initial case reports (the first time that a case is received by the counsellor), and mostly after the initial interviews with clients or case informants, they immediately looked for the members of the treatment team to whom they referred the children’s cases. Hence, all five counsellors spent very little time with their clients. This was evidenced by the information recorded for all 25 case reports analysed in this study and with reference to what counsellors said during the interviews. When asked how many times they intervened in a child’s case, counsellor B said:

Due to resources, I do counselling only two times: one initial and a follow-up visit. I do up to three times for critical cases. I refer clients to other organisations.

Referral is a two-way process since Childline counsellors refer cases to other organisations while they also get cases referred to them by other organisations. Of the 25 cases, 24 had been referred to other members of the treatment team while only one case was not referred to any other stakeholder. Table 5.3 below shows the number of cases that had been referred to the different members of the treatment team. Some cases had been referred to only one organisation while other cases were referred to many organisations.

Table 5.3: Number of cases that had been referred to different organisations by all five counsellors

NAME OF ORGANISATION	TOTAL NUMBER OF CASES HANDLED
Police (Victim Friendly Unit) (VFU)	24
Hospital (Family Support Trust) (FST)	9
School	11
Magistrate's court	3
Department of Social Welfare	3
Justice for Children Trust	1
Community leadership	1
Place of safety	1

The table above shows that members of the treatment team collaborate and help each other to address the abused children's issues. Of the 25 cases, 24 had passed through the police due to the criminal nature of sexual offences, and the police become the first port of call for most sexual abuse cases. The government hospital (Family Support Trust) had received nine cases and schools have handled 11 cases. Three cases had been sent to the magistrate's courts and to the Department of Social Welfare respectively. The Justice for Children Trust, the community leadership and places of safety, for example, a children's home, had each received one case.

The results of this study show that, from the collaboration of members of the treatment team:

1. Counsellors use most of their time for case work in discussion with other stakeholders and case informants but spend less time with the child client.
2. With some organisations, Childline does not have a strong working bond. This negatively influences the type of work done on child clients' cases.
3. Since counsellors are quick to refer, the four stages of counselling are not completed fully within a short period. Out of 24 cases that had been referred, counsellors had not done much counselling as indicated in 23 cases that ended after counselling stage 1 or 2. Hence, in these cases, all five counsellors equated referral to termination.

5.4.2 Childline Zimbabwe referral criterion

The results show that the referral criterion for Childline depends solely on the organisations involved in the work with vulnerable children. The criterion used by Childline counsellors is one devised by Delaney (2009) and it states that counsellors should refer cases and get

cases from the partnering organisations. Childline Zimbabwe counsellors refer their child clients and use all or some of the following for the referred cases:

- a referral letter is given to the client – this was done in only six of the 24 case reports referred to members of the treatment team;
- a phone call is made by the counsellor to the referral agent – this was evidenced in four of 24 case reports;
- the counsellor explains to the client where they need to go – this was evidenced in nine of 24 case reports; and
- the counsellor accompanies the child to the referral organisation – counsellors did this in six of 24 cases.

Although there were some challenges with referral of cases, counsellors saw this as a strong point since they had been involving other important stakeholders in addressing children's cases. As illustrated by Burgess *et al.* (1978), the traumatic issues of child sexual abuse need to be dealt with holistically; only one organisation could not fully address it. While each organisation has its own specific roles according to literature reviewed in chapter 3, there are some roles fulfilled by all or a number of organisations, for example provision of basic counselling. This was reported as causing some problems for both clients and counsellors. Results from the analysis of case reports and the interviews point towards the information that counsellors ended up doing duties that were not theirs, for instance, investigating cases and getting information about perpetrators, which is actually the role of police officers.

Each member organisation has its own unique roles in addressing children's issues. The roles of different organisations discussed in full details below and problems experienced through the collaboration with other stakeholders are also highlighted.

5.4.3 The roles of each stakeholder and the problems with collaboration

Social workers from the **Department of Social Welfare** (DSW) ensure the safety of the child clients. They are also the only ones having the mandate to remove a child from an unsafe environment to a safe place such as a children's home, a foster home or the child's relatives. DSW and Childline social workers work together to address the child's issues and assess places of safety for the client child. The child is then physically removed to the identified safe place. Counsellor E wrote:

The Childline social worker will speak to social welfare in Chitsa to find out what can be done i.e. can the child be taken for medical tests even if she says that nothing has happened?

However, there are various challenges that come up when different stakeholders work together. All five counsellors during the interviews cited **problems** they faced while collaborating with the Department of Social Welfare:

Counsellor A stated in the case report that:

The child slept in the Childline office because the social worker from the Department of Social Welfare denied responsibility over the case since the case was first reported to Childline before it was referred to the Department of Social Welfare.

The Department of Social Welfare therefore left Childline with the final responsibility over vulnerable children yet Childline is not given the mandate to place children in places of safety. Counsellor D added:

The child was not placed in a place of safety because the social worker from the Department of Social Welfare did not process the paper work in time.

Furthermore, while working with child clients, Childline counsellors get to know the children's vulnerabilities but they cannot do much with it since in Zimbabwe, the Department of Social Welfare function is defined in terms of the law of the provisions of the Children's Protection and Adoption Act (1972) (CPA ACT), (Chapter 33) defining a child in need of care (Kaseke, 1991; UNICEF, 2001). According to this law, Kaseke (1991, p. 5) states, "In administering the CPA Act social workers operate as Probation Officers, appointed in terms of section 47 of the Act. [Hence], Probation Officers with reason to suspect that a child is in need of care are empowered (Section 15) to remove the child to a place of safety ..." In this regard, the social workers/Probation Officers assess children's vulnerabilities and when necessary, place the children in places of safety; a role not yet legally approved for Childline. In Zimbabwe as Kaseke (1991) reports, NGOs [such as Childline Zimbabwe] were established in order to fill in the gaps in the state provision of social services. Childline counsellors reported being stuck with urgent cases for placement of children, for example, eight of the nine children who needed places of safety had not been placed due to the limited support provided by the Department of Social Welfare.

The roles of the **police's victim-friendly unit (VFU)** according to Delaney (2009) are to investigate cases and arrest the perpetrators of child sexual abuse. The police compile a case report that is used to refer the child to the hospital for medical examination. The police officers

also record the child's statement that will be presented before the courts during the hearing of the case. When children fail to open up to the police, they are often referred to Childline counsellors who use their counselling expertise to get the child to open up and they then record the child's statement. During the interviews, all five counsellors stated that they compiled children's statements for the police. The police also rate the case and decide whether it is eligible for a court hearing or whether they can solve it.

Counsellor D illustrated:

Police involved Childline because the child was now saying two names of the uncles as perpetrators. Childline social worker will have to give Sergeant Machie the child's statement.

A total of 24 of the 25 child clients' cases had passed through the hands of police. From the literature reviewed in Chapter 2 and as supported by Burgess *et al.* (1978), it is clear that the police carry the biggest responsibility for sexual abuse cases since they are usually the first ones called by reporters. However, after referring the case to the police, Childline counsellors did not seem to do any further follow-up since on the one hand they would wait to hear from the police while on the other hand the police officers do not need to be asked about their progress with the case.

The police give very little feedback or update to Childline Zimbabwe about the status of the referred cases. All five counsellors have experienced this problem as they all claimed that the police were not always co-operative. After following up with the police officers, counsellor D was warned by the police officer who stated:

You people of Childline, we do not need to be pushed, let us do our job at our pace, are you now the investigating officers?

Counsellor A stated:

When we visited the police, the information they had regarding the case was different from what we had. The police alleged that the perpetrator (the child's uncle) was in custody and yet we had just been talking to him at his home.

Such communication can hinder the counselling of children since in this last case above, it became difficult for the counsellors to proceed with the child's case. Of the 24 cases that went to the police, counsellors did not do further intervention in 13 cases, as they waited for feedback from the police.

The counsellors also complained that the police do not provide further investigations to all the child sexual abuse cases, for example they dismiss children's cases arguing that they are minor crimes. As an example, below is information extracted from one child's case report:

Counsellor A wrote:

Childline officers visited X police station and Sergeant Sithe [not real name] informed the counsellors that Mimi [not real name] had gone to Family Support Trust for an examination and the results had indicated that the child had not been abused. The police stated that the perpetrator admitted that he had just slapped the child's buttocks and that is as far as he had gone. They dismissed the case since it was a minor crime.

To this effect, Chiremba and Makore-Rukuni (2002, p. 4) echo, "the law in Zimbabwe does not adequately protect the child from abuse ... due to the failure of the law to classify all forms of sexual abuse with the same gravity that the crime deserves". In addition, under Zimbabwean law, crimes of forced penetrative sex such as rape, incest and sodomy are treated more seriously than statutory rape with indecent assault with abduction treated even less seriously (Chiremba & Makore-Rukuni, 2002).

The doctor from the **government hospital/Family Support Trust (FST)** according to Brakarsh (2006) compiles a medical examination report. This is not given to the child, counsellor or any other person other than the police officer handling the case. The report is then presented to the court during the hearing of the case. Counsellors have to wait until the police officer collects the medical report before they can get more information regarding the child's case. All counsellors have shared that this slows down the rate of service provision since they need all the relevant information for them to proceed with the case.

During the time that the child is not ready to testify in court, the **magistrate officer** refers him/her to Childline for counselling in preparation for the court. Of the 24 cases that had been referred to other stakeholders, only three cases reached the magistrate's courts. The verdicts of cases are passed by the magistrate courts. The presiding officers deliver verdicts on cases and they decide about the final sentence for perpetrators who are found guilty. Nonetheless, Childline Zimbabwe counsellors expressed their feelings that they were left out in the final stages of their clients' cases because they were not allowed to be present in court during sentencing of the perpetrator. Hence, counsellor B asserted;

We are not allowed in court yet we would have started with the child. The court asks us to counsel and empower the child before the court hearing and provide the child's statement since the child opens up to us but they expect the same child to testify to them without us whom the child trusts. They believe that our presence can influence the child's behaviour during court hearing.

All five Childline counsellors shared the same feeling, namely that they wanted to be allowed in court so that they could provide moral support to their child clients. During interviews, children and their caregivers also expressed their need for Childline counsellors to be present during the court hearing since this would boost the abused child's self-esteem. As illustrated on one child's case report, counsellor D wrote;

The child during a counselling session asked me if I could join her to the court. I assured her that we would practice the court scene in the next session but in the mean time I want to build her self-esteem/confidence.

Teachers and school counsellors are based at the **school** and they provide constant help to children in need. When teachers get child abuse cases in their schools, they are often asked for counselling assistance from Childline. From the analysis of the 25 case reports, it has been observed that in total, 11 cases have been addressed by schools. Schools have reported three of the 25 initial child sexual abuse cases to Childline. Childline has also directly referred four cases to the schools since counsellors considered the fact that teachers and/or school counsellors have more access to the children than do Childline counsellors.

To this fact, Childline's collaboration with schools was evidenced by the following case illustrations:

Counsellor A:

A visit was made to Zviyo where Mo resides with her parents. Mo was at school. We then went to the school but Mo had just left. We then talked to the school counsellor. We asked him to talk to Mo about the sexual abuse incident. We also asked the school counsellor if he could give us an update after his interview with Mo. Mo is a student at Zviyo primary school. The school counsellor is Mr Zingizi and his phone number is 000.

Counsellor E:

The social worker will call the school to get details of the teacher who has more information pertaining to the child's sexual abuse case. The case can then proceed after getting all the necessary details from the school.

All five Childline counsellors reported that they found it difficult to provide frequent follow-up sessions for children who are far away, especially in rural areas. In the four cases that had been referred to the school, there were no indications that the child was consulted before the case was transferred to the school or whether counselling between the teacher and child was successful since no further interventions were provided. Before addressing children and their caregivers, counsellors seek permission from the **community authorities**. With the support of

these leaders, working in various communities of Zimbabwe has improved. As written on the case reports, one caregiver advised counsellor A and stated:

Awareness should be directed to other children and community leaders to protect children so that sexual abuse cases are reported.

In this regard, counsellors have been able to penetrate some Zimbabwean communities on account of the work they do with community members.

To illustrate Childline counsellors' involvement with local communities, counsellor C wrote:

The social worker phoned the informant, a community member, Mrs Sethi to update her of the visit to the child the previous day.

Counsellor E wrote:

The social worker will speak to the client's relatives to get more details for example, name of 'sabhuku' [headman] in Chivi who is aware of the case.

All five counsellors have raised their concerns in trying to penetrate some communities, especially rural areas and due to the political instability in Zimbabwe over the recent years. Due to fear of victimisation, communities have been reluctant to allow intruders and NGOs to work in their areas. As discussed in Chapter 2, successful counselling is hindered when societies are adamant about their cultural or social practices that do not allow or accept work by professional counsellors.

After police investigations, the perpetrator is arrested so that he/she is no longer in contact with the child. Conversely, the abused child is removed from the abusive environment to an identified **place of safety (POS)**. For instance, a child survivor of incest can be removed from her abusive home to go and live with other relatives, foster parents or in a children's home. As discussed above, counsellors have had problems working with the Department of Social Welfare in placing children in places of safety and with the police in effecting the removal and arrest of perpetrators in order to create a safe society. In this research, the researcher could not find two child clients for interviews and questionnaire administration due to their movement to unknown places of safety.

There are few safe homes and the number of children needing this service is far greater than the available services. For instance, out of nine cases, only one child could find a place of safety. Most children's homes can only offer accommodation and food for the child. They expect Childline to look for enrolment places in schools, provide school fees, books and

school uniforms for the children they would have placed. Financial support is a service that Childline does not readily provide since the organisation has limited resources (as reported by Delaney, 2009) and Childline Zimbabwe is donor-funded. Four of the five counsellors raised this challenge. It has therefore been observed that each member of the collaborating team has important roles in addressing the CSA issue.

AIM 2: The second aim of the study was to get a deeper understanding of the different methods of counselling offered to survivors of child sexual abuse by Childline counsellors, that is –

- the counselling approaches and techniques used;
- the type and number of follow-ups done per individual child abuse case; and
- the quality of information recorded on individual case reports by each of the counsellors.

5.5 THEME 4: COUNSELLING APPROACHES

5.5.1 Counselling Approaches

Counsellors adopt a variety of psychological theories and counselling approaches that guide them in their work with sexually abused children. The discussion below illustrates how counsellors use these approaches and how many of the respondents reported making use of the approaches.

- ***Behavioural approach***

This theory was reported by three of the five counsellors. The counsellors concentrated on checking the client's behaviour and personality traits. The counsellor's view of the child as an extrovert or introvert, willingness to change behaviour and his/her efforts to motivate the child to talk about the abuse are some of the ways counsellors reported making use of in their behavioural approach during the counselling of clients. Counsellor D stated in the case report:

The child client didn't seem to be traumatised by the incident but I will need to keep talking to her because she is lying especially about school.

This approach did not seem to be widely utilized since it was used in only four cases. Counsellors A and C used it in only one of their cases while counsellor D used it in only two cases.

- ***Systems (family) approach***

The use of genograms has been common in 15 of the 25 cases. While using this theory, counsellors have involved both members of the child's nuclear and extended families. Counsellors included these people in intervention as a way to gather background information about the child's case. Commonly, people such as the child's mother, father, aunt and grandmother have been involved. Counsellor E wrote:

The social worker visited the child's home and met the maternal grandmother, aunts and uncles.

After doing a counselling session, counsellor B wrote:

The child's relatives are concerned about Katie's traumatic experience. They are requesting Childline to counsel her in order for her to get over the trauma.

All five counsellors have used the systems (family) approach to counselling. It is clear that the systems approach was used more than other approaches during counselling. Three counsellors; A, B and E reporting using it in all five cases they provided for the study. While counsellor C used it in four of her cases, counsellor D used it in two cases. Counsellors used this theory in 21 of the 25 cases reviewed. The use of this theory is shown in the wide involvement of clients' support systems where the counsellors included the child client's family members.

- ***Person-centred approach***

This theory was not reported as being used often since only two counsellors, A and D, used it. These counsellors focused only on the individual child clients by allowing them to speak freely and asking them open-ended questions. In the case reports from the two counsellors, there was no evidence of counsellors having involved the child's support system as they only focused on the child client. Counsellor A used the person-centred approach in four of her five cases reported for this study and counsellor D used it in only one of her five cases. In the case of one of counsellor A's drop-ins, the child was accompanied by her caregiver. The counsellor only talked to the child but did not discuss with the caregiver the concerns of the child and/or the caregiver. The counsellor wrote:

The child seems hurt by what took place and wants the perpetrator to be punished.

Counsellor A also concentrated her case work with another child client on the provision of health services but did not follow up at home to get in touch with the child's family members. There is evidence that this approach has not been widely used since counsellors have used it in only five of the 25 cases.

- ***Psychoanalytic approach***

Four of the five counsellors have made use of this approach. When counsellors interviewed their clients they were operating from the psychoanalytic perspective. Counsellor C looked critically at what the client said during counselling sessions. Through the use of Freud's seduction theory (as described in Freud, 2001), counsellor D addressed an incest case by viewing the child as a seductive daughter. When the counsellor interviewed the young girl, the girl was asked why she slept in her father's bed to which the girl responded she did not have her own bed and she was scared of her aunt. By asking the child the 'why' question it necessitated the counsellor to lay the blame on the vulnerable child rather than being on her side (Joyce, 1995). Psychoanalytical counsellors also look for symptoms in their clients. For instance, in her study Luca (2011) reports that therapists used the concept of avoidance of pain in order to conceptualise unexplained bodily symptoms in their clients. Luca (2011) adds that, psychodynamic therapists used the concept of developmental lack to conceptualise somatic symptoms linked to developmental problems of their clients. After the initial home visit to the child, counsellor D wrote in a case report:

The girl is not showing any symptoms of abuse, she seems happy and loves her father very much.

Counsellor E has examined the client's psychological capability and wrote;

Chie is more expressive and mentally she is more intelligent than her sister.

This approach was used in eight cases, although in these cases, counsellors had brief meetings with child clients or significant others. The psychoanalytical approach was not used for many cases since literature states that psychoanalysis is a treatment that takes a long time and a lot of sessions with clients. This is supported by Lane, Quintar and Goeltz (1998) who explain that, the psychoanalytic therapeutic dyad consists of a patient [the client] and the analyst [therapist] engaged in an intensive interpersonal relationship where therapeutic sessions are attended consistently until both parties agree to terminate the relationship. Comparing with what Lane *et al.* (1998) suggest, results obtained in this study show that Childline counsellors do not use the psychoanalytic approach in a majority of the cases because the number of sessions done with clients are very few.

- ***Cognitive behavioural approach***

This approach was used by two of the five counsellors. Counsellors concentrate on how the client's thoughts or cognitive distortions affect his/her behaviour as described by Terry and Tallon (2004). Counsellor A wrote:

The child does not seem to fully comprehend the risks involved in the behaviour she is involved in.

Counsellors reported addressing their clients' self-blame and rationalising behaviours and helped them to see that it was not their fault that they were abused but put all the responsibility on the perpetrator. Counsellor C added:

If the child has convicted herself, I aim to convince her that it was not her fault.

This was also evidenced by the view that counsellors worked a lot harder in trying to have perpetrators brought before the law. However, the counsellors did not delve deeper when addressing the sources of the clients' cognitive distortions; hence, this can imply that cognitive behavioural approach was used to limited extent.

- ***Multifactorial theories***

All five counsellors reported using this approach. A total of 11 cases from the five counsellors showed that counsellors used a combination of two or more theories in addressing the child's issues. Counsellor D illustrated her use of multifactorial /integrated approaches and reported;

I think the person-centred approach is more westernised, we need to consider our tradition, or our culture, integrating or balancing between the two. We need a situation where the counsellor has to act as an advisor. I am working on integrating counselling methods, such as systems and other eclectic models; I got information from my supervisor.

This theory was broadly used since all five counsellors could integrate two or more counselling approaches in each of the eleven children's cases where the theory was used. Hence the integrated theory was used in addressing different problems affecting individual children. For instance, the combination of behavioural, cognitive and psychoanalytic theories helped the counsellor to focus counselling in relation to the behavioural, mental and psychological effects suffered by the child after the sexual abuse. In this regard, counsellors borrow and integrate theoretical concepts from other theoretical orientations (Luca, 2011) while conducting therapeutic sessions with their clients.

Generally, as was clear from the item satisfaction scale questionnaire, three counsellors were happy with the counselling approaches they used while two counsellors were not sure or convinced about the psychological approaches they were using while counselling children. It seemed that the participating counsellors were however using the above theories in an unsystematic way. Reasons for this might be:

1. Firstly, what participants said in the interviews did not tally with what they recorded in case reports. For instance, during the interviews, two of the five counsellors stated that they made use of the person-centred approach. While analysing the case reports, the genogram, which is a systems theory concept, was drawn on a majority of these counsellors' case reports.
2. Secondly, counsellors also use theories without paying attention to which theory they are actually using. This was evidenced in the case of three of the five counsellors who described during the interviews their counselling methods but they were not able to state which theory they were operating from. For example, counsellor B stated:

We just talk to the clients, we don't immediately think about those theories of counselling so we actually don't know which theories we are using at that particular moment.

3. Lastly, in all 25 case reports, counsellors did not specifically indicate which theory was guiding their counselling of child clients. The researcher had to deduce the theory from the contents of the case reports.

5.5.2 Counselling techniques

During the interviews, all five counsellors were able to state a number of techniques of which they made use. The results of the analysis of the case reports indicate that the use of techniques by counsellors was also very limited. The techniques that were common with all five counsellors and which were reflected in a majority of the case reports and interviews are:

- **Unconditional positive regard** is found where the counsellor shows a non-judgmental attitude toward a client (Geldard & Geldard, 2008). This technique was used by three of the five counsellors. Counsellors use this technique when they take the children's stories as they were without criticising the children, case informants or caregivers. While counsellor D explored the child's fears, she assured the child of her safety before, during and after the court hearing. To illustrate this, counsellor A wrote on the case report that she listened to the child's story and accepted the child as she was.

- The analysis of the 25 case reports signifies that the **writing** technique was used by all counsellors when clients told their stories. Counsellor D gave the child client homework where she asked her client to write the story about how she was abused. The child brought what she wrote to the next session and this was discussed with the counsellor. The writing technique can also be used in combination with other techniques, for instance, during the interviews, counsellor C said:

I have used the empty chair technique for example, with a 14-year-old girl who was afraid to confront the abuser. The child thought that it was her fault that she was sexually abused because of the place she was at the time of the abuse. I made her write a letter to the abuser whom we imagined was sitting in the chair and I prepared her for the court hearing.

- According to Burgess *et al.* (1978, p. 137), **interviewing** child survivors of sexual assault is done for investigative purposes and helps by way of “assisting and supporting the child in remembering facts and details that will aid the prosecution to establish a case against the perpetrator”. Three counsellors reported making use of this technique. They mostly interviewed their clients in order to verify information of the initial case report. Counsellor C wrote in the case report that she interviewed her clients in an effort “to get more details about the case”. Counsellor A reported interviewing the alleged perpetrator and the police officers in order to verify the case details. In addition, when the child was accompanied for counselling by the caregiver, counsellor C interviewed both the child and the caregiver so that their stories could be compared.
- **Observation** in counselling is described by Geldard and Geldard (2008) as refraining to interact actively but observing and watching what is happening unobtrusively. There is evidence in the case reports of four of the five counsellors having used this technique. The counsellors mostly used observation for making assessments of what was really happening in relation to the abuse. Counsellor C used observation during home visits when she assessed the child’s home situation. The counsellor observed the child’s behaviour. In preparing a child for a court hearing, the counsellor observed the child’s fears and watched instances where the child was comfortable. Counsellor A observed the child’s play using media. The feelings and needs of the child were observed and counsellor A wrote, “The child seems hurt by what has happened.”
- **Active listening** entails paying attention and valuing the information being offered by the client(s). The counsellors actively listened when the clients and/or case informants told the child’s abuse story. The counsellors paid attention in order for them to get the background information regarding the case. The results indicate that all five

counsellors used this counselling technique when they helped their clients to tell their abuse story and to identify key issues troubling the child clients. Counsellor C used active listening to identify the main issues of a child who was sexually assaulted when the child explained what she did after the abuse had occurred. The counsellor also respected the clients' decisions in having confronted the abuser. Since active listening considers counsellors respecting their clients' view (Geldard & Geldard, 2008), counsellor D used active listening when she respected the child's feelings when the child asked the counsellor to pray for her so that she would feel strong for the court hearing. The counsellor wrote on the case report, "We both sat together quietly for 15 minutes then we prayed for her strength during the court session."

- **Questioning** involves the counsellor having to use either open-ended or closed questions while asking the clients questions with regard to the abuse. Questioning is used to raise awareness of what the counsellor needs to know about the case, and it is used during the exploration of relevant issues and feelings (Geldard & Geldard, 2008). During interviews, all five counsellors reported using open-ended questions in inviting the child to tell his/her story when they gathered information about the child's case, how the abuse happened and how the child's support system was involved in the child's case. Counsellor D used this skill and wrote in the report: "I gave the child some questions, I asked her to write her issues of concern regarding the abuse." Counsellor A used questioning to check what the child knew about the alleged abuse.

In their effort to provide emotional and psychosocial support to the clients, counsellors also devised suitable strategies to use with individual clients. Three main strategies mentioned by counsellors during the interviews and reflected on in the case reports are discussed below:

- ***Individual counselling***

All counsellors work with one client at a time; hence, they provide individual counselling. In only two of the 25 cases, the counsellors used the group approach.

Counsellor D illustrated:

I normally work with one client at a time, I only use group counselling for my support group in a children's home that I visit once or twice a month.

Counsellor B stated:

I do one-to-one method of counselling, I ask the child to demonstrate how the abuse happened, e.g. using dolls. I encourage children to talk by creating conversation in the process of relationship building.

- **Demonstrative counselling**

Three of the five counsellors made use of this strategy, and it was mainly used in trying to make the child open up in the first sessions. Children were asked to demonstrate certain activities or issues under discussion. With counsellor A, children made use of media, that is, anatomically correct dolls (see figure 5.2 below) were used to show how the abuse took place. Counsellor D asked the child client to show how she slept and her position in her father's bed.



Figure 5.2: The anatomically correct dolls; adapted from Migima (2010)

- **Play therapy**

This involves the use of media (described in section 3.2.2) and the child is allowed to make use of age-related media and play material to facilitate counselling in a non-stressful atmosphere (Burgess *et al.*, 1978). Although all counsellors stated during the interviews that they made use of play therapy, this evidence was reflected in only six of the 25 cases. These cases were drawn from three counsellors. Counsellor A allowed the client child during a drop-in visit to play with the toys in the counselling room while she observed the child's play and

discussed the case. Mberi and Makore-Rukuni (2001) state that play therapy is very useful in the case of sexually abused children since play is one of the best techniques to use in order to develop very strong relationships with child clients. Counsellors therefore allow children to play and demonstrate the sexual abuse by use of available media.

Although counsellors have stated the use of the above counselling techniques and strategies:

1. It has however been observed that counsellors mostly used the writing technique. For instance, in a case report, it was written that the counsellor engaged the child in expressive writing but there were no details supplied on what they did with what the child had written.
2. The techniques mentioned during interviews were also not fully reflected in case reports when counselling was done. In only one of the nine cases (out of 25) where child clients were contacted for counselling, there was evidence typically specifying the use of counselling techniques by listing the techniques that were used to help the child open up and relate her story of sexual abuse.

The techniques and strategies discussed in this section were those commonly stated by counsellors during the interviews and those deduced by the researcher while critically analysing all 25 case reports.

5.6 THEME 5: FOLLOW-UP

From the interviews and analysis of the case reports, there is an indication that Childline counsellors make use of four main methods to follow up on the clients' cases of child sexual abuse and start the intervention process. These are done through home visits, phone calls and short message services (SMS), visits to other stakeholders and having clients coming to Childline offices (drop-ins). When they follow-up on cases, counsellors collect background information regarding their clients. This information is then be used in determining the provision of counselling services to clients. Below are the types of follow-up that the five counsellors used for all five cases provided by each counsellor for the study. These different ways of following up are based on the analysis of all 25 case reports and are shown in Table 5.4 below.

Table 5.4: The total number and types of follow-up done by individual counsellors

Counsellor	Case type	No. of follow-up	No. of follow-up	No. of follow-up	No. of follow-up	No. of follow-up
		(case 1)	(case 2)	(case 3)	(case 4)	(case 5)
A	Incest (3)	1 home visit	1 home visit	2 home visits 3 phone calls		
	Sodomy (1)				1 home visit	
	Abduction (1)					2 police visits 1 school visit 1 phone call
B	Sodomy (2)	1 home visit 1 school visit 1 phone call	1 police visit			
	Incest (1)			1 home visit		
	Statutory rape (1)				1 drop-in 1 phone call	
	Rape (1)					2 drop-ins 1 police visit
C	Incest (3)	2 home visits	1 home visit	no follow-up		
	Rape(1)				2 drop-ins 1 phone call	
	Abduction (1)					1 home visit
D	Rape (3)	1 phone call	1 drop-in	no follow-up		
	Incest (1)				1 home visit	
	Statutory rape (1)					no follow-up
E	Incest (3)	8 home visits 6 phone calls	2 home visits 1 phone call	2 home visits		
	Statutory rape (1)				1 drop-in	
	Rape (1)					1 home visit 2 drop-ins

A total of 25 home visits where counsellors physically visited the children's residence and saw the child and/or significant others took place. There were six indirect interventions where the counsellors visited other stakeholders working on the child client's case. Here the counsellors met the child while at school and/or they talked to the school authorities, visited the hospital, the local police or the Department of Social Welfare to discuss the child's case with or without the child client. A total of 15 phone calls and/or cell phone text messages were made to clients. Lastly, nine drop-ins were addressed by all five counsellors and counsellors had clients coming over to Childline Zimbabwe offices.

The researcher observed that these follow-up methods complemented each other and counsellors used the available or possible methods each time they followed up on their clients' cases. From the four main follow-up methods identified, it was found that during interviews, all

five counsellors expressed their preference to do face-to-face counselling as they could have the opportunity to meet clients and their support systems in their natural environments. Hence counsellor D stated:

I prefer to do more home visits since I will have an opportunity to assess the child's way of life and to be able to meet the child's support systems, including parents or caregivers and other family members.

In addition, it has been further supported by the Southern African AIDS Trust (SAT) (2011) that counsellors should tell the child's caregivers of the need for follow-up visits for further counselling: six weeks, three months and six months after the sexual abuse incident. At Childline, 10 of the 25 case reports showed that case follow-up took place within the first month after the case had been reported. In a period of between one and three months, counsellors followed up on 11 cases. In four cases, counsellors took between three and six months to follow up their cases.

Therefore, it can be reported that –

1. after receiving cases, Childline counsellors spent a lot of time before they follow up on the cases; and
2. follow-up is generally low at Childline Zimbabwe as a counsellor can do very few interventions as illustrated below:

Counsellor B:

For difficult cases e.g. suicidal attempts, I counsel only twice.

Counsellor E:

Follow-ups are case-special. It depends on individual cases, or support system, sometimes I follow up only twice for a case. Since at times the child has no one to tell, I go to her for the purpose of supporting her following systems approach.

Follow-up is therefore important since counsellors would be in a position to provide counselling services to the clients.

5.6.1 Counsellor challenges during follow-up

The factors that hindered the success of their work were also highlighted by the counsellors. Based on the interviews, document analysis and participant observations, below are the main challenges that were experienced by counsellors while following up on the clients.

1. Telephones sometimes had network problems and counsellors could not contact clients. This is denoted where counsellor D wrote on a case report that she tried calling but the survivor's phone numbers sounded like they were out of order and on trying the case informant's landline, it was also not possible.
2. Limited organisational capacity: this included the shortage of transport resources such as cars and fuel. This was a challenge for clients to come over to Childline offices and for counsellors to do more home/stakeholder visits. Counsellor A during the interviews revealed that she was unable to visit some of her cases due to shortages of fuel for Childline cars.
3. The counselling environment has been observed as a source of interruption in terms of counselling sessions. Counselling sessions were disturbed since the room was also open to other staff members who pass through it when collecting materials as the counselling room is also used as a storeroom or en route to the toilet or to their offices. In the case home visits made to children's natural environments, counsellors have limited safe counselling places and they mostly make use of their vehicles. They also sit under trees or behind houses. These places are also visible to any passer-by and children do not feel free to talk about their issues. This is echoed by Geldard and Geldard (2008, p. 12) who say, "The child should feel safe to make disclosures with the confidence that doing so will not have repercussions or consequences which may be emotionally harmful or damaging."
4. Work overload and counsellor burn-out. This was signified by counsellor D who reported "I am having too many difficult cases; I am just overwhelmed with casework".
5. Few counsellors (social workers). This is in consideration with the fact that there are only 6 counsellors who have to provide counselling services for the whole country.
6. The need for counsellor security when they follow up on their clients either at Childline offices or in the communities. The researcher also observed that Childline does not have a security system in place for protecting counsellors during home visits or when they counsel clients in the counselling room.
7. Lack of in-service training for new and long-serving counsellors. From the researcher's observations, Childline does not provide in-service training for the counsellors.
8. Poor working relationships with other stakeholders. This was shown during interviews where counsellor C stated that "when I followed up with the police, the officers told me that Childline counsellors were now acting as investigating officers who did not leave to do their work".

9. Limited capacity and lack of counsellor expertise for example, counselling aspects such as techniques. This was implied through the wrong genograms drawn on case reports.

The above challenges therefore affect the limited follow-up services provided by counsellors.

5.7 THEME 6: RECORDING OF INFORMATION ON CASE REPORTS

Each child client has his/her own case report in which information regarding the sexual abuse is recorded. Counsellors write down all the interventions for each individual case report.

The recording of case information, however, posed some challenges for all participating counsellors as wrong information appeared in some case reports. For example, counsellors recorded types of sexual abuse experienced by children wrongly. This affected the quality of information contained in case reports. Little information recorded in case reports created challenges for follow-up of cases. The research results showed that 16 of the 25 reviewed case reports had insufficient information regarding the child's case. Such information left readers without full details of everything that transpired in connection with the child's case. In these reports, counsellors used difficult language and they used abbreviated forms of writing. For instance, on one of the case reports provided by counsellor C, it was recorded,

Their [sic] is need to go to Chitoro where the child is to get to the bottom of the case so that a report to the police can be made ...

When sentences are written with spelling or grammatical mistakes, it becomes difficult for readers of such a case report to understand what the counsellor actually did for the child in need of the counsellor's counselling services.

Some sentences on case reports were meaningless and contained useless information.

Counsellor E wrote,

Mrs Soko (the reporter) sympathises with the caregiver on why she is protecting her children over a serious story like this one.

The reader might have problems in understanding the meaning of this sentence. The reader might also wonder why the counsellor wrote such a sentence as the sentence does not give any information that could help in addressing the child's case.

In addition, in cases where counsellors were absent from work, it was through proper case recording that other counsellors could follow up on their colleagues' cases. Appendix 14

draws attention to the main issues that were recorded and extracted from the case reports. To show the importance of case recording, two counsellors commented in this regard:

Counsellor B:

In some of my cases, there was lack of correct or sufficient information when the case was first reported either through the helpline or drop-in.

Counsellor D:

The addresses for some of my clients were unknown. Clients moved to unknown places of safety (POS).

The problem of inadequate case recording was further evidenced by the fact that the researcher could not interview two of the clients due to insufficient contact details provided in the case reports. This problem affected all the counsellors since during the interviews; they all indicated the need to have correct case details both for initial and on-going cases.

From the 25 case reports that were selected for this study, only nine contained information that allowed readers to understand the child's case and the interventions done. In these cases, counsellors (and/or caregivers) used language which was clear and meaningful while recording initial case details. Counsellors sometimes also forgot to take note of the details, such as the nature of the child's sexual abuse case, the genogram, actions taken and actions to be taken in future interventions.

The practice of case recording was shown to be affected by the limited use of the standard Childline case reporting formats. These involve the use of forms that need to be filled in. Counsellors are required by Childline Zimbabwe to make use of such forms when recording case information. The drop-in section has two types of forms (one for the initial case recording and another one for follow-up by counsellors) (see Appendices 11a and 11b respectively). The helpline has a different form used by volunteers for initial recording of case reports (see Appendix 12). In addition, there is a client data form, which is attached to both the helpline and the drop-in report forms (see Appendix 13). All these forms are meant to guide counsellors and volunteers to know which areas to concentrate on while sourcing clients' case information and when counselling child clients. However, none of the five counsellors made extensive use of this service. Apart from the forms they had to fill in, they made use of pieces of paper for case recording. This resulted in counsellors not recording all the important information. Only five of the 25 case reports showed the general use of forms filled in by counsellors. The Childline format for reporting on case reports has been used inconsistently and important points of action have been missed out. The genograms were widely used by all

five counsellors in representing clients' cases and some diagrams have been drawn incorrectly.

5.7.1 The genogram

The genogram is a diagram that is used to represent the child and his/her family as described in Chapter 2. Counsellors have drawn genograms on the majority of the case reports to illustrate the children's family systems. Although the use of the genogram is a very important skill in counselling and as a way of illustrating the child's system (McGoldrick & Gerson, 1985), it, however, does not seem to be commonly used as many case reports had incorrect diagrams that did not properly represent the child's family.

From the 25 case reports, 15 reports showed evidence that counsellors involved the clients' support systems through the genograms drawn on the case reports. From the 15 case reports with genograms, only four reports had correctly drawn genograms as they represented the child's family situation, while 11 genograms were incorrectly drawn. This made it difficult to interpret the family relationships and what the diagrams meant. The case reports showed that the five counsellors who participated in this research had limited knowledge on how to use the genogram technique, which showed limited understanding of systems theory which utilises the concept of the genogram as a main technique. Of the 10 case reports that did not show genograms, seven reports had brief references to the fact that the client's support systems were explored but there was no narrative evidence about these systems. Three reports did not mention the exploration of the clients' support systems.

By making use of the ISSQs, the researcher investigated the counsellors' satisfaction with various counselling aspects. This relates to the second aim of the study, namely to get a deeper understanding of the counselling methods used by counsellors. Within this research report, the researcher provided information on how the psychological approaches have been used, the techniques and strategies, the follow-up for child survivors and recording of case information. Although some issues have been raised on most of the counselling aspects, the ISSQ showed that participating counsellors were happy with the majority of these aspects. The satisfactory aspects included psychological approaches; the way counsellors build relationships with clients, the referral system, the standardised procedure for Childline Zimbabwe, the counselling environment and counselling goals.

AIM 3: The last aim of the study was to explore the level of client satisfaction for counselling services received from Childline social workers/counsellors. This was based on the imminent changes in clients' lives after the onset of counselling.

5.8 THEME 7: COUNSELLING SERVICES RECEIVED

Clients have their own counselling goals. As supported by Jacobs *et al.* (2003), the child client's involvement in the establishment of treatment goals helps in the development of a therapeutic relationship. It has emerged from the interviews with clients (both children and caregivers) that they had certain goals that they wished to achieve from counselling. Examples of these are illustrated below:

Client 1:

I want to get advice and new ideas.

Client 8:

My aim is to get home visits since I get supported. In case of having HIV, maybe I get tablets. The abuser had many wives so I am scared that I might get HIV.

Client 12:

I hope to gain confidence in myself and I look forward to happiness.

Below is a summary of the goals for clients' disclosures and counselling common to the majority of the child clients and/or their caregivers as said during interviews:

1. access to counsellor advice;
2. getting psychosocial support;
3. gaining confidence; and
4. getting education on child sexual abuse issues.

5.8.1 The effects of Childline interventions on child clients

As counsellors engage their clients in the counselling process, they get to know the effects the abuse has had on the child. They can then address these effects through the provision of psychosocial support. As described in Chapter 2, the aim of addressing the effects of CSA is to ensure positive changes in clients' lives. In six of the 13 child clients who were interviewed, there were indications that Childline Zimbabwe's interventions were viewed in a positive way.

Client 3 stated:

Childline helped me. I feel that I am now open about the abuse that happened to me. Before that, I could not disclose and talk about it. I used to hide it; I did not want even the church pastor to know.

Contrary to this, seven of the 13 child clients who were interviewed hint at having gone through negative experiences after Childline interventions. When negative changes occur after intervention, clients continue to suffer from the effects of CSA. For instance during the interview, child client 6 stated:

After Childline counselling intervention, I was beaten up by my father, I am now scared and I always think about what happened to me.

It has also been observed that counsellors have not been in a position to involve children in sufficient counselling where they could provide the needed support and address the effects of child sexual abuse. In 16 of the 25 children who have not been in direct contact with the counsellors, the effects caused by the sexual abuse remained unresolved.

5.8.2 Satisfaction of clients

Table 5.5: Average child clients' satisfaction scores in percentage for each item

	DISSATISFACTION (SCORE 1–3)	AVERAGE (SCORE 4)	SATISFACTION (SCORE 5–7)
1. Counselling session/s and process from joining to termination	0%	8%	92%
2. Language use	0%	0%	100%
3. Services offered	8%	0%	92%
4. Counsellor's presentation	0%	0%	100%
5. Advice given or referral system	0%	0%	100%
6. Confidentiality observation	8%	0%	92%
7. Counselling environment	0%	8%	92%
8. Follow-up methods, e.g. phone, client visiting Childline, letters and home visits	15%	8%	77%

Generally, all 13 Childline clients who responded to the ISSQ questionnaire were happy with the eight aspects of counselling. Although all 13 clients showed a high satisfaction level with the counselling aspects, very few clients hinted on some issues that had some discrepancies.

Even though the dissatisfaction level was very low, the researcher considered this dissatisfaction as a sign of unsatisfactory services received by the clients. Bearing in mind that participants knew that the researcher was one of the Childline counsellors who was researching on her colleagues' work, an illustration to this researcher-participant relationship is provided by Nachmias and Nachmias (1990) and Geldard and Geldard (2008) who report that, respondents sometimes have a tendency to provide answers that they think the researcher wants to hear. The researcher hence made sure that she stayed neutral and involved the participants in an empathic way in order to guard against bias and ensure the validity and reliability of the study results. The counselling aspects that showed unhappiness from a few clients included the counselling process, the counselling services received, confidentiality of cases, the counselling environment and the follow-up methods used by counsellors.

From the interview and questionnaire administered to the clients, the issues about which the clients were concerned are discussed below.

5.8.2.1 *The counselling process*

During the interviews, all the clients indicated that they were happy with what was encompassed by the counselling process. This was illustrated by eight of the 13 clients who indicated that the counselling process they underwent changed their views of the abuse. Client 2 illustrated that if they had not been involved with Childline counsellors, they would have been stuck and would not have received the counselling services that transformed their lives after the abuse had been reported.

5.8.2.2 *The services offered*

Clients have received some psychosocial support but these included mostly referral services. Although the questionnaire showed that all 13 clients had been largely very happy about the referral services provided by counsellors, client 9 also complained that they moved from one organisation to the other but only received the same service (especially basic counselling). Some clients did not know which organisation would help with their specific issues. It was also illustrated by client 2 (a caregiver) during the interview that:

Due to this abuse of our child Mavhu, we have to change organisations looking for support; we go to CONTACT then to Childline, to the police, and to the Baptist church. Due to lack of knowledge, we thought Childline was influencing Mavhu. The Victim Friendly Unit police told us that Childline was negatively influencing Mavhu. We had had a negative attitude towards Childline. This was since

corrected. We now know that we are supported by Childline... through Childline intervention.

In addressing child sexual abuse issues, client 9 reported during the interview:

The perpetrator was reported to the police, he was arrested, a few days later he was out of custody. I [the mother] went back to the police to check why he was out. They told me that the police still wanted to verify some facts and they were going to pick him up again. A few days later, I reported the case to Childline and to Justice for Children Trust who explained the issues around bail payment. The perpetrator's mother was interfering with the evidence by shouting at my child since they were our neighbours. She told my 3-year-old child that she was lying that her son raped her. A few days later, the perpetrator was found dead at his house.

Furthermore, client 6 stated:

After we reported the case to the police, we do not know what happened to the perpetrator, whether he was arrested or not.

Moreover, the police departments are not advising the survivors of sexual abuse about the procedures they follow to address the reported cases. Children and caregivers are therefore left wondering what is happening to their cases. Nine of the 13 children who were interviewed expressed that they did not have much information about the verdict of their cases. For instance, this is what the clients said during the interviews:

Client 8:

We reported the case to the police, the perpetrator was refusing. He was taken by the police; he was detained for only one night, now we don't know why.

Client 11:

Nothing was heard after my father went to the police; he is still in jail we suppose.

Regarding clients' access to health, child client 10 stated:

Without Childline, nothing could have happened to me, I wouldn't have gone to the hospital, now I got treatment and medication.

During the interviews, child clients and/or their caregivers reflected as follows on what the court had done regarding their cases:

Client 2:

The case was thrown out of the courts; it was dismissed due to lack of evidence.

Client 4:

My husband was sentenced to 20 years in jail after raping our 3 daughters.

As Sadan, Dikweni and Cassiem (2001) report, the sexual offences court that had been established specifically to deal with sexual offences against women and children has three aims, namely:

- to lower the secondary trauma to survivors of sexual abuse;
- to encourage the reporting of sexual abuses through the provision of special services to survivors of sexual abuse; and lastly
- to increase the rate of conviction and sentencing of perpetrators of sexual abuse.

Clients acknowledged the role of schools in reporting sexual abuse of children. One caregiver of a child client said:

I take care of this child, Pedzie. Her parents are traders and they are never at home. I was shocked to get to know that a young girl like that knows a lot about sex. Pedzie has mentioned three people as her abusers: the gardener and his 4-year-old son and her teacher for extra lessons. The story was never going to be disclosed since Pedzie's parents were not worried. The teachers played a big role.

To illustrate the need for safety for child survivors of sexual abuse, client 4 complained that:

After my husband raped our three young daughters, the other relatives from my husband's family and our neighbours were terrorising me and my older abused child, Essa (8 years), accusing us of fabricating the abuses and letting my husband be arrested. Since I didn't get much help from the people who were dealing with the case, I decided to send Essa to my relatives in another province. I now stay here with the younger two only.

The need for case follow-up was evident with most of the clients. Below are two examples of what the children and/or their caregivers reflected:

Client 9:

The social worker was coming to visit my child. We went to the hospital together with her. The social worker told my daughter that she would be okay. We were

happy with the social worker because my daughter was taken to the hospital for treatment.

Client 10:

I got all the support I needed through all the follow-up visits made to me in hospital and in the children's home.

Three clients did not get any follow-up done for their cases after they had been reported to Childline Zimbabwe. During the interview, client 7 stated:

There was no help for me because no one came to help me.

In addition, client 12 exclaimed:

No one came.

From the illustrations above, it can be stated that follow-up plays a pivotal role in changing clients' lives. Clients get different types of help through the follow-up services provided to them by counsellors. In this regard, an illustration by 15-year-old Tendai's testimony in Southern African AIDS Trust (SAT) (2011, p. 39) stated:

I was so ashamed when my counsellor asked me what happened, but she listened and did not laugh at my story. She was the only one who knew what had happened to me. I met with her four times and she has helped me to talk more freely. She has also helped me to find a direction in my life. Although it has been very painful to talk about what happened, I now know that it was not my fault.

5.8.2.3 Confidentiality of sessions

The issue of confidentiality is one of the major aspects in the counselling of children. The importance of confidentiality for the clients is well illustrated by the clients' responses during the interviews and when filling in the questionnaires. A majority of the clients shared that counselling sessions and their contents should be kept private and only be shared between the counsellor and the client(s). Focusing on the clients' reflections, 12 of the 13 clients completed questionnaires illustrated their satisfaction with the way Childline counsellors considered confidentiality of counselling sessions.

Nonetheless one client illustrated that counsellors were not confidential. The client expressed unhappiness with this issue and the way it was addressed. In addition to this observation, the researcher, while working as a counsellor for Childline Zimbabwe, observed that it was almost common practice that counsellors talked about their clients' cases and they did so in a rather

spontaneous way. The ISSQs for clients indicated, however, that the majority of clients were happy with how Childline observed the confidentiality of clients' issues of child sexual abuse.

5.9 CONCLUSION

The results of this study show that seven main themes have emerged from the data sources used. These themes were the focus of the study.

Theme one addressed the counselling process, where goals of counsellors were described together with counsellors' satisfaction with the services they provided to their clients. Termination of counselling relationships was a concern since in none of the cases there was any plan made for the termination of the case. The types of case informants for Childline were discussed in theme two together with sources of reporting of cases. The referral of cases to different stakeholders showed how the treatment team worked, while the problems emanating from collaboration were explained in theme three. The counselling approaches, techniques and strategies that counsellors use were described in theme four. Counsellors reported using four different methods of follow-up and the number of follow-ups per case was discussed in theme five. The way counsellors recorded information in case reports illustrated the use of the forms that are filled in, the drawing of the genogram and these formed the basis of theme six. Lastly, the satisfaction of clients with different aspects of counselling services showed that child clients and their caregivers were generally satisfied with these services, and this was covered in theme seven.

However, it has been observed that counsellors face some challenges in their efforts to implement counselling services for their clients. These challenges included the limited provision of counselling services to clients due to limited individual counsellor capacity, limited organisational capacity of Childline Zimbabwe and poor working relationships between Childline and other stakeholders in the treatment team. The seven themes were therefore discussed in the researcher's effort to look at the results of the study in consideration of the three aims of this study. Chapter 6 addresses the conclusions, recommendations and limitations of the study.

CHAPTER 6

CONCLUSIONS AND RECOMMENDATIONS

6.1 INTRODUCTION

A qualitative case study research method was used in this study in order to explore and describe the counselling services that Childline Zimbabwe offers to its child clients who are survivors of CSA and to identify factors affecting counselling practice at Childline Zimbabwe. Such factors include the capacity for individual counsellors, organizational capacity of Childline Zimbabwe and the effects of working with other stakeholders. Research participants comprised of counsellors who provide the services and the clients who receive the counsellors' services. The information obtained from this study was used to provide recommendations for Childline Zimbabwe counsellors in terms of how they do counselling for sexually abused children. This information also provided a basis for the formulation of the recommendations for Childline Zimbabwe as an organisation. The limitations of the study and suggestions for further research are also discussed. From the results of the study presented in Chapter 5, it has become evident that Childline Zimbabwe predominantly operates as an advising and 'pass-on' organisation where children's cases are quickly transferred to other stakeholders. At the time of the study, only limited counselling or psychosocial support was provided to child clients by Childline Zimbabwe counsellors. In the majority of reported cases analysed in this research, counsellors could not fulfil all stages of the counselling process due to various reasons related to individual capacity of the counsellors, organisational capacity and the specific context within which Childline operates. It has been observed that Childline Zimbabwe counsellors' main activities are central to the way the counselling process and its stages are implemented and are also influenced by the process.

The aim of Chapter 6 is to synthesise the information obtained from all other chapters in order to come to a common conclusion. This chapter shows an evaluation of the research process utilised by the study, to determine whether the three aims formulated for the purposes of this study had been achieved. The recommendations and the limitations of this research are also presented in this chapter.

6.2 COMPREHENSIVE CONCLUSIONS OF THE RESEARCH

This section presents the conclusions regarding the seven main themes that have emerged from the results. These themes show what happens during the counselling process and its stages. These are discussed with more detail in the sections that follow.

6.2.1 The counselling process and its stages

The counselling process has been shown to comprise four main stages, namely

- building counsellor-client relationships;
- collection of background information;
- provision of psychosocial support; and
- the termination of counselling relationships.

In an effort to illustrate the results of this study, the seven themes have been regrouped to form categories of the four stages of the counselling process. For that reason, the researcher discusses and evaluates all themes on the basis of the four main stages of the counselling process.

6.2.1.1 *Building counsellor–child client relationships*

The first stage of counselling focuses on the **nature of the counsellor–child client relationship**. This relationship has an effect on the successful provision of counselling services. In nine of the 25 cases, child clients were contacted for initial interviews and on average, only two contacts per case were made and this provided very little information to allow the formulation of counselling relationships. Counselling relationships were influenced by the following:

1. It emerged that in sixteen of the twenty-five cases; the approaches that have been taken by counsellors in the initial meetings with clients did not always guarantee clients all the trust and safety needed to ensure the establishment of counselling relationships. For instance, counsellors addressed significant others and stakeholders before they heard the child's story. In 16 cases, the child was not contacted. In those instances where the child was accessed, he/she was mostly the last one to be addressed.
2. It was not common for counsellors to discuss with their clients the limits of confidentiality, and this was reported to hinder the building of relationships as clients

were not sure whether the relationship was confidential or not. The significance of confidentiality was also shown from the results of the client surveys where some respondents expressed their concerns about their need for confidentiality of counselling sessions. Furthermore, confidentiality was a concern amongst the counsellors as the majority of them shared that it was important to share clients' cases with colleagues as this was a way of de-briefing. Confidentiality was discussed in both theme 1 and theme 7.

3. The counsellors' enthusiasm to follow up on cases so that they could get to meet their clients and establish successful counselling relationships was also not reflected in fifteen of the 25 cases that were only followed up after one month of reporting to Childline. Counsellors therefore did not manage to come into personal contact with clients and as a result did not manage to do counselling and build relationships resulting in the failure to stimulate disclosure of child sexual abuse. Hence, the counsellors established counselling relationships with only 9 of the 25 clients.
4. The process of intervention is different for individual counsellors although all five counsellors started intervention by involving other stakeholders, the family members and community support systems after receiving the cases from the case manager. This shows that counsellors started intervention by collecting background information about the client. This covered the second stage of counselling; yet, the counsellors had not done the first stage of creating counselling relationships with clients. Hence, it was concluded that there is no standardised Childline way of counselling where all counsellors would implement the counselling stages in their chronological order in the same way.
5. Goal setting was not a major priority for the counsellors since there was no evidence that for children and/or caregivers, goals of counselling had been set. Instead, counsellors had plans of action indicating what they intended to do with their clients' cases. All counsellors indicated their weaknesses in goal formulation. This was discussed under theme 1 and theme 7. When counsellors provide psychosocial and emotional support, counselling sessions are aimed at certain benefits to the clients (Rukuni & Maunganidze, 2000). As described in Chapter 3, Geldard and Geldard (2008) state that counsellors need to understand the nature and purpose of counselling children and they need to be clear about the counselling goals and how these goals can be achieved. In none of the case reports reviewed, was there clear evidence that the counsellors were involved and that they helped clients to formulate and achieve their own goals during the first stage of the counselling process. Hence, in eight of the 25 case reports, goals of the client(s) were not reflected. In many cases,

the main goal of addressing clients on the effects of sexual abuse has not been achieved since counsellors failed to formulate counselling relationships and offer psychosocial support to the majority of clients.

6.2.1.2 Collection of background information

The second stage of counselling addressed the **collection of background information** regarding clients' problems. Here counsellors should aim to widen the view of the problem by considering the child's environment, namely considering external factors influencing the child's behaviour in relation to the issue of sexual abuse. Although counsellors achieved much in gathering information regarding children's cases, a number of issues influenced the way background information was collected.

1. The reviewed reports did not show evidence that all the interventions that were needed to collect full background information were implemented. Counsellors usually started by contacting the case informants, who comprised mostly the children's significant others. The counsellor engaged these people in interviews in order to get more detail about the case. There were minimal interventions in terms of each of the cases reviewed and this was an indication that not all the necessary information regarding the child's abuse was obtained, considering the sensitive nature of the sexual abuses. Interventions such as the use of phone calls, cellular phone messages, drop-in clients, home and school or stakeholder visits have been used in order to get information about clients' cases. The five participating counsellors mainly used home visits followed by the use of phones. Visits made to other stakeholders and drop-ins were used but to a limited extent. In most cases, limited resources hindered the follow-up and collection of clients' information. Moreover, follow-up was generally low and most cases were not being followed up soon after they had been reported. Counsellors, although they were few, received a large number of cases and this can suggest work overload and burn-out.
2. Childline Zimbabwe counsellors rely on types of case informants, namely caregivers, anonymous callers, school authorities, community members and collaborating organisations but they have very minimal involvement of the child client affected by the effects of child sexual abuse. The majority of cases had been reported by family members. Counsellors received both reliable and unreliable information from different case informants and this evoked difficulties in further use of the information obtained. The background information about a child's case helps the counsellor to map the necessary course of action. Analysis of the case reports showed that counsellors

spend a lot of time gathering background information especially from significant people in the child's life. These significant people therefore receive the direct services of counsellors rather than the child clients. This was discussed under theme 2, and provided data for the first aim of the study, namely to describe the counselling services utilised by Childline Zimbabwe counsellors. Indirect disclosures by case informants were therefore handled inadequately since counsellors concentrated on case informants rather than on the child clients who had been sexually abused. Neither child clients nor their caregivers were engaged in an adequate number of sessions that would allow them to open up to the counsellor and say more about the abuse. Counsellors, however, stated that in five of the 25 case reports, they had contacted case informants without stating which information they needed from the informants. However, the majority of the cases indicated that counsellors mainly documented information concerning the arrest of perpetrators, hence the referral of twenty-four of the 25 cases to the police. Counsellors based the child's case on information from others rather than on information from the affected child.

3. Two main ways, namely the drop-in and helpline, are used in the reporting of cases to Childline Zimbabwe. These two services are almost equally used although slightly more cases come to Childline Zimbabwe through the drop-in compared to the helpline. Of the 25 cases, thirteen had used the drop-in service while 12 had used the helpline service.

The way counsellors record information on case reports plays an important role in providing the necessary information about a child's case. Case recording was discussed under theme 6, which discussed the second aim of the study, namely to get a deeper understanding of the different methods of counselling offered to survivors of child sexual abuse by Childline counsellors, that is; the quality of information recorded on individual case reports by each of the counsellors.

1. It is through the information contained in case reports that counsellors get to know more about their clients. In sixteen of the 25 case reports, there was insufficient and/or wrong information about clients' cases documented together with meaningless sentences. The case reports were not comprehensive enough to show what comprised all the sessions with clients. Fill-in forms have not been used according to the requirements of Childline by all counsellors; hence, important information, such as identifying details for clients, has been omitted although these were clearly indicated on the fill-in forms. Instead, in twenty of the 25 case reports, all five counsellors made use of pieces of paper to record case details.

2. The vulnerability of children has also influenced the collection of background information regarding the abuse of minors since all contact with children depended mainly on their caregivers. As explained in Chapter 2, children occupy a subordinate and passive role in most societies (see section 2.4.1.4). According to Zimbabwean culture, all children are under the guidance of their caregivers, and counsellors did not bypass the child's caregivers. In the majority of the cases, that is, twenty-one of the 25 cases that show evidence of the use of systems theory. This involvement of caregivers also influenced the limited contact that counsellors had with the child clients. Counsellors have therefore not managed to collect all the information they needed about a child since they spent time trying to get hold of the caregivers before they had access to the abused child. Counsellors guided by systems theory first made contact with the child's caregivers before making contact with the child him/herself. The most vulnerable age group in this research is between the ages of 13 to 16 years, followed by those between the ages of 9 to 12 years. More girls have been abused than boys (one boy to 14 girls). In ten of the ninety-three cases reported to Childline Zimbabwe, counsellors have paid little attention to biographical information regarding the child clients since some case reports did not show the child's age or gender of the child.
3. Counsellors face problems in designing correct genograms. Genograms were discussed under theme 6. Genograms provided information for the second aim of the study, namely to get a deeper understanding of the different methods of counselling offered to survivors of child sexual abuse by Childline counsellors, that is; the counselling approaches and techniques used. The aim of using genograms is to capture the child client's important support system (see section 2.2.5). Genograms make therapy with sexually abused children easier when they are drawn correctly (CONNECT, 2001). It was clear that genograms have been widely used by all five counsellors, as indicated in 15 of the 25 case reports. In eleven of these 15 cases, genograms were, however, not drawn accurately and did not capture the child client's family situation, including external influential systems in the child's life such as the friends. The genograms found in the records were not representative enough to show the relational styles between the child and his/her family members, and this made it difficult to check which background information was represented by the genograms. In ten of the 25 cases, the genograms were omitted. Counsellors therefore had limited knowledge of the drawing of correct genograms (see section 2.2.5).
4. Classification of sexual abuse cases and putting more or less importance to certain cases seemed to be an issue. This has been observed in the way police have investigated some children's cases. Some cases have not received enough

intervention as the cases have been regarded as minor by the members of the treatment team. Counsellors also classified sexual offences in terms of whether they were minor or serious. This was the stage where they considered the urgency of children's cases for intervention, whether intervention had to take place or not. It was however not clear which criteria were used by counsellors to determine which cases were minor or serious and which cases were followed up and which ones were not. Moreover, since cases not attended to involved penetrative sexual acts –statutory rape, incest and rape – it seemed that counsellors did not find certain cases of sexual abuse very important. The cases that were attended to included cases of sodomy, statutory rape, rape, incest and abduction. In addition, cases that have been considered critical involved the sexual abuse of younger children below the age of 7 years. Failure by Childline counsellors to classify the types of child sexual abuse correctly has led to failure by counsellors to collect background information regarding different types of sexual abuses and above all, the limited services offered to the majority of the clients.

5. The seriousness of a child's case can be verified through getting information regarding the child's story from the child him/herself. In most cases, the presenting problem is different from the actual problem of the client since, according to Geldard and Geldard (2008), children are natural experts at turning aside their emotional pain and avoiding confrontation with the issues that are related to those emotional pains. In this case, the counsellor uses the appropriate skills and engages the client in face-to-face counselling and in a number of sessions as this enables the child's real problems to come up and these can then be addressed and resolved (Geldard & Geldard, 2008). In the cases reviewed for this study, some were not followed up although they turned up to be serious cases based on what the clients shared during the interviews. However as discussed in Chapter 3, the stages of case assessment need to be considered by counsellors, but in this study, as evidenced in all the 25 case reports, counsellors were not in a position to assess children's cases so that they could focus on the needs of individual clients.

6.2.1.3 Provision of psychosocial support: the actual counselling

Stage 3 of the counselling process looked at issues affecting the **provision of psychosocial support** to child clients. From the case reports reviewed, there were a limited number of cases where counsellors tried their best to improvise and deliver counselling services to clients in need. Hence out of 25 cases, only in one child's case was there evidence that the child and/or significant others got psychosocial support. As discussed above, in the majority of

children's cases, counsellors did not get further than this third stage of counselling because they had very limited contact with their clients and most children were not contacted, as was also noted in the first two stages of counselling discussed above. Therefore, in twenty-three of the 25 cases, interventions ended after the first or second stage of the counselling process.

Very little face-to-face counselling took place between counsellors and the child clients and/or their caregivers as shown in fifteen cases. Hence very little psychosocial support (as illustrated in all seven themes) was provided to the clients. In ten of the 25 children's cases, in which counsellors intervened in face-to-face counselling with their clients – either children and/or their caregivers –counsellors did not manage to address the majority of the children's emotional issues since they attended only a few sessions. In nine of the 25 cases were child clients contacted and in these cases, counselling ended at stage 1 or 2. The second aim of the study was addressed at this stage. The limited counselling was, however, influenced by a number of factors:

1. There was wide use of the treatment team since counsellors referred twenty-four of the 25 clients to other stakeholders, for instance the police and the school. Although counsellors failed to ensure face-to-face contact with the majority of child clients, they ensured the referral of cases to the necessary stakeholders. Referral is also a way of providing psychosocial support to clients (as illustrated by Delaney, 2009). There were no strong working bonds with some organisations and problems were cited but this did not terminate the working relationship completely.
2. There were no further follow-up after cases were referred to other organisations; hence, there was no post-counselling for clients.
3. Each member of the treatment team had his/her own specific roles in addressing clients' problems and these have been executed in all the cases referred to particular organisations (see section 5.4.1).
4. The police was mostly used for referral purposes since their main role is to investigate cases and arrest perpetrators. As illustrated in Chapter 3, the police carry the biggest burden due to the criminal nature of child sexual abuse cases.
5. The use of counselling theories and approaches was discussed under theme 4, and this addresses the second aim of the study, namely to get a deeper understanding of the different methods of counselling offered to survivors of child sexual abuse by Childline counsellors, that is; the counselling approaches and techniques used. According to the literature reviewed in Chapter 2 and the results presented in Chapter 5, there is no specific theory that fits a particular age group or a specific type of CSA.

All the theories discussed above in Chapter 2 highlighted the psychological approaches necessary for guiding counsellors in order to provide valuable counselling to clients. These theories can be used for all age groups and for all types of CSA. Theories were, however, used in a way that did not show much planning on the part of the counsellors. Counsellors did not show an understanding of the various psychological theories that were guiding them during their practice. Different techniques that were derived from different psychological theories were used, and this reflected the use of the multifactorial theories of counselling. The systems approach as well as psychoanalytic and behavioural theories was frequently used although in eleven of the 25 cases, counsellors reported integrating two or three theories. However, in two of the 25 case reports, there was no indication that theories and techniques were utilised by the counsellors although in 23 of the 25 cases, at least one or more theories were used. These theories were, however, mainly used during the first two stages of counselling.

6. Although the counsellors used a variety of counselling techniques during their interventions with the clients, the counsellors' expertise in utilising counselling techniques that enable clients to disclose and share with the counsellors the abuses also seemed to be a major challenge. Counsellors frequently used such techniques as expressive writing, observation, active listening and questioning.
7. The counselling strategies have been discussed under theme 4. Individual, demonstrative, group and play therapy strategies were used by the counsellors with the latter two strategies being used to a very limited extent. Individual counselling was not much used in face-to-face counselling with an individual child but it was more used in the sense that the counsellor focused on an individual child's case while collecting background information regarding the child. Although the literature reviewed in Chapter 3 highlighted the feasibility of the use of group and play therapy in the provision of psychosocial support to child clients, there were very few incidences where these strategies were used.
8. The interventions that were done are explained in this section 6.2.1.3 in an effort to show what exactly Childline counsellors do with the child clients affected by the effects of child sexual abuse. These interventions have been discussed under all seven themes. It is through this discussion that the first aim of the study is also attended to. The aim is to describe the counselling services utilised by Childline Zimbabwe counsellors. In the cases that the counsellors followed up, the main counselling interventions that were done included initial interviews with the child and/or caregiver/case informant, gathering background information and contacting other

stakeholders for referrals. When a case comes to Childline, initial case recording is done either by volunteers in the helpline or by social workers during drop-in sessions. It has been observed that drop-in initiatives are more helpful for clients since clients immediately get initial face-to-face counselling as compared to helpline cases, where there is only telephonic contact.

9. Follow-up of cases was discussed under theme 5, and this provided information for the second aim of the study namely to get a deeper understanding of the different methods of counselling offered to survivors of child sexual abuse by Childline counsellors, that is the type and number of follow-ups done per individual child abuse case. While counsellors embarked on home visits, they had access to a few child clients and/or their caregivers in their natural environment for face-to-face contact. The analysis of the case reports showed that counsellors in their effort to address clients' issues of child sexual abuse, advised, educated and provided their clients with general information regarding CSA. Clients have also been referred to the necessary stakeholders mostly soon after the initial contact with the counsellor. Since referral forms the bulk of counsellors' interventions, further information in this regard is provided in section 6.2.2.
10. Assessment of children's cases helps counsellors to be in a position to relate to their clients and evaluate the services they are providing to their clients as they document the counselling services being provided. Information in this section will also address the third aim of the study, namely to explore the level of client satisfaction for counselling services received from Childline social workers/counsellors. This was based on the imminent changes in clients' lives after the onset of counselling. It has been stated above in section 6.2.1.2 that assessment has an influence on the classification of types of sexual abuse. Throughout the counselling process, counsellors use assessment. It has been observed that counsellors have not been using this tool maximally since they did not have enough contact with their clients. It is through that contact that the provision of psychosocial support to clients is done. Furthermore, counsellors cannot assess the progress of cases when psychosocial support is not provided to clients. In the nine child clients' cases that have been addressed by Childline counsellors, there is an indication that the counsellors' interventions can point to some help provided to clients. There has also been clients who had negative consequences after they had become involved with Childline. Although it is also common that when negative effects come up, counsellors can learn from it, it is the assessment of their intervention methods for each case that helps the counsellors to address these negative issues. In sixteen of the 25 clients' cases, the

effects of child sexual abuse have not been completely addressed since the sixteen clients were not reached by counsellors.

11. Counsellors assumed that initial case reports contained the correct information regarding the alleged child abuse. For some reports, verifying the information proved to be a challenge for counsellors since some cases have not been treated sensitively. Some cases have anonymously been reported to Childline by community members who suspected sexual abuse but these members had no evidence that the abuse actually took place. In their effort to follow up on such cases, counsellors brought the sexual abuse issues to children who in fact had not experienced sexual abuse. This can disturb the child's emotional and psychological state. This was evidenced through the caregiver who said: We only heard from Childline, we as parents didn't know what was happening. The counsellor brought us a surprise. I [the father] was caught unaware, I felt bad; it provoked lots of questions. First of all, why didn't the anonymous caller tell us, the parents? I felt that it was too extreme. I have no trust for my neighbours anymore. I feel that our neighbours are jealous. It was shocking for us since we had not heard anything about the case. It is psychologically affecting our son.

6.2.1.4 Termination of counselling relationships

Termination of counselling relationships marks the fourth and last stage of counselling. Just like all the other stages of counselling, the way termination of a counselling relationship is done affects the overall view and outcome of the whole counselling process (discussed under theme 1) and the counsellor needs to be familiar with issues and skills involved in terminating counselling relationships with his/her clients (Rukuni & Maunganidze, 2000). In none of the child clients' cases reviewed for this study, was any evidence that termination was done according to the stages of the termination process, and counsellors tended to equate referral with termination. A number of issues affecting case termination by counsellors have come up, namely:

1. Counsellors had limited knowledge about the execution of the termination process, and the majority of the cases were terminated prematurely.
2. Failure by counsellors to assess the progress of their cases properly led to cases being terminated before all the stages of counselling had been reached. Although termination is usually done by mutual consent between the counsellor and the client (Rukuni & Maunganidze, 2000), there was no evidence that counsellors discussed the issue of termination with their clients.

3. In spite of the holistic nature of sexual abuse cases and the need to refer cases, counsellors were not in a position to provide further post-counselling after a case had been referred to other collaborating agencies. The poor relationships among members of the treatment team made it difficult for counsellors to continue intervening where a case had been referred.
4. The challenges that counsellors faced in their work were in relation to the individual capacity of counsellors, organisational capacity and other external factors (discussed below in section 6.2.3). These challenges also enhanced limited case intervention, which led to termination of cases. Termination in this regard refers to stopping further interventions by the counsellor.
5. The plan for the termination process was however not reflected in all case reports. For cases that were still on-going, there were no plans in the case reports to show how termination was going to be done.
6. The information from the previous sections where counselling stages 1, 2 and 3 were discussed, and especially the fact that there was actually very little contact with the child clients, explains the reason why termination was not properly done. There was very limited psychosocial support and no termination of cases was reported although there were cases that were not being attended to for a longer time before data collection for the study commenced. Premature termination was done mainly after stage 1 or stage 2. Since there was no follow-up after referral, counsellors equated referral to termination. In addition, the fact that there was limited follow-up of children's cases also reveals that counsellors were not in a position to get to the termination stage.
7. Clients have also been able to share their views with regard to the services they have received. Counsellors were not able to help clients to set up their own counselling goals; hence, only counsellors' goals have been considered. Consequently, the effects of the provision of counselling services to clients have not received attention by any of the counsellors even though counsellors went on to stop intervening in these cases. Therefore, clients' cases were ended without the clients realising that the counselling relationships had been terminated. Most clients however expected that counsellors would still follow up on their cases soon or later.
8. As indicated by the ISSQ, in general, clients were satisfied with the services provided to them by counsellors. Clients highlighted the Childline counselling process as a favourable one although a few others were not very happy with this process. Clients

illustrated that the services they received included psychosocial support, referral and follow-up services.

In summary, in the cases studied for this research, the four stages of counselling have contributed to the provision of information about how Childline Zimbabwe counsellors implement the counselling process. However, notable issues came up from each of the seven themes, and these seemingly influenced the provision of services that lead to the counselling process.

- Stage 1 showed that counsellors were not really in a position to build counselling relationships with their clients.
- Stage 2 provided information that, although counsellors have invested most of their services in the gathering of background information regarding the child clients and mostly about the arrest of the perpetrator, most of this information has been collected from the significant others rather than from child clients.
- Stage 3 indicated that not much psychosocial support and counselling had been offered to child survivors of sexual abuse and the majority of the cases that were reviewed had been referred to other organisations that offer child protection services. Counsellors were not able to spend much time with their clients.
- Lastly, stage 4 showed that the majority of cases had not been terminated properly in addition to the fact that the first three stages of counselling had not been done sufficiently. Generally, counsellors were not in a position to address the effects of child sexual abuse adequately. The results showed that a large number of child clients suffered psychological, behavioural, emotional and physical effects of sexual abuse. Since not much face-to-face counselling was done with child clients, it is logical that these effects remained unresolved.

6.2.2 Referral

Referral has been discussed under theme 3, and it highlighted data needed to address the first aim of the study, namely to describe the counselling services utilised by Childline Zimbabwe counsellors. Referral has emerged to be the main focus for Childline Zimbabwe as the majority of cases, that is, twenty-four of the 25 children's cases were referred to members of the treatment team without counsellors having spent a lot of time with the child clients' cases in order to fulfil all stages of the counselling process.

Counsellors did not seem to have many options for counselling interventions, except the involvement of other stakeholders. The role of the treatment team was discussed in Chapter 3. Based on their reliance on referral of cases to other organisations, Childline counsellors were therefore predominantly seen as working as referring agents rather than counselling agents psychosocially supporting their clients. Counsellors have involved as many as possible other important stakeholders in addressing the child's case. The child client's case is therefore quickly sent to other actors in the treatment team after the initial interview or intervention.

Almost all the case reports reviewed in this study showed that the cases have been reported to the police who are the main reference point for sexual abuse cases and because of the serious nature of the offence. On one hand, referral is quite an important way of intervention considering that 24 of the 25 cases had been reported to the police. Besides the police's victim-friendly unit (VFU), children's cases have also been addressed by other actors, including nine of the 25 cases that were referred to a hospital, eleven of the 25 cases to schools and three of the 25 cases to the courts. In addition, three of the 25 cases were handled by the Department of Social Welfare, one case was referred to the lawyers for children, one case was referred to the community leadership and one child was removed to a place of safety. On the other hand, in nine of the 25 cases, counsellors managed to talk briefly to the abused child. The police and the hospital had been involved in the initial stages of intervention because of their roles in investigating and verifying the occurrence of the abuse. Other stakeholders, including the Department of Social Welfare, community leadership, schools and places of safety have not always been involved in all children's cases. For example; the Department of Social Welfare, the child's school and the place of safety were mainly involved in the case of children who needed to be placed in places of safety. There are, however, very few places of safety and many child clients had no option but to continue living within their nuclear or extended families where further victimisation was a possibility. Childline counsellors do not determine whether the child's case goes to court or not; it is only the police who have the mandate to do so. This was a challenge for participating counsellors who could not proceed with the case, for instance, of the thirteen clients who were interviewed, cases of nine child clients were either left pending for a long time, not sent to court or were dismissed by the courts due to lack of evidence.

The nature of child sexual abuse is indeed serious and the matter needs to be addressed by multiple agencies since only counselling by Childline counsellors is not enough. It has become evident from the way counsellors have handled the majority of the cases that only counselling or providing psychosocial support cannot solve this problem; referral has therefore taken precedence over face-to-face counselling. Childline Zimbabwe is not in a position to provide all the necessary counselling services that the child needs. Clients and their caregivers can

therefore not assume that by going to Childline Zimbabwe, the child will receive all the necessary counselling services. The Childline policy documents ponders on the multisectoral approach hence, Childline works as a service which is directed for or on behalf of the child by providing direct intervention services, such as counselling, referral and active listening (for helpline calls and drop-ins) (as reported by Delaney, 2009). Participating Childline Zimbabwe counsellors, however, reported concentrating on referral, and this was their strong point, while they were involved in the other direct interventions, although to a lesser extent. There was therefore limited outreach (home visits) or face-to-face counselling with their child clients. The listening services were mostly provided by volunteers at the helpline desk. Counsellors also provided advice to their child clients even though they referred them to other stakeholders.

The confidential nature of the cases was nonetheless not considered sensitively as some clients expressed their concerns for their cases to be handled carefully by different stakeholders. Clients have not been able to make full informed decisions on the involvement of other partners. Attaching referral letters to a case report also reflects the interventions in terms of the child's case (see Appendix 15). Some counsellors omitted this important aspect of counselling since of the 24 referred cases, eighteen case reports had no referral letters attached although these cases were actually referred to other stakeholders.

It seemed that, due to the difficult work contexts and personal, organisational and/or external challenges faced by counsellors, the participating Childline counsellors found it appropriate to address sexually abused children by giving advice and referring them rather than providing psychosocial support. In relation to child sexual abuse cases, the enacted or practical counselling showed that counsellors were not in a position to provide direct interventions but they largely involved other stakeholders, even though Childline Zimbabwe policy prioritises both direct interventions with abused children (through face-to-face counselling, group work, or role plays) and the involvement of other agencies (as described by Delaney, 2009). Considering the way counsellors handled their cases of child sexual abuse as reported, that shows that referral was done in the majority of cases since 24 of the 25 cases had been referred. The results also show that in 23 of the 25 cases, direct interventions which mainly involved case informants ended at either stage 1 or stage 2 of the counselling process, showing that there were very limited face-to-face counselling interventions.

6.2.3 Factors influencing counsellors' work

From the current counselling services, it has been found that Childline Zimbabwe counsellors work under very difficult circumstances. Counselling might be influenced by three main issues namely:

- the capacity of individual counsellors;
- the organisational capacity of Childline Zimbabwe; and
- the external factors involving the effects of working with other stakeholders involved in the treatment team.

These issues are briefly described below and they also address all three aims of the study.

6.2.3.1 Individual capacity for counsellors

All five counsellors highlighted the effects of burnout as an aspect that hinders their work.

Counsellor C asserted:

Listening to abuse stories on a daily basis involves us mentally, emotionally, physically, socially, behaviourally and psychologically.

In this regard, Cattanach (2008, p. 167) states, “Sometimes the stories of abuse send the therapist reeling, shocked and disgusted by their cruelty.”

Counsellor B expressed:

The nature of the children’s problems; the suffering from the painful sexual experiences are really extraordinary. These issues add to our distress and difficulties in getting to terms with our work.

Counsellor D added:

I am having too many difficult cases; I am just overwhelmed with casework.

In terms of what has been happening with Childline Zimbabwe counsellors, Geldard and Geldard (2008) highlight that, if the counsellor becomes emotionally involved with the child’s painful issues, he/she will be distressed and become overwhelmed. Counsellors reported also not being in a position to deal with triggers in counselling. Managing their time for casework has also been a major challenge as counsellors always have backlogs and work overload.

Counsellors’ expertise in counselling also influences the quality of their work. Intervention is based on individual counsellors’ expertise during the initial case assessment. As reported in the results in Chapter 5, counsellors base their assessment of cases on the initial reports, and these initial reports do not always contain all the important case details. Hence, counsellors have shown their weaknesses in implementing counselling as they possessed limited

knowledge in the use of the counselling process, including the use of theories, techniques, stages and strategies for counselling.

6.2.3.2 Organisational situation

The organisational context in which Childline Zimbabwe counsellors work might impact on the counselling services provided to child clients. On one of the 25 cases, there was no intervention done by the responsible counsellor. For fourteen of the 24 cases where counsellors intervened on the children's cases, interventions have been delayed since action was taken between one and six months after the initial case reports. For instance, in worst scenarios, the child died before any intervention could take place. During one of her home visits, a counsellor heard this from the caregivers:

Magouya kuzoitei henyu? Makanonoka mwana wacho akatofa mavhiki maviri apfuura". (Why do you come here now? You are really delayed; that child you are asking for already died two weeks ago.)

It is because of situations like these that clients are also not satisfied by Childline Zimbabwe's counselling services since clients are expressing their feelings for the urgent need for Childline's services at the time cases are reported. In another case, the counsellor found during the initial home visit the family attending a funeral since the child in question had passed away. Serious implications might arise upon the counsellor's delay to intervene. It leaves the counsellor having guilty feelings and viewing him/herself a total failure as illustrated by one counsellor who sobbed and shared:

It didn't turn out the way I wanted it to be ... but I was too late for the child, I only talked to her once then she committed suicide before I could visit and talk to her again.

Based on the findings of this study, the counsellors have been largely affected by too much work and this has resulted in them having limited time for casework. Having a lot of work was also due to the small number of counsellors. Counsellors furthermore have many other extra organisational and departmental duties, such as meetings and workshop attendances. Childline Zimbabwe, as a non-governmental body that is donor-funded, experiences challenges of limited funds and resources needed for the day-to-day running of counsellors' tasks. However, according to the participants in this research, the hindrances to be able to carry out the expected counselling services also include a shortage of resources such as fuel and transport to go for field work. Childline had only four functional cars for both Harare and Bulawayo branches and these catered for all six counsellors and all the other outreach and administrative staff members. Furthermore, there were only two drivers at the two branches

and these also had to drive the two counsellors without driving licenses when they needed to go for case visits.

It has also been observed that Childline managers mainly allow counsellors to manage their own individual counsellors' work and that there is very little assessment and follow-up on counsellors' work by Childline managers. Moreover, the counsellors' concerns and work-related problems are rarely addressed. For instance, the use of cars by counsellors as well as administrative staff was in most cases regarded as a challenge due to the lack of coordination among counsellors and their colleagues.

Above all, as pointed by the literature reviewed in this study, the child clients' confidence can be diminished by the poor counselling environment. This can be a cause for concern since at Childline Zimbabwe the researcher observed limited and uncomfortable counselling spaces. The counselling room is also open to other staff members at any time since it is also used as a store room. The small counselling room is separate from the main building which houses all the other staff members. This might indicate that the counselling room is insecure for both the counsellors and the clients. For example in one incident, the counsellor had a violent client in session and the counsellor squeezed through a very narrow door in her effort to escape when the teenage boy client became agitated. Counsellors also have no safe places for counselling clients during the times when they visit clients at home or at school. All five counsellors have reported that at the client's home, the counsellor mostly conduct counselling sessions behind the house; and at school, counselling is done behind classrooms or in the staffroom where clients are seen by other children.

6.2.3.3 External factors

Some clients live very far and counsellors fail to travel long distances to find the clients. Poor road networks, absence of road signs and lack of road maps also limit counsellors from reaching their counselees. Sometimes caregivers are uncooperative as they fail to disclose children's whereabouts.

The participating Childline counsellors reported having had difficulties entering some communities in Zimbabwe, especially due to the political and economic instability in Zimbabwe. Many participants, both from rural and urban areas, had little information about Childline Zimbabwe and its work before their child was sexually abused. Some communities were ignorant about Childline's role in protecting children's rights, and this made it difficult for counsellors to provide counselling to some clients. This was evidenced by eight clients participating in the interviews who reported that they did not know Childline Zimbabwe and its

roles. Of these eight participants, five were from rural areas while three were from urban areas.

The Zimbabwean law does not fully protect survivors of child sexual abuse. Different types of CSA carry different weights in terms of how serious the abuse is. As reviewed in Chapter 2, the effects of abuse are different for different children and for different cases. The results show that the law-enforcing agents consider penetrative sex as causing the most severe effects, therefore these attract serious sentences. For instance, in a case where Childline social worker/counsellor A reported on a case report

Childline visited a police station and Sgt X informed the officer that M had gone to Family Support Trust for a medical examination and the results had indicated that she had not been abused. The police said the perpetrator only slapped the child's buttocks and that is as far as he had gone.

Therefore, some types of sexual abuse are treated seriously while others are not. Authorities from the treatment team therefore rate CSA cases differently. This made it difficult for counsellors to address a number of children's cases since some cases were regarded as minor as evidenced in nine of the 13 children's cases whose verdicts were either unknown, pending, dismissed or the perpetrators freed by the court.

Although literature reviewed in Chapter 3 advises a multisectoral stance in addressing the child sexual abuse scourge, the results show that collaborating organisations have also contributed to the challenges faced by Childline Zimbabwe counsellors while they carried out their work. This is so because various organisations such as the Department of Social Welfare and the police have failed to maintain an amicable working relationship. There was also no mutual agreement by most members of the treatment team about their roles in addressing children's concerns; hence, their roles were not clear and there were some incidences of duplication of duties. An example is where the Department of Social Welfare's counselling function is defined in terms of the law of the provisions of the Children's Protection and Adoption Act (1972) (CPA ACT), (Chapter 33) (UNICEF, 2001) while Childline Zimbabwe also has the counselling aspect as one of their roles (as described by Delaney, 2009). The poor communication resulted in member organisations misrepresenting each other in the presence of the very clients they all needed to help as explained in section 5.8.2.2. Furthermore, the limited resources in most agencies have also been a cause of problems among collaborating organisations. Some organisations, such as government bodies, have not done their tasks and complained that Childline as an NGO should provide them with financial support and other resources. Since Childline is a non-governmental organisation working within a shrinking economy, they were not at all in a position to provide such resources as transport and funds.

Officers from the treatment team, especially from the police and the magistrate's courts, provided only limited feedback on the status of clients' cases, and clients were kept wondering what was happening with their cases after they had reported them. Counsellors highlighted their need for support from other organisations so that the aims of a treatment team could be fulfilled for the benefits of the child clients.

6.3 RECOMMENDATIONS

Three forms of recommendations have been formulated. These recommendations are based on the following

- suggestions for improving the service provision by Childline Zimbabwe counsellors;
- improvements in organisational support for counsellors; and lastly
- a suggestion for further research to be implemented as regards to counselling of child survivors of sexual abuse.

6.3.1 Recommendations for counsellors

The following recommendations may be regarded as guidelines, and the researcher suggests that they should be used in accordance with the Childline Zimbabwe, Childline International and the health professions policies in counselling. These recommendations were derived from the participants' responses, the researcher's perspectives and also from the literature reviewed for this study. In terms of the provision of counselling services, recommendations for counsellors/social workers are as follows:

- For all cases, counsellors are advised to record and document useful information that helps them in their work with child clients. Training is inadequate and the results indicate that counsellors have a lack of adequate skills in order for them to make the correct use of the genogram technique. The genogram clearly shows the relationships between the child client and the other people influencing his/her behaviour and the perpetrator's link to the child.
- The need to terminate counselling relationships should be emphasised to all counsellors since none of the counsellors indicated how they intended to terminate counselling relationships. Schroder (1997 cited in Kanyowa, 2003) suggests that the curative or absolute stance in the termination process leads to a clean break with clients although clients may be left feeling like failures or deprived when the effects of sexual abuse remained unresolved. Furthermore, Kanyowa (2003) suggests that

termination can be done in the form of health maintenance or a provisional termination where the counsellor leaves room for the client to come back whenever he/she wants to. This might, however, create a dependency syndrome for some clients who fail to acknowledge that the counselling relationship is over and that it is no longer necessary. In this sense, counsellors need to master the recommended ways of terminating counselling relationships.

- Practitioners dealing with children affected by CSA should have sufficient knowledge about the traumatic effects of CSA including the behavioural, emotional, physical, psychological and social aspects in order for them to address the effects. Child sexual abuse is typically devastating. Each child's case is unique; there is therefore a need to do some intervention in every case. The presenting problem might be different from the actual problem, which normally comes up during counselling after a trusting relationship with the client has been established. Therefore, case assessment by individual counsellors needs to be done cautiously to avoid ruling out genuine cases.
- The family plays an important role in the counselling of children. Counsellors should therefore provide psychosocial support and counselling to family members as well; hence, the combination of individual and family therapy is recommended for addressing CSA of children holistically. Therapists ought to remember that there is no right or wrong approach to counselling. It is therefore vital that counsellors keep up to date with the changes in the approaches to counselling of children, and training in various counselling approaches would yield positive results. As Rukuni and Maunganidze (2001) put it, culture – in Zimbabwe in particular and Africa in general – is changing along with the changes incorporated and influenced by various societal groups. Perhaps what is more interesting in the counselling profession, according to Schwartz (2008), is the multiculturalism in our society so counsellors need to integrate the ancient healing practices with modern ones to enhance the counselling process. "Similarly, many contemporary psychotherapists subscribe to an eclectic/integrationist approach" (Geldard & Geldard, 2008, p. 64). This is well supported by Ward *et al.*'s (2006) unified theory of sexual offending explained in Chapter 2. Theories help counsellors to have a better understanding of clients' behaviour. Counsellors should therefore adopt a theory or theories that best suit the client's situation and the nature of the problem.
- Childline Zimbabwe counsellors should have knowledge about the members of the treatment team and their roles (described in section 3.8). This would help practitioners in their service provision. When collaborating with other stakeholders, including teachers and school counsellors, Childline counsellors should agree on their roles with

regard to helping sexually abused children. To this effect, counsellors need to be well equipped with counselling and communication skills for use with children, caregivers and other stakeholders. There is also a need for counsellors to reinstate clients' faith in the role of law-enforcing agencies, such as the police and the magistrates. This would help to coordinate the way the law-enforcing agencies investigate and prosecute perpetrators so that real service delivery can be ensured. Counsellors are therefore urged to help children to report all abuses that have already happened as soon as they can so that action can be taken to avoid or stop further abuse.

- Group therapy approaches play a vital role in the counselling of sexually abused children in terms of the advantages discussed above in Chapter 3. Group therapies are therefore recommended for use with large groups of children as this may curb the problem of case overload. Every social worker at Childline Zimbabwe is linked to at least one children's home or foster home where the social worker organises group counselling for the children at their place of safety. Here, group therapy models are used to counsel children with different types of problems but group therapy is not yet one of Childline Zimbabwe's main approaches to the counselling of victims of CSA. Play therapy is also not fully utilised by all counsellors, and counsellors need good training on its use.

6.3.2 Recommendations for Childline Zimbabwe

The organisation needs to ensure favourable environments for the counsellors to enable the delivery of services. Counsellors need to be aware of what they are expected to do by the organisation. It is a problem when counsellors are not really sure of the organisational expectations of their work. Hence:

- Induction of new counsellors is important and in-service training for all counsellors should be organised. There is need to provide volunteers with training in case recording. This is important for counsellors since they use the case details to understand the nature of the case so that they can begin follow-up.
- From the child client's suggestions, the organisation should plan more outreach programmes and reach more communities as this helps with service delivery. Childline Zimbabwe is not well known in many communities in Zimbabwe. Television and radio programmes where child abuse issues are discussed could help in this regard. In this regard, organisational publications could be shared and distributed to various communities. A Childline Zimbabwe logo showing the organisation's main themes and activities should be displayed on all the organisation's cars and publications.

- Officers are referred to as “counsellors” or “social workers”; it is therefore recommended that officers get one name in order to avoid role confusion. There is need for employing more counsellors to cater for the large number of clients. There is also a need to have male counsellors due to the recent increase in boy children needing counselling. Comparing the total number of cases (sexual and other types of child abuse) that Childline Zimbabwe receives to the number of counsellors employed by Childline Zimbabwe, it is clear that counsellors are overburdened by the large numbers of cases received and which need to be acted upon. This can cause problems as a result of low follow-up of all cases and counsellor burn-out. On average, one counsellor has 30 on-going cases per month.
- There is a need to examine the law which classifies the types of sexual offences (minor or serious offences) and Childline should advocate for this through their collaboration with law-enforcing agents. In addition, Childline should advocate for the consequences of child sexual abuse linked to cultural and religious practices so that these practices and resulting consequences may be included in Zimbabwe’s Constitution. This should be done in consideration of the effects of abuse on different children. Punishment should be given to all perpetrators regardless of the type of sexual abuse they have committed and considering the concerns of the survivors of CSA.
- The bond between the treatment team members should be reviewed so that a strong relationship may be maintained amongst all member organisations for the benefit of survivors of CSA. There is a need to advocate for child survivors to be given the right to choose who should represent them during court hearings for their cases. This is in consideration of the needs and concerns of the clients and counsellors for their call for Childline counsellors to be present during case sentencing so that the child can be provided with emotional and moral support.
- Childline, government bodies and other non-governmental organisations (NGOs) should occasionally be involved in meetings and workshops where they can discuss their roles in protecting children against sexual abuse and exploitation. In such workshops, each stakeholder is kept up to date with what is happening in this field, and together these participating stakeholders should come up with a plan of action to ensure provision of the necessary services to their clients. The treatment team members must be familiar with the resources of their community and those of their agency (as suggested by Burgess *et al.*, 1978). A community plan can be agreed upon by member organisations. In order to improve the quality of life for children and their caregivers, all resources should be identified and made available to all communities,

and responsibilities of each organisation should be mutually agreed upon (the affirmation of the holistic approach discussed in section 3.8). As Burgess *et al.* (1978) illustrate, the examination for child sexual assault would be much more effective if it is defined in its broadest terms. Frequent meetings of the counselling department with all staff members where ideas/experiences are shared are necessary and confidentiality issues should be dealt with as an organisation.

6.4 LIMITATIONS OF THE STUDY AND SUGGESTIONS FOR FURTHER RESEARCH

The current research investigated the counselling services provided by Childline counsellors to child clients who are survivors of child sexual abuse. Due to the sensitive nature of the problem of CSA addressed in the study, some limitations and problems have been encountered. These include:

- The study of sexual abuse is a very sensitive topic so obtaining valid qualitative and quantitative data was a challenge. The sensitivity of the issue of sexual abuse seemed to make some clients reluctant to answer questions from the researcher whom they did not know well. Accessing and locating some of the subjects was also a problem since some of them had been moved to places of safety. This affected the research results since the total number of client respondents was reduced by 20%. This contributed to an even smaller sample, rendering difficulties for generalising the research findings.
- Due to language proficiency, especially with children seven years and under, the feelings of the caregivers have been represented rather than those of sexually abused young children.
- Because the researcher was researching a system of which she was a part, it was very difficult to differentiate the researcher from this system and the data that she gathered. The researcher faced some difficulties in the analysis stage, especially because of the realisation that she was working with the counsellors being researched, her data was too broad and lacked some focus and her research aims were poorly formulated. The researcher revisited these three factors and with consultation from her promoter and reading the literature sources, the researcher rectified this problem and reformulated the research aims. The researcher then managed to go through the analysis stage.
- This study had limitations in the sense that only children whose cases were reported to Childline were used as participants for this study. This limited the external validity of the findings.

Although there were a considerable number of challenges in this study, the evaluation of the services offered by Childline Zimbabwe shows that the results of this study and the subsequent recommendations will contribute a great deal to the counselling of sexually abused children in Zimbabwe. Despite the above-mentioned limitations, the researcher recommends that future research planned in the field of counselling child survivors of child sexual abuse consider these limitations when they choose the participants, consider the resources needed for the execution of the study or when considering the types of questions to be asked to the participants during interviews. The researcher also observed that Childline Zimbabwe and the counsellors needed to be informed about their current services and the impact of such services to the clients. The counsellors would also be in a position to use the results of this study in improving their service provision to child clients affected by CSA.

Vast numbers of studies (as evidenced in the literature reviewed in Chapter 2 and 3) have been done in the field of counselling and more specifically regarding sexual abuse of children. There is however still need to continue research in this field since the issue of sexual abuse continues to affect many children globally and it is also influenced by the changes that are affecting our society. There are always many issues to be addressed in relation to the problems of CSA, among others

- issues of the severity of effects caused by various types of sexual abuse to individual children;
- the investigation and prosecution of perpetrators of CSA;
- the availability of options required to address the issue of CSA;
- causes of non-disclosure of CSA; and
- the counselling methods needed for various age groups.

To this effect, Richter *et al.* (2005, p. 11) state that the problem of child sexual abuse “requires a coordinated, considered and integrated response that is informed by sound research and policy formulation”. Further research questions that may be explored in relation to this study, which explored the counselling services offered to child clients affected by CSA, are as follows:

- To what extent does the local cultural context and value system interfere with the counselling practice (e.g. the social acceptance of “small” indecent behaviour like mere touching ...)?
- To what extent do financial and logistical limitations in organisations affect counselling practice?

- Is there any relationship between poor counsellor expertise and burnout of counsellors working with sexually abused children?

It is also necessary to investigate the suitability of the counselling process for sexually abused children in different backgrounds, cultures and contexts and, finally, a study to compare this study done in Zimbabwe to other studies done in other countries could also be fruitful.

6.5 FINAL CONCLUSIONS OF THE STUDY

One main observation has been obtained from this study, namely Childline Zimbabwe counsellors provide very little face-to-face counselling and psychosocial support but they do much toward referral of sexually abused child clients to other 'child safe organisations'. This observation has been formulated on the basis of the issues discussed above. The majority of child sexual abuse cases that have been reported to Childline Zimbabwe have been addressed by means of referral. First of all, it became clear that counsellors devote much time to the gathering of background information regarding children's cases while providing limited psychosocial support to the children and/or case informants. Secondly, based on findings from the study, it seemed that the four counselling stages of the counselling process have not been fulfilled and this can be an indication to the hindrance to counselling services for all 25 cases reviewed in this study. Thirdly, provision of face-to-face counselling to child clients has been shown as a big challenge for Childline Zimbabwe counsellors, and this was influenced by the difficult work context of the participating counsellors. The factors that contributed to this context emanated from a number of both intrinsic and extrinsic motivational factors such as the limited capacity of individual counsellors including the effects of counsellor burnout and counsellors' expertise in counselling and limited capacity of the organisation to provide counsellors with the needed resources such as cars and fuel.

Childline Zimbabwe as a donor-funded organisation also has limited capacities to provide a good working environment for the counsellors. Hence, the limited resources contributed to the challenges faced by participating counsellors in their quest to provide counselling services. There were also other external factors influencing counsellors' work, as reported during the research. These included failure by the treatment team members to form amicable work relationships, a lack of corporation by some community members, including clients and their caregivers, and the effects of the conflicting Zimbabwean political, social and economic situation.

However, counsellors have shared their willingness to offer their services provided that they get support and help from Childline Zimbabwe and collaborating agencies. The counsellors

have also stated that their efforts need to be recognised, firstly by Childline and secondly by the local communities because of their role in protecting children from sexual abuse so that they feel committed and take up the challenges in the counselling of child clients. Discussions during departmental meetings and during the interviews provided a platform for counsellors to air their views about the challenges they face and to suggest plans for effectual counselling at Childline Zimbabwe in future. Although counsellors have been confronted with all these challenges, they still applied the holistic approach to counselling and managed to make use of the treatment team members. Referral has therefore emerged as a major way of addressing the majority of cases of child sexual abuse.

The factors influencing Childline Zimbabwe counsellors' provision of counselling services to the child clients who are survivors of child sexual abuse should not be viewed in isolation and individually but they should be considered holistically in order to get a complete insight into the work reality of Childline Zimbabwe. Participation of the counsellors, the clients and their caregivers, Childline Zimbabwe and other stakeholders has played an influential role in the provision of counselling and referral services to abused children and their families. Counsellors refer abused children to other agencies and they also get referrals from other agencies. This fulfils the holistic way of addressing the child sexual abuse problem as reviewed in Chapter 3 and according to the Childline Zimbabwe policy documents.

Understanding the client's phenomenal world is at the base of any counselling process or theoretical paradigm. (Nowell, 2012).

REFERENCE LIST

- Abdollahian, E., Mokhber, N., Balaghi, A., & Moharrari, F. (2013). The effectiveness of cognitive-behavioural play therapy on the symptoms of attention-deficit/hyperactivity disorder in children aged 7-9 years. *ADHD, Attention Deficit and Hyperactivity Disorders*, 5(1), 41-46.
- Africaid. (2013). *About Africaid*. Retrieved from <http://www.africaid-zvandiri.org/about>
- Alliance for Children's Entitlement to Social Security. (2003). *Social security policy and law reform update*. Retrieved from <http://www.ci.org.za/depts/ci/pubs/pdf/rights/polcom/updatemay03.pdf>
- Allagia, R. (2010). An ecological analysis of child sexual abuse disclosure: Considerations for child and adolescent mental health. *Journal of the Canadian Academy of Child and Adolescent Psychiatry*, 19(1), 32-39.
- American Academy of Child and Adolescent Psychiatry. (2008). Child sexual abuse. *Journal of American Academy of Child & Adolescent Psychiatry*, 5(9) Retrieved from http://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families_Pages/Child_Sexual_Abuse_09.aspx
- American Psychological Association. (2013). *Understanding Child Sexual Abuse: Education, Prevention, and Recovery*. Retrieved from <http://www.apa.org/pubs/info/brochures/sex-abuse.aspx>
- Anonymous. (2003). Sexual offenses. *Utah Criminal Code*. Retrieved from http://www.usu.edu/saavi/pdf/utcc_sexual_offenses.pdf
- Anonymous. (2010). *Child pornography*. Retrieved from http://en.wikipedia.org/wiki/child_child_pornography
- Asgeirsdottir, B. B., Gudjonsson, G. H., Sigurdsson, J. F., & Sigfusdottir, I. D. (2010). Protective Process for depressed mood and anger among sexually abused adolescents: The importance of self-esteem. *Personality and Individual Differences*, 49(5), 402-407.
- Axline, V. M. (1993). *Play therapy*. New York, NY: Ballantine Books.
- Bani, M. (2011). The use and frequency of verbal and non-verbal praise in nurture groups. *Emotional and Behavioural Difficulties*, 16(1), 47-67.

- Barbaree, H. E., & Marshall, W. L. (2006). *The juvenile sex offender*. New York, NY: The Guilford Press.
- Barlow, A. R. (1981). *Gestalt therapy and gestalt psychology: Gestalt-antecedent influence or historical accident*. Retrieved from www.gestalt.org/barlow.htm
- Barriere, D. (2008). Child abuse effects: Definition of sexual abuse. *Canadian Red Cross Respect ED Training Program*. Retrieved from <http://www.child-abuse-effects.com/definition-of-sexual-abuse.html>
- Bartson, S. Smith, M. & Corcoran, C. (2011). *EMDR Therapy: A guide to making an informed choice*. Retrieved from <http://www.anapsys.co.uk/emdr.pdf>
- Becvar, D. S., & Becvar, R. J. (2006). *Family therapy: A systemic integration*. Boston, MA: Pearson Education.
- Bedi, P., Haverkamp, B. E., Beatch, R., Cave, D. G., Domene, J. F., Harris, G. E., & Mikhail, A. (2011). Counselling psychology in a Canadian context: Definition and description. *Canadian Psychology/Psychologie Canadienne*, 52(2), 128-138.
- Beitchman, J., Zucker, K., Hood, J., DaCosta, G., Akman, D., & Cassavia, E. (1992). A review of the long-term effects of child sexual abuse. *Child Abuse and Neglect*, 16(1), 101-118.
- Berlin, F. S., & Krout, E. (1994). *Pedophilia: Diagnostic concepts, treatment, and ethical considerations*. Baltimore, MD: Johns Hopkins Hospital.
- Bickley, J., & Beech, A. (2001). Classifying child abusers: Its relevance to theory and clinical practice. *International Journal of Offender Therapy and Comparative Criminology*, 45(1), 51-69.
- Brakarsh, J. (2006). *Helping sexually abused children*. Harare: Family Support Trust.
- Bratton, S. C., Ray, D., Rhine, T., & Jones, L. (2005). The efficiency of play therapy with children: A meta-analytic review of treatment outcomes. *Professional Psychology: Research and Practice*, 36(4), 376-390.
- Breakwell, G. M., Foot, H. & Gilmour, R. (1993). *Doing social psychology: Laboratory and field exercises*. Cambridge, CB: Cambridge University Press.
- Burgess, A. W., & Grant, C. A. (1988). *Children traumatized in sex rings*. Philadelphia, Pennsylvania: National Center for Missing & Exploited Children. Retrieved from <https://www.ncjrs.gov/App/Publications/abstract.aspx?ID=110733>
- Burgess, A. W., Groth, A. N., Holmstrom, L. L., & Sgroi, S. M. (1978). *Sexual assault of children and adolescents*. Lexington, MA: D.C. Health and Company.

- Bwititi, K. (2011, June 4). Sodomy on the rise. *The Saturday Herald*. Retrieved from <http://www.zimpapers.co.zw/index.php?>
- California Coalition against Child Sexual Assault. (2008). *Report: Research on rape and violence*. Rape Prevention Resource Center. Retrieved from <http://search.mywebsearch.com/mywebsearch/redirect/jhtml?searchfor=www.calcasa>
- Campbell, C., Skovdal, M., Mupambireyi, Z., & Gregson, S. (2010). Exploring children's stigmatisation of AIDS-affected children in Zimbabwe through drawings and stories. *Social Science & Medicine*, 71 (5), 975-985.
- Cattanach, A. (2008). *Play therapy with abused children*. London: Jessica Kingsley.
- Chantler, K. (2005). From disconnection to connection: 'Race', gender and the politics of therapy. *British Journal of Guidance & Counselling*, 33(2), 239-256.
- Chigwedere, L. (2004). *Counselling processes and practices III*. Module CD401. Harare: Zimbabwe Open University.
- Chikovore, J. (2004). *Gender power dynamics in sexual and reproductive health: A qualitative study in Chiredzi District, Zimbabwe*. (Published doctoral dissertation). Umeå University: Umeå. Retrieved from www.diva-portal.org/smash/get/diva2:142634/FULLTEXT01.PDF
- Chikwanha, T. (2013). Child abuse cases on increase. *The Daily News Live*. Retrieved from <http://www.dailynews.co.zw/articles/2013/02/06/child-abuse-cases-on-increase>
- Childline Zimbabwe. (2009). *Case Records*. Harare: Childline Zimbabwe Counselling Department.
- Chimuka, M. (2011, April 22-28). Chinamwali: Old habits die hard. *Kwayedza: The Herald Online*. Retrieved from <http://www.herald.co.zw/index.php>
- Chiremba, W., & Makore-Rukuni, M. N. (2002). *Substance and person abuse*. Module CD 210. Harare: Zimbabwe Open University.
- Chomba, E. (2012). Risk factors in sexually abused children reporting to the one stop centre at University teaching hospital in Zambia: Breaking the Silence. Lusaka: *University of Zambia, University Teaching Hospital*. Retrieved from <http://www.intechopen.com/books/sexual-abuse-breakingthe-silence/risk-factors-in-sexually-abused-children-reporting-to-the-one-stop-centre-at-university-teachinghos>
- Cohen, L., Manion, L., & Morrison, K. (2000). *Research Methods in Education*. New York, NY: RoutledgeFalmer.

- Coll, R. K., & Chapman, R. (2000). Choices of methodology for cooperative education researchers. *Asia-Pacific Journal of Cooperative Education*, 1(1), 1-8.
- CONNECT. (2001). Certificate in Systemic Family Counselling. *Manual 1*. Harare, Zimbabwe: Zimbabwe Institute of systemic therapy.
- Connors, M. E. (1994). Symptom formation: An integrative self psychological perspective. *Psychoanalytic Psychology*, 11(4), 509-523.
- Conradie, H. (2001). The structure and functioning of child pornography. *Crime Research in South Africa*, 4(4), 1-15.
- Court Reporter. (2010, November 5). Man fondles daughter (3). *The Zimbabwe Herald*, p. 3.
- Craddock, D., & Mathias, H. (2009). Assessment options in higher education. *Assessment & Evaluation in Higher Education*, 34(2), 127-140.
- Craig, L. A., & Giotakos, O. (2011). Sexual offending in psychotic patients. In D.P. Boer, R. Eher, M. K. Miner, F. Pfafflin, & L. A. Craig, (Eds.), *International perspectives on the assessment and treatment of sexual offenders: Theory, practice and research* (pp. 464-478). Retrieved from <http://obrela.gr/wp-content/uploads/2013/02/Paperc24-Craig-Giotakos.pdf>
- Delaney, S. (2009). *Counselling practice guide*. Amsterdam: Child Helpline International.
- Denzin, N. K. & Lincoln, Y. S. (2005). *The sage handbook of qualitative research*. London: Sage.
- Domestic Violence Act [Chapter 5: 16]. (2006). The Zimbabwe Domestic Violence Act 14/2006. Retrieved from http://www.africalegalaid.com/1Manager/Download/474/21493/4321/117791/EN/4321_117791_vKqY_Z
- Duffany, A. & Panos, P. T. (2009). Outcome Evaluation of a Group Treatment of Sexually abused and Reactive Children. *Research on Social Work Practice*, 19(3), 291-303.
- Duva, S. M., Silverstein, S.M., & Spiga, R. (2011). Impulsivity and risk-taking in co-occurring psychotic disorders and substance abuse. *Psychiatry Research*, 186, 351-355.
- Eckenrode, J. (2004). The prevention of child abuse and neglect. *Encyclopedia on Early Childhood Development*. Montreal, Quebec: Family Life Development Center of Cornell University.
- Eisold, K. (2002). Jung, Jungians, and Psychoanalysis. *Psychoanalytic Psychology*, 19(3), 501-524.
- Elliott, A. (1998). *Freud 2000*. Cambridge: Polity Press.

- Encyclopedia of mental Disorders. (2013). *Exhibitionism, Children, Causes, DSM, Effects, Therapy, Drug, Person, People*. Retrieved from <http://www.minddisorders.com/Del-Fi/Exhibitionism.html>
- Esere, M. O., Idowu, A. I., Durosaro, I. A., & Omotosho, J. A. (2009). Causes and consequences of intimate partner rape and violence: Experiences of victims in Lagos, Nigeria. *Journal of AIDS and HIV Research*, 1(1), 001-007. Retrieved from <http://www.academicjournals.org/jahr/PDF/Pdf2009/Oct/Esere%20et%20al.pdf>
- Finkelhor, D. (1984). *Child sexual abuse: New theory and research*. In T. Ward, D. L. L. Polaschek, & A. R. Beech (Eds.), *Theories of sexual offending* (pp. 19-31). West Sussex: Wiley.
- Finkelhor, D., & Brown, A. (1985). The traumatic impact of child sexual abuse: A conceptualization. *American Journal of Orthopsychiatry*, 55(4), 530-541.
- Flournoy, J. (1996). Incest prevention: The role of the paediatric nurse practitioner. *Journal of Paediatric Health Care*, 10(6), 246-254.
- Fouché, A., & Joubert, J. M. C. (2009). Facilitating disclosure of child sexual abuse victims in the middle childhood: A seven-phase forensic interview protocol. *Acta Criminologica*, 22(2), 41-59.
- Fox, S. & Nkosi, Z. (2003). *Child sexual abuse: A handbook for parents and caregivers*. Johannesburg: Centre for AIDS Development, Research and Evaluation (CADRE).
- Freud, S. (2001). *The standard edition of the complete psychological works of Sigmund Freud: A case of hysteria, three essays on sexuality and other Works*. London: Hogarth Press.
- Geldard, K., & Geldard, D. (2008). *Counselling children: A practical introduction*. London: Sage.
- Gneezy, U., Leonard, K. L., & List, J. A. (2009). Gender differences in competition: Evidence from a matrilineal and patriarchal society. *Econometrica*, 77(5), 1637-1664.
- Golafshani, N. (2003). Understanding reliability and validity in qualitative research. *The Qualitative Report*, 8(4), 597-607. University of Toronto. Retrieved from <http://peoplelearn.homestead.com/medhome/qualitative/reliab.validity.pdf>
- Goldman, J., Salus, M. K., Wolcott, D., Kennedy, K. Y. (2003). *A coordinated response to child sexual abuse and neglect: The foundation for practice*. Retrieved from <https://www.childwelfare.gov/pubs/usermanuals/foundation/foundation.cfm>

- Gordon, H. & Grubin, D. (2004). Psychiatric aspects of the assessment and treatment of sex offenders. *Advances in Psychiatric Treatment*, 10(1), 73-80.
- Grimm, A. L. (2013). An examination of why permitting therapy dogs to assist child-victims when testifying during criminal trials should not be permitted. *Journal of Gender, Race & Justice*, 16(1), 263-292.
- Grotsky, L., Camerer, C., & Damiano, L. (2000). *Group work with sexually abused children: A practitioner's guide*. Thousand Oaks, CA: Sage.
- Grubin, D. (1998). Sex offending against children: Understanding the risk. *Police Research Series, Paper 99*. London: Research Development Statistics. Retrieved from <http://217.35.77.12/research/england/justice/fprs99.pdf>
- Gwirayi, P. (2010). The role of macro-systemic contexts in understanding the aetiology and epidemiology of child sexual abuse in Southern Africa. *Journal of Sustainable Development in Africa*, 12(2), 253-268. Clarion University of Pennsylvania. Retrieved from http://www.jsd-africa.com/Jsda/V12/No2_Spring2010_B/PDF/The%20Role%20of%20Macro-Systemic%20contexts.pdf
- Haeny, A. M. (2014). Ethical considerations for psychologists taking a public stance on controversial issues: The balance between personal and professional life. *Ethics & Behaviour*, 24(4), 265-278.
- Haight, W. L. (1998). Gathering the spirit at first Baptist church: Spirituality as a protective factor in the lives of African American children. *Social Work*, 43(3), 213-221.
- Hall, D. K., Mathews, F., & Pearce, J. (1998). Factors associated with sexual behavior problems in young sexually abused children. *Journal of Child Abuse & Neglect*, 22(10), 1045-1063.
- Hanson, R. K., Gizzarelli, R., & Scott, H. (1994). The attitudes of incest offenders: Sexual entitlement and acceptance of sex with children. *Criminal Justice and Behaviour*, 21(2), 187-202.
- Hanson, R. K., Gordon, A., Harris, A. J. R., Marques, J. K., Murphy, W., Quinsey, V. L., & Seto, M. C. (2002). Sexual abuse. *A Journal of Research and Treatment*, 14(2), 169-194.
- Hanzi, R. (2006). *Sexual abuse and exploitation of the girl child through cultural practices in Zimbabwe: A human rights perspective*. (Unpublished master's dissertation). University of Pretoria, Pretoria.

- Harman, J. (2011). Confidentiality in family dispute resolution and family counselling: Recent cases and why they matter. *Journal of Family Studies*, 17(3), 204-212.
- Hartill, M. (2009). The sexual abuse of boys in organized male sports. *Men and Masculinities*, 12(2), 225-249.
- Healthwise Staff. (2010). *Sexual Conditions Health Center*. Retrieved from <http://www.webmd.com/sexual-conditions/electrocautery-for-genital-warts>
- Heiberg, T. (2001). *Commodities in stigma and shame: An international overview of Save the Children's work against child sexual abuse and exploitation*. Retrieved from <http://www.resourcecentre.savethechildren.se/sites/default/files/documents/2398.pdf>
- Heinonen, E., Lindfors, O., Laaksonen, M. A., & Knekt, P. (2012). Therapists' professional and personal characteristics as predictors of outcome in short- and long-term psychotherapy. *Journal of Affective Disorders*, 138(3), 301-312.
- Herman, J. (1981). Father-Daughter Incest. *Professional Psychology, Vol.12 (1)*, 76-80.
- Higginbotham, A. (1995). Standards and ethics for counselling in action. *International Journal of Social Psychiatry*, 41(2), 155.
- Hilden, M., Sidenius, K., Langhoff-Ross, J., Wijlma, B., & Schei, B. (2003). Women's experiences of the gynaecologic examination: Factors associated with discomfort. *Acta Obstetrica et Gynaecologica Scandinavica*, 82, 1030-1036.
- Hill, A. (2006). Play Therapy with sexually abused children: Including parents in therapeutic play. *Child and Family Social Work*, 11(4), 316-324.
- Hill, C. E. (2001). *Helping Skills: The Empirical Foundation*. Washington, DC: American Psychological Association.
- Hing, A. D. A. H. (2010). *The impact of child sexual abuse (CSA) on the school life experiences and academic performance of adult CSA survivors*. (Unpublished doctoral dissertation). Nelson Mandela Metropolitan University, Port Elizabeth.
- Hlupo, T. & Tsikira J. (2012). Still Caught-Up in the Cultural Abyss: The Plight of the Girl Child. *Journal of Emerging Trends in Educational Research and Policy Studies (JETERAPS)* 3(3), 234-240.
- Hough, M. (1998). *Counselling skills and theory*. Musselburgh: Scotprint.
- Hove, R. C. (1992). *Statement on Zimbabwe's progress in the implementation of the ICPD 1994 Programme of Action: Permanent Mission of the Republic of Zimbabwe to the United Nations*. New York. Retrieved from <http://www.un.org/popin/unpopcom/32ndsess/gass/state/zimbabwe.pdf>

- Huby, G. (1997). Interpreting silence, documenting experience: An anthropological approach to the study of health service users' experience with HIV/AIDS care in Lothian, Scotland. *Social Science & Medicine*, 4(8), 1149-1160.
- Hufstader, C. (2006). *Zimbabwe looks to new domestic violence law*. Retrieved from <http://www.oxfam-america.org/articles/zimbabwe>
- Hughes, D. R. (2001). *The symptoms of sexual disturbance among children*. Retrieved from <http://www.protectkids.com/abuse/symptoms.htm>
- Isom, M. D. (1998). *The social learning theory*. Retrieved from <http://www.criminology.fsu.edu/crimtheory/bandura.htm>
- Ivey, A. E., & Ivey, M. B. (2008). *Essentials of intentional interviewing: Counselling in a multicultural world*. Belmont, CA: Thomson Brooks/Cole.
- Jacobs, J. E., Bleeker, M. M., & Constantino, M. J. (2003). The self-system during childhood and adolescence: Development, influences and implications. *Journal of Psychotherapy Integration*, 13(1), 33-65.
- Jager, J. (2012). Facilitating children's views of therapy: An analysis of the use of play-based techniques to evaluate clinical practice. *Clinical Child Psychology and Psychiatry*, 18(3) 411-428.
- Jeanty, G. C., & Hibel, J. (2011). Mixed methods research of adult family care home residents and informal caregivers. *The Qualitative Report*, 16(3), 635-656. Retrieved from <http://www.nova.edu/ssss/QR/QR16-3/jeanty.pdf>
- Joyce, P. A. (1995). Psychoanalytic theory: Child sexual abuse and clinical social work. *Clinical Social Work Journal*, 23(2), 199-214.
- Jung, C. G. (1969). *The Archetypes and the collective unconscious*. London: Routledge & Kegan Paul.
- Kalliala, M. (2006). *Play Culture in a changing world*. London: Open University Press.
- Kambarami, M. (2006). *Femininity, sexuality and culture: Patriarchy and female subordination in Zimbabwe*. Africa Regional Sexuality Resource Centre in Collaboration with Health Systems Trust, South Africa. Retrieved from <http://www.arsrc.org/downloads/uhsss/kmabarami.pdf>
- Kanyowa, T. (2003). *Marriage and family counselling*. Module CD 307. Harare: Zimbabwe Open University.
- Kaseke, E. (1991). Social work practice in Zimbabwe. *Journal of Social Development in Africa*, 6(1), 33-45.

- Kattakayam, J. (2012, February 1). 10-year jail for digital rape. *The Hindu, Today's Paper, National*. Retrieved from <http://www.thehindu.com/todays-paper/tp-national/article2849290.ece>
- Killian, B., & Brakarsh, J. (2005). Therapeutic approaches to sexually abused children. In L. Richter, A. Dawes, & C. Higson-Smith (Eds.), *Sexual abuse of young children in southern Africa* (pp. 367-394). Cape Town: HSRC Press.
- Klein, D. N., Schwartz, J. E., Santiago, N. J., Vivian, D., & Vocisano, C. (2003). Therapeutic alliance in depression treatment: Controlling for prior change and patient characteristics. *Journal of Consulting and Clinical Psychology, 71*(6), 997-1006.
- Knell, S. M. (1995). *Cognitive-behavioural play therapy*. Maryland: Rowman & Littlefield.
- Krivacska, J. J. (1989). Primary prevention of child sexual abuse: Alternative, non-child directed approaches. *Interpersonal Psychotherapy, 1*(4). Retrieved from www.ipt-forensics.com/journal/volume1/j1_4_1.htm
- Krueger, R. B. & Kaplan, M. S. (2001). The Paraphilic and Hypersexual Disorders: An Overview. *Journal of Psychiatric Practice 7*(6), 391-403)
- Kuhl, P.K. (2010). Brain Mechanisms in Early Language Acquisition. *Neuron, 67*(5), 713-727.
- Lalor, K. (2004). Child sexual abuse in sub-Saharan Africa: A literature review. *Child Abuse and Neglect, 28*(4), 439-460.
- Lalor, K. (2005). Child Sexual Abuse in sub-Saharan Africa: Child protection implications for development policy makers and practitioners. Development Research Briefings, No.3, (pp.1-25). Retrieved from arrow.dit.ie/cgi/viewcontent.cgi?article=1001&Content=aaschsslrep
- Lamont, A. (2010). *Effects of child abuse and neglect for children and adolescents*. Melbourne: Australian Institute of Family Studies.
- Lane, R. C., Quintar, B., & Goeltz, W. B. (1998). Directions in Psychoanalysis. *Clinical Psychology Review, 18*(7), 857-883.
- Lanning, K. V. (2010). Child molesters: A behavioral analysis for professionals investigating the sexual exploitation of children. *National Center for Missing & Exploited Children, Office of Juvenile Justice and Delinquency Prevention (OJJDP)*. US Department of Justice. Retrieved from http://www.missingkids.com/en_US/publications/NC70.pdf
- Lather, P. (1986). Issues of validity in openly ideological research: Between a rock and a soft place. *Interchange, 17*(4), 63-84.

- Latif, A. (2001). *Counselling of children & adolescents*. Module CD 207. Harare: Zimbabwe Open University.
- Laws, D. R., & Marshall, W. L. (2003a). Sexual abuse: A brief history of behavioral and cognitive-behavioral approaches to sexual offenders. Part 1: Early developments. *A Journal of Research and Treatment*, 15(2), 75-92.
- Laws, D. R., & Marshall, W. L. (2003b). Sexual abuse: A brief history of behavioral and cognitive-behavioral approaches to sexual offenders. Part 2: The modern era. *A Journal of Research and Treatment*, 15(2), 93-120.
- LeCompte, M. D., Preissle, J., & Tesch, R. (1993). *Ethnography and qualitative design in educational research*. London: Academic Press.
- Leedy, P. D., & Ormrod, J. E. (2005). *Practical research: Planning and design*. Upper Saddle River: Pearson Prentice-Hall.
- Lennon, J. E., & Barbato, P. F. (2001). The emotions: A vocabulary before the language. *The Journal of the Imagination in Language Learning and Teaching*, VI. Retrieved from <http://www.njcu.edu/cill/vol6/lennon.html>
- Lindenfeld, D. (2009). Jungian Archetypes and the discourse of history. *The Journal of Theory and Practice*, 13(2), 217-234.
- Liu, Y. & Wang, C. (2011). Oedipus Complex in Literature Works. *Journal of Language Teaching and Research*, 2 (6), 1420-1424
- Loffell, J. (2005). Policy responses to child sexual abuse in South Africa. In L. Richter, A. Dawes, & C. Higson-Smith (Eds.), *Sexual abuse of young children in southern Africa* (pp. 250-262). Cape Town: HSRC Press.
- Lopez-Fernandez, O., & Molina-Azorin, J. F. (2011). The use of mixed-methods research in the field of behavioural sciences [Abstract]. *Quality & Quantity*, 45(6), 1459-1472. Retrieved from link.springer.com/article/10.1007/s11135-011-9543-9
- Luca, M. (2011). A qualitative study of psychodynamic and cognitive behavioural therapists' conceptualisations of medically unexplained symptoms in their clients. *Counselling and Psychotherapy Research: Linking research with practice*, 11(4), 291-299.
- Madu, S .N. (2001). Childhood forcible sexual abuse and victim-perpetrator relationship among a sample of secondary school students in the Northern Province (South Africa). *Crime Research in South Africa*, 2(2), 1-13. Retrieved from www.crisa.org.za/downloads/rape.pdf

- Makhubu, L. Y. (2005). *Dealing with sexually abused children: A framework for social workers in the South African justice system*. (Unpublished master's dissertation). University of South Africa, Pretoria.
- Makore-Rukuni, M. N. (2002a). *Assessment Methods in Counselling*. Module CD 205. Harare: Zimbabwe Open University.
- Makore-Rukuni, M. N. (2002b). *Assessment methods and techniques in counselling II*. Module CD 305. Harare: Zimbabwe Open University.
- Marmarosh, C. L., & Giorgio, A. T. (2013). Adult attachment anxiety: Using group therapy to promote change. *Journal of Clinical Psychology: In Session*, 69(11), 1172-1182.
- Martin, L., Turcotte, M., Matte, L., & Shepard, B. (2013). The counselling and psychotherapy profession in Canada: Regulatory processes and current status. *British Journal of Guidance & Counselling*, 41(1), 46-57.
- Maundeni, T. (2009). Care for children in Botswana: The social work role. *Social Work and Society International Online Journal*, 7(1), 13-27. Retrieved from <https://www.socwork.net/sws/article/view/41/344>
- Mberi, E., & Makore-Rukuni, M. N. (2001). *Counselling of special populations*. Module CD 101. Harare: Zimbabwe Open University.
- McClintock, L. (2002). *An evaluation of the management of children with ADHD (attention deficit hyperactivity disorder) in the classroom*. (Unpublished master's dissertation). Queens University of Belfast, Belfast. Retrieved from <http://gtcni.openrepository.com/gtcni/bitstream/2428/5828/7/>
- McGoldrick, M., & Gerson, R. (1985). *Genograms in family assessment*. New York, NY: Norton & Company.
- McGregor, K., Gautam, J., Glover, M., & Jülich, S. (2013). Health care and female survivors of childhood sexual abuse: Health professionals' perspectives. *Journal of Child Sexual Abuse*, 22, 761-775.
- McLeod, S. (2008). Psychosexual Stages. Retrieved from <http://www.simplypsychology.org/psychosexual.html>
- Meiselman, K. C. (1978). *Incest: A psychological study of causes and effects with treatment recommendations*. San Francisco: Jossey-Bass.
- Menard, C., Bandeen-Roche, K. J., & Chilcoat, H. D. (2004). Epidemiology of multiple childhood traumatic events: Child abuse, parental pathology, and other family-level stressors. *Social Psychiatry and Psychiatric Epidemiology*, 39(11), 857-865.

- Men's Health. (2011). *Klinefelter syndrome: Topic overview*. Retrieved from <http://men.webmd.com/tc/klinefelter-syndrome-topic-overview>
- Mfenqe, P. P. (2005). *The role of principals in the induction of new educators in their schools*. (Unpublished master's dissertation). Nelson Mandela Metropolitan University, Port Elizabeth. Retrieved from <http://www.nmmu.ac.za/documents/theses/pMfenqe.pdf>
- M.I.G.I.M.A. (2010). *Anatomical dolls & child sexual abuse prevention books, CDs & DVDs*. Retrieved from http://www.migima.com/shop/cart.php?target=product&product_id=1&Category_id=1
- Miller, L. (2013). Sexual offences against children: Patterns and motives. *Aggression and Violent Behaviour*, 18, 506-519.
- Misurell, J. R., Springer, C., & Tryon, W. W. (2011). Game-based cognitive-behavioral therapy (GB-CBT) group program for children who have experienced sexual abuse: A preliminary investigation. *Journal of Child Sexual Abuse*, 20(1), 14-36.
- Monahan, K., & Forgash, C. (2008). Enhancing the health care experiences of adult female survivors of childhood sexual abuse. *Women & Health*, 30(4), 27-41.
- Money, J. (1988). Commentary: Current status of sex research. *Journal of Psychology & Human Sexuality*, 1(1), 5-15.
- Morrison, K. (2004). Training updates. *Child Abuse Review*, 13(4), 277-284.
- Morrison, T. (1996). Partnership and collaboration: Rhetoric and reality. *Child Abuse & Neglect*, 20(2), 127-140.
- Moushey, B., & Dvorchak, B. (2012). *How the justice system fails victims of child abuse*. Retrieved from http://www.huffingtonpost.com/bill-moushey/game-over-child-abuse-justice_b_1429902.html
- Mullen, P. E., & Fleming, J. (1998). *Issues in child abuse prevention: Long term effects of child sexual abuse*. No. 9. Retrieved from <http://www.aifs.gov.au/nch/pubs/issues/issues9/issues9.html>
- Murray, L. K., Familiar, I., Skavenski, S., Jere, E., Cohen, J., Imasiku, M., Mayeya, J., Bass, J. K., & Bolton, P. (2013). An evaluation of trauma focused cognitive behavioural therapy for children in Zambia. *Child Abuse & Neglect*. 37, 1175-1185.
- Musoko, C. (2011, September 29). Zimbabwe: Child rape - a serious social disorder. *The Herald*. Retrieved from <http://allafrica.com/stories/201109290409.html>

- Mutandwa, C. (2012). *How can criminal justice work constructively with Shona justice to provide effective remedies to child sexual abuse victims?* Research partnership programme, Danish Institute for human rights (DIHR). Retrieved from <http://humanrights.dk/files/pdf/Engelsk/Research/RPP/Caleb-report-OK.pdf>
- Myer-Hopkins, N., & Laaser, M. (1995). *Restoring the soul of a church: Healing congregations wounded by clergy sexual misconduct*. Collegeville, MN: The Liturgical Press.
- Mynhardt, J. C., Appelgryn, A. E. M., Moore, C., & Nieuwoudt, J. M. (2008). *Readings in Social Psychology: Reader for PSY482-V*. Pretoria: University of South Africa.
- Nachmias, C., & Nachmias, D. (1990). *Research methods in the social sciences*. London: St. Martin's Press.
- Nelson-Jones, R. (2000). *Introduction to counselling skills: Text and activities*. London: Sage.
- Nelson-Jones, R. (2003). *Basic counselling skills: A helper's manual*. London: Sage.
- Nowell, A. (2012). Ethics. *International Journal of Psychology*, 47(1), 356-365.
- Oaklander, V. (2001). Gestalt play therapy. *International Journal of Play Therapy*, 10(2), 45-55.
- Oppenheim, A. N. (1979). *Questionnaire design and attitude measurement*. Reader in social psychology, London school of economics and political science. London: Heinemann.
- Ortmann, J. (1980). The treatment of sexual offenders: Castration and antihormone therapy. *International Journal of Law and Psychiatry*, 3(4), 443-451.
- Parliament of Zimbabwe. (2001). *Zimbabwe Sexual Offences Act [Chapter 9: 21] Acts 8/2001, 22/2001*. Retrieved from http://www.parlzim.gov.zw/attachments/article/95/SEXUAL_OFFENCES_ACT_9_21.pdf
- Patton, M. Q. (2002). *Qualitative research and evaluation methods*. London: Sage.
- Passarella, C. M., Mendes, D. D. & Mari, J. J. (2010). A systemic review to study the efficacy of cognitive behavioural therapy for sexually abused children and adolescents with posttraumatic stress disorder. *Revista de psiquiatria clinica*, 37(2), 60-65.
- Paulauskas, R. (2013). Is causal attribution of sexual deviation the cause of thinking errors? *International Education Studies*, 6(4), 20-28.
- Peel, T. & Peel, B. (2013). *Zimbabwe culture: Zimbabwe's culture is both rich and diverse*. Retrieved from <http://www.victoriafalls-guide.net/zimbabwe-culture.html>

- Pennstate Children's Hospital. (2010). Health & disease information: A to Z topics. *Child Sexual Abuse*. Retrieved from <http://www.hmc.psu.edu/childrens/>
- Perls, F. (1973). *The gestalt approach & eye witness to therapy*. New York, NY: Science and behavior books.
- Pervan, S., & Hunter, M. (2007). Cognitive distortions and social self-esteem in sexual offenders. *Applied Psychology in Criminal Justice*, 3(1), 75-91.
- Phasha, T. N. (2010). Educational resilience among African survivors of child sexual abuse in South Africa. *Journal of Black Studies*, 40(6), 1234-1253.
- Piaget, J. (1972). *Play, dreams and imitation in childhood*. London: Routledge & Kegan Paul Ltd.
- Pistorius, K. D., Feinauer, L. L., Harper, J. M., Stahmann, R. F., & Miller, R. B. (2008). Working with sexually abused children. *The American Journal of Family Therapy*, 36(3), 181-195.
- Polusny, M. A., & Follette, V. M. (1995). Long-term correlates of child sexual abuse: Theory and review of the empirical literature. *Applied and Preventive Psychology*, 4(3) 143-166.
- Prentky, R. A. (1997). Sexual abuse, arousal reduction in sexual offenders: A review of antiandrogen interventions. *A Journal of Research and Treatment*, 9(4), 335-347.
- Pryor, D. W. (1996). *Unspeakable acts: Why men sexually abuse children*. New York, NY: New York University Press.
- Psych Central. (2012). *Surviving child sexual abuse*. Retrieved from <http://psychcentral.com/lib/surviving-child-sexual-abuse/00014827>
- Rape, Abuse and Incest National Network (2009). *Sexual assault*. Retrieved from <http://www.rainn.org/get-information/types-of-sexual-assault/sexual-assault>
- Rector, R. (2012). *Out-of-wedlock childbearing and paternal absence: Trends and social effects*. Retrieved from <http://www.catholicculture.org/culture/library/view.cfm?recnum=1446>
- Regehr, C. & Glancy, G. (1997). Survivors of sexual abuse allege therapist negligence. *Journal of American Academy of Psychiatry and the Law*, 25(1), 49-58.
- Rhatigan, J., & O'Leary, E. (2004). Counselling in the area of child sexual abuse within the family. *International Journal for the Advancement of Counselling*, 13(1), 3-9.
- Richter, L., Dawes, A., & Higson-Smith, C. (2005). *Sexual abuse of young children in southern Africa*. Cape Town: HSRC Press.

- Richter, L. M., & Dawes, A. R. L. (2008). Child abuse in South Africa: Rights and wrongs. *Child Abuse Review, 17*(2), 79-93.
- Robins, R. W., Gosling, S. D., & Craik, K. H. (1999). An empirical analysis of trends in psychology. *American Psychologist, 54*(2), 117-128.
- Rogers, M. L. (1991). Evaluating an alleged satanic ritualistic abuser: What we don't know. *Interpersonal Psychotherapy 3*(3). Retrieved from www.ipt-forensics.com/journal/volume3/j3_3_4.htm
- Rosler, A., & Witztum, E. (2000). Pharmacotherapy of paraphilias in the next millennium. *Behavioural Sciences and the Law, 18*(1), 43-56.
- Rukuni, M. N., & Maunganidze, L. (2000). *Theories and practices in counselling*. Module CD 102. Harare: Zimbabwe Open University.
- Rukuni, M. N., & Maunganidze, L. (2001). *Theories and practices in counselling 2*. Harare: Zimbabwe Open University.
- Ryan, A., Safran, J. D., Doran, J. M., & Muran, C. (2011). Therapist mindfulness, alliance and treatment outcome. *Psychotherapy Research, 22*(3) 289-297.
- Sadan, M. (2005). Challenges of services evaluation in the Wynberg and Cape Town sexual offences courts and their related services. In L. Richter, A. Dawes, & C. Higson-Smith (Eds.), *Sexual abuse of young children in southern Africa* (pp. 367-394). Cape Town: HSRC Press.
- Sadan, M., Dikweni, L., & Cassiem, S. (2001). Pilot assessment. *The Sexual Offences Court in Wynberg & Cape Town and related services*. Retrieved from http://www.endvawnow.org/uploads/browser/files/assessment_Sexual_Offences_Court
- Save the Children Sweden. (2005). *Child sexual abuse and exploitation in South Africa*. Braamfontein: Aislinn Delany.
- Schaefer, C.E. (2011). *Foundations of Play Therapy*. New Jersey: John Wiley & Sons.
- Schwartz, B. K. (2008). *The sex offender: Offender evaluation and program strategies*. Kingston: Civic Research Institute.
- Scully, D., & Marolla, J. (1984). Convicted rapists' vocabulary of motive: Excuses and justifications. *Social Problems, 31*(5), 530-544.
- Shafer, I. (1999). *Remarriage in the church: Pastoral solutions*. Retrieved from <http://astro.temple.edu/~arcc/marriage.htm>
- Shechtman, Z., & Leichtentritt, J. (2010). Group therapy: The association of process with outcomes in child group therapy. *Psychotherapy Research, 20*(1), 8-21.

- Simon, L. M. J., Sales, B., Kaszniak, A., & Kahn, M. (1992). Characteristics of child molesters: Implications for the fixated-regressed dichotomy. *Journal of Interpersonal Violence*, 7(2), 211-225.
- Smith, L. M. (1994). Lifting the veil of secrecy: Mandatory child abuse reporting statutes may encourage the Catholic Church to report priests who molest children. *Law & Psychology Review*, 18 409-421.
- Smith, S., Adam, D., & Kirkpatrick, P. (2011). Using solution-focused communication to support patients. *Nursing Standard*, 25(52), 42-47.
- Southern African AIDS Trust. (2011). Guidelines for counselling on child sexual abuse: Supporting community responses to HIV and AIDS in southern Africa. *HIV Counselling Series*, 2. Retrieved from http://www.satregional.org/sites/default/files/publications/SAT_child_sexual_abuse_english.pdf
- Srsic, A. & Rice, E. H. (2012). Understanding the experience of girls with EBD in a gender-responsive support group. *Education and Treatment of Children*, 35(4), 623-646.
- Stokes, T. N. (1994). Counselling. *The British Journal of General practice: The Journal of the Royal College of General Practitioners*, 44(380), 139.
- S.T.O.R.M. TEXAS. (2010). *Signs of child abuse: Child abuse and neglect*. Retrieved from <http://stormtx.wordpress.com/child-abuse-stats/signs-of-child-abuse/>
- Strauss, A. & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory*. London: Sage.
- Suprina, J. S., & Chang, C. Y. (2005). Child abuse, society, and individual psychology: What's power got to do with it? *The Journal of Individual Psychology*, 61(3), 250-269.
- Terre Blanche, M. T., Durrheim, K., & Painter, D. (2007). *Research in practice: Applied methods for the social sciences*. Cape Town: UCT Press.
- Terry, K. J., & Tallon, J. (2004). *Child sexual abuse: A review of the literature*. New York, NY: John Jay College.
- The Holy Bible. (N.d). *The New Testament: King James Version*. Retrieved from <http://www.searchthebible.com>
- Thomas, C. (2009). *Forced and early marriage: A focus on central and Eastern Europe and former Soviet Union countries with selected laws from other countries*. Addis Ababa: United Nations.

- Townsend, L., & Dawes, A. R. L. 2005. Individual and contextual factors associated with the sexual abuse of children under 12: A review of recent literature. In Richter, A. Dawes, & C. Higson-Smith (Eds.), *Sexual abuse of young children in southern Africa* (pp. 55-94). Cape Town: HSRC Press
- Trinity College Dublin. (2003). *Student counselling service: Child sexual abuse*. Trinity College Dublin. Retrieved from www.mic.ul.ie/adminservices/counsellingservices/Documents/6ChildSexualAbuse.pdf
- UNICEF. (2001). *A study on street children in Zimbabwe*. Retrieved from http://www.unicef.org/evaldatabase/files/ZIM_01-805.pdf
- UNICEF. (2010). *Child protection: Child protection from violence, exploitation and abuse*. Retrieved from <http://www.unicef.org>
- UNICEF. (2012). *Caring for Child Survivors of Sexual Abuse: Guidelines for health and psychosocial service providers in humanitarian settings*. Retrieved from http://www.unicef.org/pacificislands/IRC_CCSGuide_FullGuide_lowres.pdf
- UNICEF Pacific. (2006). *Commercial sexual exploitation of children (CSEC) and child sexual abuse (CSA) in the Pacific: A regional report*. UNICEF, UNESCAP and ECPAT. Retrieved from [http://www.unicef.org/lac/Break_the_Silence_Initiative-Fact_sheet\(1\).pdf](http://www.unicef.org/lac/Break_the_Silence_Initiative-Fact_sheet(1).pdf)
- University of Southern Queensland. (2010). *Student services: What is counselling?* Retrieved from <http://www.usq.edu.au/student-services/counselling/whatiscounselling.htm>
- Urombo, R. (2000). *Ethics in counselling*. Module CD 104. Harare: Zimbabwe Open University.
- Valentino, K., Cicchetti, D., Toth, S. L., & Rogosch, F. A. (2006). Mother-child play and emerging social behaviours among infants from maltreating families. *Developmental psychology*, 42(3), 474-485.
- Vander Mey, B. J. (1988). The sexual victimization of male children: A review of previous research. *Child Abuse & Neglect*, 12,(1) 61-72.
- Van Niekerk, J. (2005). At the coalface: The Childline experience. In L. Richter, A. Dawes, & C. Higson-Smith (Eds.), *Sexual abuse of young children in southern Africa* (pp. 263-275). Cape Town: HSRC Press.
- Van Zijl, K. (2008). *The utilization of gestalt play therapy concepts and techniques with the pediatric hematology/oncology patient*. (Unpublished master's dissertation). Pretoria: University of South Africa.

- Veldhuis, C. B., & Freyd, J. J. (1999). *Groomed for silence, groomed for Betrayal*. In M. Rivera (Ed.), *Fragment by fragment: Feminist perspectives on memory and child sexual abuse* (pp. 254-282). Charlottetown, PEI: Gynergy Books.
- Walker, M. (2004). Supervising practitioners working with survivors of childhood abuse: Counter transference; secondary traumatization and terror. *Psychodynamic Practice: Individuals, Groups and Organisations*, 10(2), 173-193.
- Wagner-Moore, L. E. (2004). Gestalt therapy: Past, present, theory, and research. *Psychotherapy: Theory, Research, Practice, Training*, 41(2), 180-189.
- Wall, M. D., Amendt, J. H., Kleckner, T. & du Ree Bryant, R. (1989). Therapeutic compliments: Setting the stage for successful therapy. *Journal of Marital & Family Therapy*. 15(2), 159-167.
- Ward, T., Polaschek, D. L. L., & Beech, A. R. (2006). *Theories of sexual offending*. West Sussex: Wiley.
- Ward, T., Siegert, R. J. (2002). Toward a comprehensive theory of child sexual abuse: A theory knitting perspective. *Psychology, Crime & Law*, 8(4), 319-351.
- Waterhouse, L. (1993). *Child abuse & child abusers: Protection and prevention*. London: Jessica Kingsley.
- Whitehall, S. (2011). Fear can be conquered to allow a person to lead. *International Journal of Leadership Studies*, 7(1), 6-17. Retrieved from http://www.regent.edu/acad/global/publications/ijls/new/vol7iss1/IJLS_Vol7Iss1_Winter2011.pdf
- Widom, C. S. (1995). Victims of childhood sexual abuse: Later criminal consequences. *National Institute of Justice: Research in Brief*. Retrieved from <http://www.cj.msu.edu/>
- Willig, C. (2001). *Introducing qualitative research in psychology: Adventures in theory and method*. Buckingham: Open University Press.
- Women Organized Against Rape. (2013). *WOAR Counselling services*. Retrieved from <http://www.woar.org/counselling/children-services.php>
- Ziegler, D. J., & Hjelle, L. A. (1992). *Personality theories: Basic assumptions, research, and applications*. New York, NY: McGraw-Hill.
- Zululand EcoAdventures. (2011). *Zulu reed dance*. Retrieved from <http://www.eshowe.com/article/articlestatic/24/1/20/>

Appendix 1

SEMI-STRUCTURED INTERVIEW FOR COUNSELLORS

The researcher administered the interviews to all the participants individually due to the confidential nature of the study.

1. How do you prepare for a counselling session for sexually abused children?
2. Do you make a plan before handling any sexual abuse case?
3. How do you ensure confidentiality when dealing with such cases?
4. Which counselling techniques are you normally using for your child sexual abuse cases?
5. Which counselling approach/theory do you use when helping children who are sexually abused? If more than one, list them according to the one frequently used to the least used.
6. How many times do you follow up on child sexual abuse cases?
7. From the Childline perspective, comment on the procedure for handling child sexual abuse cases.
8. What other services do you offer to your clients who are sexually abused?
9. How do you deal with trigger issues? (These are emotions that are experienced by the counsellor due to the memories caused by the client's problems and these experiences can cause stress to the counsellor.)
10. From your experience, what are the successes you have experienced when you dealt with child sexual abuse cases?
11. Where do you think you need to improve in terms of helping children who are survivors of sexual abuse?
12. Can you think of any successful counselling story with a child who was sexually abused? Explain what happened.
13. Can you think of any unsuccessful counselling story with a child who was sexually abused? Explain what happened.
14. Which types of child sexual abuse cases have you handled at Childline?
15. What are your areas of expertise in helping children who are sexually abused?
16. How do you measure progress for your cases of sexual abuse?
17. What do you wish to achieve at the end of every session or counselling relationship?
18. How do you determine the time to terminate a counselling relationship with survivors of sexual abuse?

Appendix 2

SEMI-STRUCTURED INTERVIEW FOR CLIENTS AND CARE-GIVERS

To be responded to by participants aged 8 years and above; for children 7 years and under, their care-givers will respond due to language difficulties.

CLIENTS' PERSONAL INFORMATION REGARDING CHILD SEXUAL ABUSE

1. What was your first impression after the sexual abuse happened? (How did you find out that your child was sexually abused? – for guardians)
2. How did you react?
3. Who was the perpetrator?
4. What happened to the perpetrator?
5. What was the verdict or sentence of the case?
6. Did you feel or notice any changes in yourself after the sexual abuse? (Are there any changes in the survivor that were noticed after the abuse? – for guardians)

INFORMATION REGARDING CHILDLINE ZIMBABWE INTERVENTIONS

7. What happened to those changes (mentioned in number 6 above) after Childline's intervention?
8. What do you think could have happened if Childline had not intervened?
9. What type of change has happened since Childline intervention? State the positive or negative changes.
10. How did you feel after the initial intervention with Childline?
11. How do you value the home visits or phone calls made to you – do they change anything?
12. What do you wish to gain from a counselling relationship with a Childline counsellor?
13. Overall, what sort of services did you receive from Childline?
14. How did these services help you?
15. Generally, what makes you happy or unhappy about Childline's interventions?
16. Are there any suggestions for improvement that you would like to give to Childline?

Appendix 3

THE 8-ITEM SATISFACTION SCALE QUESTIONNAIRE (ISSQ) FOR COUNSELLORS

On a scale of 1-7, indicate to what extent you are satisfied with the following. Tick one box where you see appropriate:

KEY: 1 = Extremely not satisfied, 2 = Fairly not satisfied, 3 = Slightly not satisfied, 4 = Neither satisfied nor not satisfied, 5 = Slightly satisfied, 6 = Fairly satisfied, 7 = Extremely satisfied

How strongly are you satisfied or not satisfied with the following items representing aspects of counselling:

	Not satisfied			Satisfied			
	←						→
	Extremely	Fairly	Slightly	Neither	Slightly	Fairly	Extremely
	1	2	3	4	5	6	7
1. Counselling approaches for child sexual abuse cases							
2. Joining/relationship building with client							
3. Termination of sessions							
4. How you got the case							
5. Referral system							
6. Standardised procedure for Childline							
7. Counselling environment							
8. Counselling goals							

Appendix 4

THE 8-ITEM SATISFACTION SCALE QUESTIONNAIRE FOR CLIENTS AND CARE-GIVERS

On a scale of 1-7, indicate to what extent you are satisfied with the following. Tick one box where you see appropriate:

KEY: 1 = Extremely not satisfied, 2 = Fairly not satisfied, 3 = Slightly not satisfied, 4 = Neither satisfied nor not satisfied, 5 = Slightly satisfied, 6 = Fairly satisfied, 7 = Extremely satisfied

How strongly are you satisfied or not satisfied with the following items representing aspects of counselling:

	Not satisfied ←				→ Satisfied		
	Extremely	Fairly	Slightly	Neither	Slightly	Fairly	Extremely
	1	2	3	4	5	6	7
1. Counselling session/s and process from joining to termination							
2. Language use							
3. Services offered							
4. Counsellor's presentation							
5. Advice given or referral system							
6. Confidentiality observation							
7. Counselling environment							
8. Follow-up methods e.g. phone, client visiting Childline, letters and home visits							

Appendix 5 A

INFORMED CONSENT FORM FOR PARTICIPANTS

Dear Research Participant

My name is Julliet Masama. My contact details are: No. 67 Lomagundi Road, Avondale West, Harare, Zimbabwe. My telephone number is +263 912 346 745.

I am a student studying towards a Master's degree in Psychology at the University of South Africa (UNISA). I am conducting a research regarding the counselling services offered by Childline Zimbabwe to its clients.

I am interested in finding out more about the counselling approaches used by the counsellors at Childline Zimbabwe and to find out whether the approaches are benefiting the survivors of child sexual abuse. I am carrying out this research for two main reasons: (i) to show exactly what Childline Zimbabwe counselling department is doing and, (ii) to help the counsellors or social workers at Childline Zimbabwe to improve their services to the communities. The purposes of this research are to test the quality of counselling services offered to survivors of child sexual abuse by Childline counsellors and to explore the satisfaction of the clients from the counselling services received from Childline social workers/counsellors.

The results of the study will be documented in a thesis. No personally identifiable details will be released; only averaged information will be used. I have chosen you to respond to my research questions because:

- 1 You are one of the Childline counsellors and you are offering counselling services to Childline clients.
- 2 You are one of the Childline clients and you are receiving counselling services offered by Childline Zimbabwe.

You have the right NOT to answer any question that you feel uncomfortable with, or to withdraw from the research project any time you feel like doing so.

Your response to each question asked is of utmost importance. There are no right or wrong answers. The researcher will not reveal under any circumstances, your personal information to any third party as all the information you provide will be treated as strictly confidential as possible. The interview process will take approximately less than an hour. If you do not understand any of the questions, please feel free to ask me for clarity.

Afterwards, a short questionnaire will be administered to you on completion of the interview. The questionnaire will approximately take 10 minutes.

I (names in full) hereby agree to participate in research regarding Childline's counselling services to the survivors of child sexual abuse. I understand that I am participating freely and without being forced in any way to do so. I also understand that I can withdraw from this participation at any time should I not want to continue and that this decision will not in any way affect me negatively.

The purpose of the study has been explained to me, and I understand what is expected of my participation. I understand that this is a research project and its purpose is not necessarily to benefit me personally.

I have received the telephone number of a person to contact should I need to speak about any issues that may arise from this participation.

I understand that this consent form will not be linked to the interview and questionnaire, and that my answers will remain confidential.

I understand that, if at all possible, feedback will be given to my organization or be published as the results of the completed research.

For additional information or questions, you can contact my supervisor:

*Mr George M. Skosana
University of South Africa (UNISA)
Department of Psychology
Tel: +27 12 429 2093. Fax: +27 12 429 3414*

.....
Signature of participant

.....
Date

.....
Signature of Researcher

.....
Date

Appendix 5 B

ADDITIONAL CONSENT TO AUDIO RECORDING

In addition to the above consent to participate in the research, I hereby consent/do not consent to the audio recording of this interview for the purpose of data capturing. I understand that no personally identifying information or recording concerning me will be released in any form. I understand that these recordings will be kept in a safe environment and will be erased once data capture and analysis have been completed.

.....

Signature of participant

.....

Date

.....

Signature of Researcher

.....

Date

Thank you for your co-operation.

Appendix 6

ETHICS

Based on Paul Davidson Reynolds' (1979) Composite code of ethics, cited in Nachmias and Nachmias (1990, pp.333-337).

1. I showed my responsibility in the execution of the research project and I was in charge of all decisions regarding procedural matters and ethical issues related to the project.
2. I was consistent with all the actions conducted as part of this research and I was consistent with the ethical standards of both Childline Zimbabwe workers and the community.
3. I considered the ethical issues from the perspective of the participant's society.
4. I was aware that if unresolved or difficult ethical dilemmas were to arise during data collection, assistance or consultation would be sought with colleagues or appropriate professionals.
5. I used informed consent in obtaining participants for the research.
6. Participants were in a position to give informed consent otherwise it should be given by those responsible for the participants.
7. Informed consent was at all times obtained in writing.
8. I sought official permission from the management to use any organisational data (case reports, general statistics of CSA cases, counselling guide and codes of conduct).
9. Participants were fully aware of all data gathering techniques (mp3 devices), the capacities of such techniques, and the extent to which participants will remain anonymous and data confidential.
10. Participants had the option to refuse to participate in the research.
11. Participants knew that they had an option to be able to terminate involvement at any time.
12. I used no coercion (explicit or overt), to encourage individuals to participate in the research project.
13. The dignity, privacy, and interests of the participants were respected and protected.
14. I ensured that the welfare of all participants took priority over all other concerns.
15. Privacy was always considered in the perspective of the participants and the participants' culture.
16. I organised my data through the use of pseudonyms such that anonymity of participants was ensured.

17. Where confidentiality or anonymity could not be guaranteed, the participants were made aware of this and its possible consequences before involvement in the research. Hence, I told them that sensitive child sexual abuse information will be discussed and that they should feel free to discuss such issues.

.....
Signature of Researcher

.....
Date

Appendix 7

ETHICS AROUND RESEARCH FINDINGS

1. Research data would be confidential and all participants would remain anonymous, unless they (or their legal guardians) have given permission for release of their identity.
2. The final research report would be a public document that will be freely available to all.
3. The final document would be kept and accessible from the director of Childline Zimbabwe and also in the counselling department of Childline.
4. I have described research procedures fully and accurately in the final report, including all evidence; my conclusions were objective and unbiased.
5. I provided full and complete interpretations for all data and I prevented misinterpretations in writing my final research report.
6. Since Zimbabwe has various ethnical groups and is multicultural, I used English which is a neutral language of the host society.
7. I also gave appropriate credit to all participants contributing to this research.

.....

Signature of Researcher:

.....

Date

Appendix 8

PROFESSIONAL CODE OF CONDUCT

As a researcher, I needed to be ethical in the way of executing the study so that I could contribute to the development of systematic and verifiable knowledge regarding the counselling of sexually abused children (as suggested by Nachmias & Nachmias, 1990). According to Nachmias and Nachmias (1990), the ethical “codes comprise the consensus of values within the profession” (p. 332). Below are the ethics that professionally guided me during the execution of this study:

1. I conducted the research while maintaining the integrity of the research enterprise and not to diminish the potential for conducting research in the future.
2. I used my best scientific judgment for selection of issues for empirical investigation.
3. I considered and evaluated the potential benefits to the participants and the society at large when I decided to conduct the study with human subjects.
4. I explained to the participants about the risks including potential therapeutic effects and that they were free to ask for further counselling from Childline if they needed it.
5. I conducted this research so that it represented competent, objective and scientific findings.
6. I was precise and made sure that there was no bias in the design, conduct or reporting of the research findings; I was as objective as possible.
7. I described the procedure used to select and obtain the participants (see Appendix 5 A, sections 1 and 2).
8. I explained to all participants what would happen to the research report (see Appendix 7).
9. Names and addresses of the researcher should be left with participants so that the researcher can be traced subsequently (see Appendix 5 A).
10. I made every effort to be familiar with, and respect, the host cultures in which the study was being conducted.
11. I presented myself and cooperated with members of the host society.

.....

Signature of Researcher

Appendix 9 A

DEMOGRAPHIC DATA FOR COUNSELLORS

Date:	
Gender of counsellor	
Male	1
Female	2
Age of counsellor	Years:
Educational level (circle the appropriate number)	
Preschool	1
Primary	2
Secondary	3
Tertiary	4
Other (please specify)	5
Qualifications obtained (circle the appropriate number)	
Certificate	1
Diploma	2
Degree	3
Other (please specify)	4
Marital status (for counsellors), circle the appropriate number)	
Single	1
Dating	2
Married	3
Divorced	4
Widowed	5
Other (please specify)	6

Appendix 9 B**TYPES OF CHILD SEXUAL ABUSE DEALT WITH**

Type of child sexual abuse dealt with (circle the appropriate number)	
Rape	1
Incest	2
Sodomy	3
Penetrative sex	4
Indecent assault	5
Oral sex	6
Child marriage	7
Child abduction	8
Child pornography	9
Other (please specify)	10

Appendix 10 A

DEMOGRAPHIC DATA FOR CHILDREN

Date:	
Gender of child	
Male	1
Female	2
Age of child	Years:
Educational level	
Infant	1
Preschool	2
Primary	3
Secondary	4
Other (please specify)	5

Appendix 10 B**TYPE OF CHILD SEXUAL ABUSE EXPERIENCED**

Type of child sexual abuse experienced (circle the appropriate number)	
Rape	1
Incest	2
Sodomy	3
Penetrative sex	4
Indecent assault	5
Oral sex	6
Child marriage	7
Child abduction	8
Child pornography	9
Other (please specify)	10

Appendix 11 A

CHILDLINE DROP-IN REPORT FORM



CHILDLINE ZIMBABWE

(Please complete as fully as possible)

Case No Date

Length of visit Time

IDENTIFICATION PARTICULARS

Name of child and/or Name of visitor

Date of birth () Sex:

Child's address Visitors add. (If diff)

.....

Telephone Tel

Relationship of visitor to child

Problem category

Sexual Physical Neglect Emotional Child labour

Pregnancy School based Financial Relations Health

HIV and AIDS JD/truancy Legal Custody Birth reg

Suicidal Bullying Other (state nature)

NATURE OF THE PROBLEM (brief)

.....

.....

.....

.....

CLIENT'S OWN STORY

.....
.....
.....
.....
.....

GENERAL COMMENTS (Evaluation)

.....
.....
.....
.....

ACTION TAKEN/TO BE TAKEN/RECOMMENDATIONS

.....
.....
.....
.....

GENOGRAM

Diary Date: (*next appt)

Counsellor

Date Place of interview

Appendix 11 B



DROP-IN FOLLOW-UP FORM (FOLLOW-UP AND HOME VISIT CONTINUATION FORM)

CHILDLINE ZIMBABWE

Social Worker/Volunteer

Date of Visit

Origin of case

Drop-in	Referral (include source name)	Aerogram	Helpline	Outreach	Other

Case Number

Nature of follow up:

Phone call Call duration

Home visit Home visit # Home visit duration

Counselling session #

Person seen at time of visit and relationship to client (If different)

.....

Perpetrator (if applicable)

.....

No. of children seen:

Case Assessment 1 2 3

Case Details/Current Situation

.....
.....
.....
.....
.....
.....

Plan

- *
- *
- *
- *

Case Status (Please explain, giving reasons whether the case is closed, ongoing or referred)

.....
.....
.....

Signed

Date

Appendix 12

HELPLINE FILL-IN FORM



CHILDLINE ZIMBABWE

<i>For Office Use Only</i>		
Copy of Form Sent	Date	Initial

CHILDLINE ZIMBABWE – CALL REPORT SHEET: CONFIDENTIAL

Case No Volunteer Name Vol No Date

Time of Call	Duration of Call (mins)	Call from:	
		Home	<input type="text"/>
		School	<input type="text"/>
		Phone Box	<input type="text"/>
		Other	<input type="text"/>

Caller Details (i.e. always the person who calls)

FC	<input type="text"/>
MC	<input type="text"/>
AF	<input type="text"/>
AM	<input type="text"/>

Third Party Details (i.e. if call is mainly about a child other than the caller)

FC	<input type="text"/>
MC	<input type="text"/>
AF	<input type="text"/>
AM	<input type="text"/>

Age/School Grade

Name: 1st
Last

Name: 1st
Last

Address:

Town:

Address:

Town:

Tel No:
School:
Language used:

Tel No:
School:
Caller/Third Party Relationship:

CONCERNS / PROBLEMS

(The main headings you would use to describe the call for instance sexual abuse, relationship problems, alcohol/drugs, pregnancy etc.).

- 1.
- 2.
- 3.
- 4.

REFERRAL/FOLLOW UP

(Indicate if any action needs to be taken or has to be taken as a result of the calls e.g. referral to Childline Social Workers or for counselling/stickers/send information etc.).

.....

.....

.....

.....

CALL DETAILS (continue on follow-up sheet if necessary)

.....

.....

.....

.....

Appendix 13

CLIENT'S DATA FORM



CHILDLINE ZIMBABWE

CHILDLINE ZIMBABWE – CLIENT DATA FORM: CONFIDENTIAL

Nature of contact: <input type="checkbox"/> Drop-in <input type="checkbox"/> Outreach <input type="checkbox"/> Helpline <input type="checkbox"/> Aerogramme <input type="checkbox"/> Email	Child status: <input type="checkbox"/> SPO <input type="checkbox"/> SMO <input type="checkbox"/> DO <input type="checkbox"/> Vulnerable <hr/> Location <input type="checkbox"/> Rural <input type="checkbox"/> Urban.....	Gender of child: <input type="checkbox"/> Male <input type="checkbox"/> Female	Child's age: <input type="checkbox"/> 0-6yrs <input type="checkbox"/> 7-9 yrs <input type="checkbox"/> 10-12 yrs <input type="checkbox"/> 13-15 yrs <input type="checkbox"/> 16-17 yrs <input type="checkbox"/> 18 + yrs <input type="checkbox"/> Unknown
Who was the child staying with at the time of the contact: <input type="checkbox"/> Family <input type="checkbox"/> Extended family <input type="checkbox"/> Living alone <input type="checkbox"/> Living with friends <input type="checkbox"/> Street <input type="checkbox"/> Shelter/institution <input type="checkbox"/> Other <input type="checkbox"/> Unknown	Reason for contact: <input type="checkbox"/> Physical abuse <input type="checkbox"/> Sexual abuse <input type="checkbox"/> Emotional abuse <input type="checkbox"/> Neglect <input type="checkbox"/> Witness to violence <input type="checkbox"/> Bullying <input type="checkbox"/> Domestic violence <input type="checkbox"/> Unspecified other	Commercial exploitation: <input type="checkbox"/> Bonded child labour <input type="checkbox"/> Domestic child labour <input type="checkbox"/> Child prostitution/child sexual exploitation <input type="checkbox"/> Child trafficking <input type="checkbox"/> Other child labour <input type="checkbox"/> Kidnapping <input type="checkbox"/> Children being used for begging <input type="checkbox"/> Children used for criminal activity <input type="checkbox"/> Children in armed conflict <input type="checkbox"/> Unspecified and other	
Homelessness/runaways/basic needs: <input type="checkbox"/> Seeking shelter <input type="checkbox"/> Missing children <input type="checkbox"/> Children calling for food <input type="checkbox"/> Repatriation <input type="checkbox"/> Employment opportunities <input type="checkbox"/> Death of a child on the street <input type="checkbox"/> Abandoned <input type="checkbox"/> Orphaned <input type="checkbox"/> Financial aid & resources <input type="checkbox"/> Unspecified and other	HIV & AIDS: <input type="checkbox"/> Bereavement <input type="checkbox"/> Parents (or family) with HIV/ AIDS <input type="checkbox"/> Children living with HIV/ AIDS <input type="checkbox"/> Children orphaned due to HIV/ AIDS <input type="checkbox"/> Information about AIDS <input type="checkbox"/> Unspecified and other	Peer relationships: <input type="checkbox"/> Problems with friends <input type="checkbox"/> Partner relationships <input type="checkbox"/> Unspecified and other	

<p>School-related:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Teacher problems <input type="checkbox"/> Other adult-related problems <input type="checkbox"/> Academic problems <input type="checkbox"/> Performance anxiety <input type="checkbox"/> Homework <input type="checkbox"/> School drop-outs <input type="checkbox"/> Unspecified & other 	<p>Legal matters:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Advice & information <input type="checkbox"/> Child in need of legal representation <input type="checkbox"/> Child witness <input type="checkbox"/> Birth registration <input type="checkbox"/> Law in conflict with children's rights <input type="checkbox"/> Child marriage <input type="checkbox"/> Unspecified & other 	<p>Child substance use and abuse:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Information on substances & misuse <input type="checkbox"/> Addiction <input type="checkbox"/> Unspecified & other
<p>Disabled child:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Child disability <input type="checkbox"/> Parent disability 	<p>Sexuality:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Information about sexuality & facts of life <input type="checkbox"/> Pregnancy <input type="checkbox"/> Sexual identity <input type="checkbox"/> STIs/STDs <input type="checkbox"/> Contraception <input type="checkbox"/> Masturbation <input type="checkbox"/> Sexual fantasy <input type="checkbox"/> Unspecified & other 	<p>Family relationships:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Divorced/separated/parents in conflict <input type="checkbox"/> Child custody and access <input type="checkbox"/> Maintenance and child support <input type="checkbox"/> Parent/child relationships <input type="checkbox"/> Sibling relationships <input type="checkbox"/> New family/blended family <input type="checkbox"/> Bereavement <input type="checkbox"/> Adoption issues <input type="checkbox"/> Parents with addiction or mental health problems <input type="checkbox"/> Unspecified & other
<p>Psycho-social/mental health:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Boredom <input type="checkbox"/> Body/physical appearance <input type="checkbox"/> Loneliness <input type="checkbox"/> Lack of confidence <input type="checkbox"/> Eating disorders <input type="checkbox"/> Fear & anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Identity & purpose of life <input type="checkbox"/> Phobias & obsessions <input type="checkbox"/> Self-harm <input type="checkbox"/> Suicide <input type="checkbox"/> Unspecified & other 	<p>Physical health:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Access to health care <input type="checkbox"/> Concerns about illness <input type="checkbox"/> Hospitalisation <input type="checkbox"/> Unspecified & other 	<p>Information requested:</p> <ul style="list-style-type: none"> <input type="checkbox"/> About the Helpline <input type="checkbox"/> About children's issues/rights <input type="checkbox"/> Thank you for assistance <input type="checkbox"/> Unspecified & other
<p>Discrimination:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Racism-related <input type="checkbox"/> Immigration-related <input type="checkbox"/> Employment-related <input type="checkbox"/> Access to education <input type="checkbox"/> Mental & physical health <input type="checkbox"/> Unspecified & other 		

Appendix 14

THE INFORMATION RECORDED ON CASE REPORTS

CLIENT IDENTIFICATION PARTICULARS

- Full name
- Age/date of birth
- Sex of child
- Care-giver/reporter's details
- Language used
- Contact details: home address, school, telephone numbers, email address
- Directions to get to the child victim

CHILD'S STORY

- Background information pertaining to the client's problem
- The types of abuse experienced by the client
- The main issues and counselling goals of the child client

PROBLEM CATEGORY (SEXUAL)

Incest, rape, sodomy, indecent assault, pornography, statutory rape, digital penetration, child marriage, indecent exposure, pregnancy, child play, homosexuality, fondling and oral sex.

Genogram

Family background
Other support systems

ABUSER DETAILS

- Name, age, address and relationship to child

FOLLOW-UP

- Telephone
- Home visit
- Visit to other stakeholders
- Child coming to Childline offices

ACTION TAKEN/TO BE TAKEN

- What the counsellor has done
- The counsellor's plans and actions taken and to be taken
- Referral system
- Where intervention took place
- Name of counsellor

CASE EVALUATION

- Counsellor's own assessment of the case, whether serious, urgent or easy to follow.
- Vulnerability status of the child client
- Details whether case is ongoing, closed or referred.

CASE SOURCE

Whether the case came to Childline via the:

- Drop-in
- Helpline

CASE INFORMATION

- Case number
- Date of report
- Time of report
- Duration of session

Appendix 15

CASE REFERRAL FORM

(From Childline Zimbabwe to a treatment team member)



CHILDLINE ZIMBABWE

To: Date:

 Case Reference No

Dear Sir/Madam

Re: REFERRAL FOR SERVICES FROM YOU/YOUR ORGANISATION FOR:

Our client, Mr/Ms/Mrs/Miss Date of Birth: (M) / (F)

Of address:

Contact No.:

is being referred to you for your attention.

Nature of concern(s):

.....

Proposed action for you to take:

.....

Yours sincerely

Name: Signed:

Position:

----- Tear off -----

Please fill in this section of the referral form, tear it off and return it to the referrer.

Client's name:

Reference number (if applicable):

Action taken by you/your organisation:
.....
.....
.....
.....
.....

Name:

Signature:

Contact No:

Position:

Date:.....

Appendix 16

EXAMPLES OF THE RECORDED OBSERVATIONS

Observation 1:

Place: Childline Zimbabwe training room

Date: 06-04-2009

Time: 8 am.

Description: All the staff members at Childline Zimbabwe participated in the meeting where each member presented what they worked on the previous week and their work plans for the following week. Childline counsellors presented various children's cases, regarding the interventions, challenges, successes and outcomes from the work done. The researcher (one of the counsellors) recorded all the relevant information being said by the other counsellors.

Observation 2:

Place: Childline counselling room

Date: 12-03-2009

Time: 12 noon.

Description: The researcher was present in the counselling room while counsellor B had a counselling session with a child client. The researcher recorded relevant information such as the counselling methods used, the verbal and non-verbal communication skills between the counsellor and the client, how play therapy was utilised and the joining and termination of the counselling session.

Observation 3:

Place: Glenview Township, Harare

Date: 09-03-2009

Time: 2 pm.

Description: The researcher went for a home visit with counsellor A and was present in the sessions that the counsellor did. The counsellor first had a session with the child client and afterwards with the caregivers of the child. The child was then brought to a place of safety in the neighbourhood. The researcher observed all the interventions and recorded the important information including the two counselling sessions done with the client and with the caregivers then how the child was placed in a place of safety.

Appendix 17

EXAMPLES OF INFORMATION RECORDED IN THE LOG BOOK / AUDIT TRAIL

Meeting with the counselling supervisor

Date: 30 March 2009

Place: Avondale shopping centre

Participants: The researcher and the counselling supervisor

Description: The researcher shared her ideas of wanting to embark on a study with her counselling supervisor. From this discussion, it came up that it was better to adopt a research design that would involve collection of both qualitative and quantitative data. Data collection methods were identified as semi-structured interviews, questionnaires and analysis of Childline Zimbabwe documents such as statistics of child sexual abuse. The supervisor also suggested that data could be analysed through the use of Epi Info; a software package designed for epidemiologic statistics used by public health community of practitioners and researchers. Together with the supervisor the researcher discussed how grounded theory could also be adopted in the study.

Departmental Meeting

Date: 8 May 2009

Place: Childline training room

Description: A meeting was held in the counselling department to discuss counsellors' concerns regarding the services they were providing and the researcher's intentions to do the research with Childline counsellors and their clients. Present were the counselling manager, the researcher and four counsellors at the Harare office. The questions asked by the participants and answers provided were noted. Below is an extract of the issues discussed:

- The counselling manager explained the main issues to be discussed in the meeting.
- The use of the standardized Childline counselling procedure was a cause of concern as all counsellors were urged to make sure that clients had to pass through the important stakeholders such as the police's victim friendly unit, the hospital's family support trust and the department of social welfare.
- This procedure was done in order to fulfil the holistic nature of the child sexual abuse problem.

- Counsellors explained that it came with challenges that for some cases, counsellors found it difficult to involve all the necessary organisations due to transport problems and limited cooperation by these stakeholders.

The researcher then introduced the study to all the counsellors. Counsellors asked some questions regarding the research process. Below is an extract from the discussion:

Counsellor D: How are our responses going to be treated in the final report?

Researcher: The confidentiality of all the participants is going to be respected. No names would be mentioned and pseudonyms were going to be used.

Counsellor B: When you visit our clients, do we have to be present because they do not know you?

Researcher: It is not necessary for you to be present while I collect research information from your clients, I will explain my purposes of visiting them and I will also let them know that participation is on voluntary basis. That they can choose information they like to share with me.

Email communication

Date: 06 July 2009

Time: 12:50pm

Place: Childline Zimbabwe Harare office

Description: The researcher sent an email to the director of Childline explaining how she intended to do her masters in psychology study. The director replied affirming the importance of such a study to Childline Zimbabwe and commented on the selection of research participants. Below is the extract from the director's e-mail: [Julliet, this looks great, I would really appreciate if Bulawayo branch could be included in this, we could look in covering your expenses for two nights in Bulawayo and maybe do six interviews in Bulawayo. Let me know your thoughts, Thanks]. The researcher welcomed the director's advice. This helped the researcher in the identification of research participants. Initially the researcher had a plan of basing her result in the Harare branch only. Both the researcher's email and the director's reply were printed and filed.

Data Collection in Bulawayo

Date: 29 July to 31 July 2009

Time: 8am to 5pm

Place: Bulawayo branch

Description: The researcher visited the Bulawayo Childline branch for three days. During her stay in Bulawayo, the researcher had a meeting with the Childline social worker where challenges faced by this branch were identified. The social worker illustrated how difficult it was for her as the only one serving the whole province, she had problems of burnout, work overload and only one car for all staff members in this branch was not enough. She had so many urgent cases and it always took time before she could address initial cases. Afterwards, the five client children who would participate in the research were identified. The five case reports were collected and photocopied. The researcher together with the Bulawayo social worker did home visits for the children clients in Bulawayo. The researcher had an opportunity to observe some of the social worker's counselling sessions. One such session was where the counsellor made use of anatomic dolls that she brought to the child's home. The child demonstrated the rape act that she experienced by use of the dolls. Semi-structured interviews and ISSQ were administered to three client children and a separate set of interview and questionnaire was administered to the social worker.