THEME ONE - DEFINING STRESS, CRISIS AND TRAUMA

Stress:

- The strain we feel at different times in our lives or in different situations.
- A set of external forces impinging on an individual (unemployment, high crime rate)
- A set of psychological and physiological reactions experienced – sweaty hands, racing heart, negative self-talk.
- Nerves, anxiety, panic, tension, pressure.
- Stress should be considered an opportunity for growth; the spark that pushes us to challenge the situations we find ourselves in and to find new ways of coping.

The extent to which the individual experiences stress depends on:

- The event itself
- The individual's personality
- The individual's ability to cope

Crisis:

- A normal reaction that an individual has to a difficult experience that they have not had to face before.
- When a person is in a crisis they feel confused, overwhelmed and unable to cope.
- It may be an external event - work related, losing money; or an internal event caused by development – becoming a wife etc.
- Crisis can be a turning point – an opportunity for an individual to discover and use inner strengths to adjust to a changing world, find relevant supportive resources and learn new skills that can be generalised to resolve future crises.

Trauma:

- Situations "*in which the victims are rendered powerless and great danger is involved*"
- A profound deviation from normal life experiences
- Sudden, overwhelming and unanticipated.
- Individual experiences fear, helplessness. Loss of control and extreme powerlessness.
- The trauma inducing situations suggests a threat of injury or death of the person or others around them.
- Expected loss – parent, job. Loosing several family members, or an accident, natural disaster = unexpected, overwhelming, out of the ordinary.

Judith Herman: "*Traumatic events are extraordinary, not because they occur rarely, but rather because they overwhelm the ordinary human adaptions to life"*

- Involve threats to life or bodily integrity, or close personal encounter with violence and death.
- Individual feels helplessness and terror

The effects of trauma:

- Because of intensity and magnitude, trauma overtaxes the human's ability to cope.
- May damage the mental health.
- Traumatised people feel and act as though their nervous systems have been disconnected from the present.
- Person is left with a persistent expectation of danger, an imprint of the traumatic event that does not want to fade and a numbing response of giving up that becomes generalised.
- Impact of trauma on psyche has major influence on the individual's normal ways of thinking and feeling – so previous coping mechanisms are no longer effective / functional.
- Traumatic events may impact on the person's personhood, individuality and humanity. The impact of the trauma may be aggravated by the insensitive handling of those who deal with them after their traumatic event.

Different kinds of trauma

Caused by nature – natural disaster: flood, fires, hurricanes
Caused by humans – an atrocity – man made catastrophes: war, terrorism, bus disasters, civil unrest
Unintentional violence – car accident, culpable homicide
Intentional violence – physical assault, sexual assault, domestic violence, hijacking – all of which encompasses forms of victimisation involving a threat to life, health and limb. Sexual trauma falls within this category.

Direct vs indirect trauma

- Traumatic event may affect witnesses and those who have direct contact with the direct victim = **indirect traumatisation.** Any person who witnesses a death, rape, assault of another is at risk of being traumatised.
- Symptoms experienced by victims of indirect trauma can be identical to those of the victims of direct trauma.
- Policeman, journalists, helping professionals – need to take precautions against this; have access to debriefing sessions
- Loved ones and family members / children of victims of trauma also can suffer indirect trauma.
- An individual can be both a direct and indirect victim of trauma. i.e. child witnesses mother being raped (indirect) whilst being held hostage during a robbery (direct)

Single vs Multiple trauma

Single event – armed robbery / loss of a limb / cancer
Multiple – a person who has been hijacked several times.

Continuous vs complex trauma

Continuous traumatic stress:

- where people are exposed to on-going trauma. i.e live in areas of high levels of violence and constantly exposed and constant threat.
- They appear to develop a 'numbing' response to any new or additional traumatic events, making it more difficult to detect they are traumatised.
- May be mistakenly regarded as being lethargic / depressed. As they don't understand what is happening to them – they don't ask for help.

Complex trauma:

- situations in which victims experience prolonged repeated traumatic events; usually a relationship between the victim and the offender .
- Marital rape / child who is sexually abused by parent.
- Very damaging – victim is under the control of the offender and cannot escape for extended periods

People respond differently to all experiences of stress / crises. What is stressful to one person, may be regarded as a crisis by another, and as trauma by another.
There is a hypothetical continuum that plots stress, crisis and trauma and demonstrates the increase in intensity from stress to trauma. Each person perceives his or her individual experiences in a unique way and practitioners should never use their definition of stress crisis and trauma, but the client's definitions.

Defining Sexual Trauma

i. It's a trauma of a sexual nature
ii. The trauma creates emotional turmoil for the survivor
iii. The trauma may impair the trauma survivors functioning in certain areas, such as self-esteem, relationships and others with sexuality.
iv. These problems may only manifest much later, when the4 survivor develops an understanding of the wrongness of the activities he or she participated in, given that his or her participation my even have been passive.

- Sexual trauma often involves not just one single event, but a series of events.
- Sexual trauma affects a person's sexual adjustment, wounds their soul, and impacts on many areas of his or her social functioning, creates havoc with health (HIV after rape)

Critical issue: the extent to which a person is affected by an unanticipated outcome. It is trauma when it is unanticipated, the victim experiences a sense of powerlessness and has to deal with perceived threats to the self of loves ones.

Rape and child sexual abuse

Physiological origins of sexual trauma

Theories – impotence, cancer of the genitals, HIV, infertility – all create a sense of helplessness, they are unplanned and unexpected, thereby creating confusing in the lives of

their victims. They impact on self-esteem, relationships with others, sexuality and can be life threatening (HIV, Cancer)

Female Genital mutilation – a traditional practice in some African cultures – may result in sexual trauma.

The impact of Trauma

- Trauma is a blend of different behaviours, feelings and physical responses.
- You cannot stereotype survivors with a set of responses.
- Symptoms should always been seen as normal responses to abnormal situations.
- Vast variables at work when individual is traumatised: age at the time of incident, relationship with the perpetrator; their gender; duration of trauma, amt. of violence involved, psychological history, perspective of the trauma.

The body's response to an abnormal amount of stress

- Threat arouses the sympathetic nervous system, causing an adrenalin rush, and the threatened person to go into a state of alert;
- Invokes feelings of fear and anger, person becomes poised for strenuous action to **fight** or to **escape** the threat.
- When the person is unable to resist, escape, then a traumatic reaction occurs. Person's self-defence system becomes confused and disorganised, resulting in person having prolonged changes in physical arousal, emotion, cognition and memory.
- These individuals startle easily and usually have strong reaction to stimuli that may be associated with the traumatic event. The increase in arousal effects sleep and wakeful times.

Responses to fight and escape described as **approach** and **avoidance** (Roth & Cohen)
Processes may be unconscious, conscious or both.
Approach enables the person to be prepared for the acute stressful event.

- They enable the person to gather information necessary to take action and provide an opportunity for affective release.
- This response allows individuals to integrate the experience into their perceptions of themselves and the world; it also produces difficulties as it increases the experience of negative effects, to a potentially dangerous level, resulting in the person having heightened anxiety reactions and non-productive worry.

Avoidance reduces the emotional impact of the event;

- It protects the individual from becoming emotionally overwhelmed and dysfunctional.
- But it may result in blocking out of information needed to lead to productive action.
- Prolonged use of the avoidance strategy tends to create emotional numbness and avoidance of certain aspects of the self and of life.

Shattering fundamental assumptions

Individuals have assumptions about themselves and the world they live in, that they use to recognise, plan and act upon in all situations that they are called to deal with. Assumptions are their reality. Persons are not fully aware of these beliefs of assumptions – but they form a back drop that influences the way they approach situations and the way they feel about the world they find themselves in. Assumptions are usually positive and reassuring.

Trauma affects a person physically and emotionally, as well as upsetting their beliefs about the self, human nature and the nature of the world. Because the assumptions are challenged, the individual is likely to experience further psychological distress. Person is left with doubt about whom or what can be trusted and what they should believe.

Three assumptions a victim is forced to consider:

1. **they are personally invulnerable** – trauma causes "It can't happen to me " to change to "it's happened once before, who says it can't happen again"
2. **the world is orderly and meaningful** ; people generally assume that by being careful, honest, good they can avoid disasters. The assumption is that bad things do not happen to good people. When disaster strikes they ask "why did it happen to me", they must have done something wrong? Or they have been singled out to be taught a lesson: an assumption that leads to self-blame.
3. **they are good and strong people** - being victimised leads to a loss of positive self-image. They are overcome by helplessness, vulnerability and powerlessness, all of which has a negative impact on self-esteem. Trauma causes victims to blame themselves. Term 'victim' is disempowering, suggests damaged, always different due to what has happened to them.

Trauma and Post-Traumatic Stress Disorder (PTSD)

Continuum range: Brief stress reaction that a person can deal with and recover from on his own – to a much more intense reaction described as trauma.

DSM-IV = Diagnostic and Statistical manual of mental disorders)

PTSD = psychological disorder associated with severely traumatic experiences giving rise to a cluster of recognisable symptoms:

Person experiences extreme trauma and develops 3 clusters of symptoms

1. Re-experiencing the trauma
1. Avoidance of the trauma related stimuli
2. Symptoms of increased arousal.

   Symptoms must be present for more than one month and significantly impair the person functioning. Symptoms are caused by the intensity and duration of the event and the meaning of the event to the survivor and their loved ones. It DOES NOT depend on a person's mental state – it can happen to ANYONE – even the strong and "in control" personality.

The origins of the symptoms are caused by:

1. the intensity and duration of the stressful event and
2. the meaning attached to the event by the survivor and significant others.
3. PTSD can be acute or have delayed onset (from one year – up to 40 years)

DSM-IV criteria for Post-Traumatic Stress Disorder

- Exposure to a traumatic event involving actual or threatened death or injury, to which the person responds with horror and feelings of helplessness.
- The person re-experiences the trauma in the form of dreams, flashbacks, and intrusive memories.
- The person displays evidence of avoidance behaviour, a numbing of emotions and reduced interest in others and the outside world.
- They experience physiological hyper-arousal, shown in insomnia, agitation, irritability, outbursts of rage.
- Symptoms last longer than a month
- Symptoms affect individual victims functioning in different areas of their life such as work, relationships with loved ones, and their self-esteem.

NB: the above merely is an aid to make a diagnosis – it is NOT a description of the victims psychological experience.

<u>These criteria should be regarded as an 'aid to diagnosis' rather than a description of the victim's psychological experience.</u>
PTSD is a disorder that usually strikes psychologically healthy individuals after extreme life events, but it can exacerbate pre-existing psychological problems. One cannot rely solely on the above classification to understand all the experiences of survivors of trauma.

PTSD experienced by

- holocaust survivors
- war veterans
- refugees
- victims of violent crimes
- survivors of sexual abuse
- Accidents
- Community disasters
- Losing a loved one tragically
- Nonsexual assaulted
- Battered woman in shelters
- Rape victims.

Recovery from Trauma

"Resilience" – the survivor's ability to thrive in difficulties

- Some people are able to survive trauma and proceed without permanent emotional scarring.
- Resilience is likely to develop from both internal (person's temperament, warm, easy going, positive self-esteem, good problem solving skills, sociability) and environmental factors (supportive relationships, congenial work environment, positive community responses and resources available)
- Survivors carry the scars of their trauma for diff. lengths of time.
- Some people deny their traumatic experiences for a long length of time – and then get caught by a small, less significant event that reminds them of the supressed event. This can trigger emotional reactions and cause unexpected chaos.
- Some survivors may be preoccupied with their trauma for the first year and then put it behind them and move on due to loving support received at the time.
- Trauma recovery deals with reworking the trauma so as to enable survivors to integrate the trauma into their lives.
- To achieve healing they have to disabuse their minds of notions that they are dysfunctional and different.
- Healing is said to begin when these persons start to:
  - reconnect with their strengths ,
  - identify defences that previously kept them "locked into" the trauma and
  - find ways of dismantling these defences.
- These survivors adopt a more rational pattern of thinking and behaving.
- Survivors don't need to be 'fixed', rather they benefit from supportive assistance to enable them to mobilise their own inner healing and creative powers.
- Trauma counselling is a process whereby traumatised people are enabled to work through their distressing memories to the point where they feel better.
- Unless they have a chance to address their feelings regarding their abuse, these feelings may impact on their relationships with friends, lovers, children, their self-esteem, their relationships with their bodies and their career performance.

Goal in recovery is

→ to enable the survivor to achieve "ordinary levels of effective functioning"

- The ability to give energy to everyday life
- Experiencing psychological comfort, instead of constantly experiencing pain and distress
- The ability to experience gratification, to enjoy life's pleasure when they happen
- Developing hopefulness regarding the future, being able to plan for the future, displaying commitment to these plans
- The ability to adequately perform social roles as parent, spouse, member of community.

For some – trauma leaves an imprint on the survivor's perceptions about themselves and life; in order to move on they need to rework these perceptions. The trauma will never be completely cured and forgotten, but the survivor will reach a stage where it will cease to cause as much pain and disruption as it once did.

The trauma counsellor – personal qualities.

- The quality of the helper's presence is the most critical healing component.
- The role of the counsellor is one of a facilitator rather than teach or doer.
- Emphasis is placed on developing a special kind of relationship with the survivor, one built on four conditions identified by **Carl Rogers** – a **Phenomenologist** – who developed the **Person Centred Approach to helping.**

Personality qualities – the C O R E of a counsellor: (Rogers)
C = Unconditional Positive Regard
O = Personal Power
R = Respect
E = Empathy

These conditions are:

1. The unconditional acceptance and respect for the person
2. A deep regard and understanding of his or her experiences
3. A commitment to being fully transparent and genuine in this relationship
4. An appreciation of the person's personal power to find unique and relevant solutions to his or her troubles.

- The relationship built is free from advice giving, instructing, coercing and manipulating.
- It acknowledges the survivors inherent capacity to heal and refrains from dictating the pace of therapy.
- Emphasis is placed on listening and empathising with survivors, and when indicated, suggesting ways to help them regain control of their lives. The helper is not preoccupied with skills to treat the survivor, but more concerned about their `way of being' with the survivor.

Helpers Qualities

- Warm, Sensitive, Caring, Nurturing attitude
- Essential qualities as they reassure survivors that they are understood, respected and within the context of the helping relationship, safe enough to lower their defences and review the impact that the trauma has had on every area of their lives.
- Helper must be sensitive to the survivor's emotions and courageous enough to deal with their pain and helplessness.
- Positive approach to life, good problem solving skills and flexibility are vital to give hope.
- Demonstrate a strong belief in the survivor's inherent potential to heal and recover.

Helpers need to be fully aware of their own motivation for working in this field. Should they be survivors of trauma, they can still work in this field but they must pay attention to:

- Be self-aware of the impact that the abuse has had on their personal life.
- Take special care of their physical, psychological, emotional and social health
- Arrange regular debriefing consultations with professional colleagues regarding the counselling they are rendering.
- Be able to deal with their personal issues outside the context of work.
- Helpers should not assume that their trauma makes them any more or less able to deal with the trauma of others.

Knowledge needed to work in the field of sexual trauma.

Knowledge protects survivors from experiencing further pain - it also protects the counsellor when dealing with the law and service providers.

NB: Well trained counsellors have:

- a systematic body of knowledge of sexual abuse
- coping skills – assertiveness ; anger and stress management; relaxation
- Medication knowledge – referral to doctors
- Gender sensitivity training
- Code of ethic – Professional Values (RICS)
    - R = Respect
    - I = Individualisation (uniqueness)
    - C = Confidentiality
    - S = Self determination
- Understanding of the law
- Therapeutic skills:
    - Listening
    - Probing
    - Empathy
    - Advanced communication skills
    - Immediacy

The general tasks of the helper

- Help survivors rework the trauma and track its impact on their physical, psychological and social areas of functioning.
- Counsellors empower the survivor to develop, rediscover coping skills.
- Survivors are supported whilst they admit the trauma and identify the harmful ways it has impacted on their lives, accept that they were not responsible for the abuse, and introduce changes to enable them to adjust to their new reality.

Goals of treatment (adult & children)

- Enable the survivor to freely express thoughts and feelings in a safe, trusting context.
- Help survivors to understand why they feel like they do, to assist them to master their emotions.
- Reduce / eliminate symptoms of Post-traumatic stress
- Assist survivors to be more confident, competent, in control of their lives.
- Correct any misconceptions survivors have about trauma
- Relieve survivors feeling of self-blame
- Enable survivors to re-establish trusting, healthy relationships
- Assist survivors (directly / indirectly) to cope with interface between them and the process in the criminal justice system.

THEME TWO - SEXUALITY

Sexuality has as much to do with total personality and non-genital functioning, as it does with erotic responses and reproductive functioning. There are many factors that affect sexual functioning. Factors:

- Genetic
- Physical health
- Knowledge about genitals
- Understanding the mechanics of sex
- Knowledge about sexual diseases, pregnancy
- Attitudes about the body and bodies of others
- Beliefs about rights and responsibilities of people
- Religious and cultural values regarding sexuality

The psychosexual perspective of a person is not static and plays a role in shaping lifelong sexuality.
The psychosexual perspective is that part of human sexuality that reflects cultural, ethical values and norms of the society in which the person lives.

Historical perspectives on sexuality

- Sexual values and norms have, and will continue to, change rapidly as society evolves.
- Judaism influenced sexual behaviour as rules for sexual conduct were defined:
- Adultery was forbidden
- Homosexual acts condemned
- Sex considered neither good or bad – not restricted to reproduction purposes
- **Ancient Greece** – adult male responsible for adolescent boy's intellectual and moral development and permitted to engage in homosexual acts with adolescent. Yes exclusive acts of homosexuality between adults frowned upon. Acts with pre-pubescent boys was illegal. Woman considered "chattels" (possessions of men) and "gynes" – bearers of children.

- Christianity considered celibacy as ideal. Sex lust was recognised to have come from the downfall of Adam and Eve and this lust separated man from God.

- Islamic, Hindu, ancient Oriental sexual attitudes were more positive.
- Sexuality and sexual pleasure were seen as an integral part of Eastern religions. Sex was viewed as important blending of energies that helped humans with their spiritual transformation.

- Sexual revolution – 1960's – Advances in media technology, birth control measures and reproductive technologies, human rights movement and feminism. These changes challenged modern societies to unveil the secrecy surrounding sexuality.
- Lowe refers to the change as a transition from traditional morality to **New Morality .**

Traditional morality versus the "New Morality"

People are generally more open and permissive regarding premarital sexual intercourse, same sex sexuality and extramarital sexual intercourse.

New morality regards sex as a normal drive, entitled to some form of expression. Sexual standards are no longer considered to be the main source strengthening the moral fibre of society. Human sexuality is acknowledged as a basic human function that can be expressed in un-harmful ways.

Changed values of sexual behaviour

- New morality proposes more openness around issues of: masturbation, same gender sexuality, premarital sexuality, sex aids, sexual development and contraception.
- New morality proposes responsible actions from everyone so that they behave in sexually moral ways.
- Morality is the ability to respect and care for your fellow human beings. It has little to do with the way you enjoy your sexuality, unless you break a special trust or violate the rights of others for your own gratification. Morality is firmly entrenched in the recognition of, and appreciation and respect for, human rights.

There are two main ways of influencing human sexual behaviour,

1. sexual scripting
2. gender role typing / gender role socialisation

1. Sexual scripting

- Social rules are *explicitly* defined, by law, or they *implicitly* defined by implied social expectations.
- Common law crimes – rape, indecent assault, bestiality, incest and crimen injuria.
- Statutory laws - regulating prostitution, defilement, sex with a minor etc. All clearly defined in the law therefore *explicitly* spelt out.
- *Implicitly* implied / unspoken sexual expectations – sexual behaviour is a private matter, sex should only take place in a committed relationship, pregnancy should occur within wedlock. Implicitly prescriptive sexual expectations change to suite the times.

Principles inherent in the New Morality:

- Faithfulness to, and consideration for others, is highly valued.
- Coitus should only be couple with friendship and love. Love and not marriage becomes the prerequisite of sexual needs.
- Exploitation of a sexual partner is rejected.
- A high standard of respect for self and others. High standards of morality do not necessarily correspond to traditional and religious standards.
- Actions such as gossiping, using others for one's personal gain, winning at all costs, greed, are considered greater social violations than premarital sex.

2. Gender Role Socialisation

- Gender is socially and culturally constructed.
- At each stage of life (infancy, early childhood, latency, adolescent, adulthood) religion, culture and even socioeconomic status shape the lives of males and females differently; these influences impact human sexuality.
- Gender stereotypes are a possible factor contributing to sexual victimisation. Two poles of the stereotyping continuum are: patriarchal and expressive.

PATRIARCHAL	**EXPRESSIVE**
Men own everything, including woman and children	People do not own people
Sex is considered a biological drive . Sexual satisfaction of men is regarded as a prerequisite for their health. Woman's sexual functioning is related to procreation, not sexual satisfaction.	Sex is considered a basic human function, equally appropriate to men and woman. All forms of sexuality are acceptable as long as they occur only between consenting adults. Communication and intimacy are highly regarded.
Men are considered to have sexual drives whilst women are expected to be passive sexual beings who need to fulfil their male partners sexual needs	The sexual drives of men and woman are considered to be equal.
Ejaculation is considered important for men and orgasm unimportant for women.	Satisfactory sexual experiences are equally important for both genders. There is less emphasis on orgasm or climaxing and more emphasis on mutual stimulation and pleasure.
Non-marital sexual relationships are acceptable for men, but certainly not for woman.	The emphasis is on mutual fidelity and legitimate pursuit of sexual pleasure for all persons. Extramarital sex is not condoned because of the breach of fidelity.
Men are the breadwinners and women are economically dependent on their partners. The duty of the woman is to keep her partner happy.	A more egalitarian relationship is considered appropriate. The couple work together to ensure that their needs, and the needs of their family, are fulfilled.

Children's sexual development

- Humans start having sexual feelings from as early as being in the uterus – in the most basic sense.

- Sex games involve curiosity and making comparisons and contrasts. Feeling, penetrating parts of the body with fingers, objects.

Infancy through to preschool:

- Male foetus can have spontaneous erections accompanied by `generalised pleasure response'. Once born, male babies have penile erections.
- Female babies experience similar responses – but we are less aware.
- Children touch their genitals as it feels good. They are curious, and enjoy the sensation and stimulation hasn't been abused, but one should be alert to the possibility.

Appropriate adult management:

- Rules of acceptable social and sexual behaviour should be taught in such a way that children do not feel ashamed of their sexuality and genitals.
- The child should be gently stopped so that they do not feel later inhibited to ask about sexual matters, gender differences.
- Normal sanctions should be applied, just like those used to address others transgressions of important family rules.
- Respect for other people's bodies an their right to privacy should be clearly instilled.
- Questions about bodies and sexual behaviour should be simply answered using language the child understands. Long explanations are not appropriate to pre-schoolers level of cognitive and emotional development.

The primary school child:

- Children of this age remain curious about sexual behaviour, even though they remain highly critical of nudity.
- Quick to sense adults discomfort or unwillingness to discuss sexual topics.
- Sex education can be misleading as parents talk about the boys' penis and testicles, but don't refer to the vulva of the girl (they refer to vagina – incorrect)
- Children are exposed to sexual matters through the media - if parents respond with panic it conveys the message that sex is dirty and should be kept secret. Children should have it explained that adult activity is reserved for caring couples who are mature enough to consider the consequences of their actions.
- By the time children start attending school, they should have learned rules about sexual behaviour and body privacy.
- Children past the age of five who rub their genitals frequently, or engage with other children in adult-like sexual behaviour might be dealing with emotional anxieties that my have little to do with sex, or may be indicating they are being sexually exploited, emotional abused.

Appropriate adult responses

- Younger children should be reminded of the rules about body privacy and sexual touching.
- If inappropriate behaviour persists, then sanctions should be put in place.

- If child is masturbating / exposing himself in public – then gentle limit setting "I know it feels really good, but the pace to do it is in the privacy of bedroom/bathroom"
- Acknowledge the child sensations and prescribe appropriate ways of dealing with the need.
- Encourage children to talk to adults about a range of topics, allows children to feel they can trust adults to provide them with accurate info.
- Boys should be informed about girl's genitals and vice versa.
- When children ask a question about sex, very important for parent to ask child why they think the answer is, as often they have created an answer in their own mind. This will provide clues about the extent of the information the child needs to hear.
- Adults must not overwhelm young children with biological facts about sex that they cannot understand, or have no need to know till they are older.
- A five year old does not need to know about fallopian tubes, but does need to know that babies are born through the vaginal opening rather than mother's bottom.
- Children must be taught the proper names for things they can see and touch and it should be acknowledged that touching or rubbing their genitals can feel quite nice. This will give the message that it's permissible to talk about things sexual.
- Information does not promote experimentation; it enables people to make informed decisions.
- Customs, beliefs, values and rules about sexual behaviour must be made explicit to children and explained.
- The older primary child needs to be prepared for puberty.
- Caring relationships with high levels of respect, honesty and support are critical for this stage of development.
- Sex education is ineffective on its own. It is a part of a much more involved life education process that needs to incorporate communication skills, relationship skills and social responsibilities towards the self and others.

The teenager:

- Adolescents are acutely aware of the physical changes they experience; they have to integrate these changes into their existing identity to form an integrated whole. The way they view their body is intricately linked with how they view themselves, and the way others see them.
- Strong and urgent sexual feelings, often coupled with peer pressure to engage in sexual activity.
- Masturbation increases in frequency, too shy to ask for reassurance and try to work out their sexual attitudes, basing their decisions on what they have learnt from their peers.
- It's critical that they have access to reliable sex education during this stage.
- Peer group pressures vary from one community to another and also reflect the ethnic and economic subcultures within communities.
- At this age – they believe that STI's, HIV/AIDS and pregnancy can happen to other people, not them.

- They tend to want to be involved in adult behaviour and are therefore prone to being coerced into situations they cannot manage.

Appropriate adult management

- Affirming and reaffirming adolescents helps them to feel positive about themselves.
- Keep lines of communication open; give full information and guidance when needed.
- Parents should help children grow up to feel comfortable about their own sexuality and be responsible about it.
- When asked a question of a sexual nature, parent should ask the adolescent what they think, with acknowledges that their opinions are also respected.
- Sexual leaning must include an emphasis on values and attitudes.
- Adolescents should be taught the difference between good sex (being respectful to their partner, and being responsible) and bad sex (where others are used for their own gratification)

Healthy families

- Healthy sexuality involves more than healthy anatomy.
- Communication open, responsive and affirming
- Respect for individuality of members
- Family boundaries and the role that each family member has to play is clearly defined.
- Sexuality is conveyed as something normal and pleasurable. Engagement of children in sexual acts strictly prohibited.
- Each family members rights and responsibilities are made explicit
- Rules and guidelines for sexual behaviour made clear to family members
- Age appropriate info. About sexuality given
- Strong extrafamilial support from other members of extended community

THEME THREE - THEORETICAL APPROACHES

1. Psychoanalysis
2. The medical model
3. The feminist perspective
4. Systems theory
5. Child sexual abuse syndrome
6. Abuse-related accommodation

1. Freud and Psychoanalysis

- **Hysteria –** focus of scientific interest in latter stages of 19th century.
- Father of study of hysteria = Jean-Martin Charcot – French neurologist. First person to document the characteristic symptoms of hysteria (motor paralysis, sensory losses, convulsions, amnesia)
- Relied on female patients for live demonstrations.
- Believed symptoms were psychological because they could be induced and relieved through hypnosis.
- Freud studied under Charcot, with Breuer, concluded that hysteria was a condition caused by psychological trauma that could affect "even people of the cleverest intellect, strongest will, greatest character, highest critical power"
- Breuer, Freud and Janet – strong competitors to unravel the mystery of hysteria. All three believed that:
- Unbearable emotional reactions to traumatic events produced an altered sense of consciousness, which in turn induced hysterical symptoms.
- Janet and Freud believed relief could come by bringing suppressed memories to the fore.
- **Freud created a safe therapeutic context for trauma suffers to recover their traumatic memories and verbalise the intense feelings associated with them. This method became the basis of psychoanalysis.**
- He explored the sexual lives of his patients, and revealed that the underlying source of pain precipitating patient's hysteria involved one or more occurrences of premature sexual experience. Called the seduction theory. Freud asserted that most of his female patients reported being molested as children, by adult relatives. Respected members of society.
- Social implications of Freud's theory – hysteria was so common and so, by implication, it suggested perverted acts against children were endemic among the poor and rich.
- Work was repudiated. Only when he reformulated his ideas did he receive positive recognition.
- New theory suggested that children's conflict over their own sexual fantasies towards a parent induced their trauma.
- Young boy's sexual interest as the **Oedipus complex**
- Young girl's sexual fantasy about her father as the **Electra complex.**

Assumptions and main theoretical concepts of psychoanalysis

- Freud's psychoanalytic approach stressed the importance of the helper creating a safe therapeutic environment for the hysterical person to work through his / her unhappy memories.
- Issues were deeply imbedded in their unconscious; would create sufficient psychological tensions, leading to physical manifestations, referred to as hysteria.
- Unconscious consisted of thoughts, feelings, motives, impulses and events that the individual were kept out of the awareness of their conscious ego.
- Therapist role to make unconscious conscious and deal with the anxiety of the memories.
- In order to cope – patient developed defence mechanisms to protect themselves from overwhelming thoughts and feelings.
- **Repression**: the individual excludes from consciousness threatening or painful thoughts and desires.
- **Denial**: coping with anxiety by "closing our eyes" to the existence of anxiety producing reality
- **Regression**: individual returning to less mature developmental level.
- **Projection**: Individuals attribute own unacceptable thoughts, feelings, behaviours to others.
- **Transference** is a basic concept of the psychoanalytical approach – refers to the clients unconscious shifting to the therapist, of feelings, attitudes, fantasies (positive and negative) that stem from the persons reactions to significant person in the patients past.
- By reliving past through transference process, patients gain insight into ways in which it obstructs their present functioning.
- Therapist must be aware of their own feelings, and how they become entangled in the therapeutic relationship.
- Psychoanalytic approach requires the therapist undergo psychoanalysis to become conscious of their own psychological issues.
- **Free Association** = Patient encourage to communicate whatever comes to mind – however painful, illogical, irrelevant it seems; primary tool to help patients uncover repressed material.
- **Interpretations** = technique used in the analysis of free associations, dreams, resistances, transference feelings. Therapist points to underlying meaning of behaviour to accelerate the process of uncovering unconscious material.
- Freud believes that dreams analysis = essential for uncovering unconscious material.
- "**Insight**" suggests patient has developed an awareness of the causes of his present difficulties. An emotional and intellectual awareness of the connection between past experiences and present problems.

2. The medical model / paradigm.

- Paradigm preoccupied with presenting signs and symptoms of abuse and developing a full medical history of the patients suffering.

- Clinician designs treatment plans to correspond to the diagnoses that have been developed based on information.
- Like modernism – it represents a scientific approach to dealing with problems; it simplifies complex conditions by identifying their causes and measuring effects.
- Empirically motivated treatment approaches to these illnesses, which tries to objectify and simplify the helping process.
- Goal of medical model = develop a universal classification system of illness and pathology, to develop common terminology, and formulate reliable treatment responses that can be duplicated.
- Diagnostic and Statistical manual (DSM-IV is most recent) that objectively describe each mental health disorder according to recognised patterns of signs and symptoms.
- DSM-VI makes effort to pay attention to environmental factors of the patient. It has no specific diagnosis for sexual victimisation, but has provided categories to help practitioners to classify specific abuse related disorders.
- Value of this in certain contexts:
- Rendering an opinion about the signs and symptoms presented by a child sexual abuse victim in a forensic situation that could lead to conviction.
- Practitioners' world over familiar with system of classification – it offers a universal language, devoid of theoretical orientations, for them to speak about mental illnesses.

Criticisms of the medical model:

1. Too scientific
2. Too reliant on generalisations about health / mental health.
3. Risk of ignoring professional value of individualisation due to effort of classifying information – as this fails to emphasise the uniqueness of each case.
4. Linear approach – oversimplifies complex phenomena into cause-effect equations. Focus on the disease, damage, pathology – not the survivors' strengths / variables that may impact the situation.
5. Victims may feel labelled and further disempowered as they become passive recipients of a diagnosis and treatment plan.
6. Patient not seen holistically

Medical model underplays:

1. That survivors have the necessary competencies to develop their own coping responses,
2. That trauma prompts them to reconnect with their strengths and abilities in a desperate effort to heal them.
3. The medical model describes the set of symptoms but fails to explain how / why trauma results in those symptoms.

Common disorders diagnosed in person who have experienced child sexual abuse:

PTSD – Post Traumatic Stress Disorder

- Diagnosed on people who develop symptoms after other traumatic experiences such as MVA, torture, kidnapping, sexual abuse.
- PTSD highlights the presence of a traumatic event and symptoms of intrusive re-experiencing, such as flashbacks and nightmares, voidance of situations, or people, that resemble the event, and hyper arousal (alert scanning of environment / jumpiness)
- Symptoms last more than a month and may be short (less than three) chronic (more than three) or have a delayed onset.

Acute Stress Disorder

- DSM-IV distinguishes between PTSD and acute stress disorder.
- In Acute stress disorder, the symptoms surface within four weeks of the even and persist for no longer than four weeks.
- Distinguishing feature = the presence of dissociative symptoms, where a person `separates' or `splits away' from the experience. A numbing, detachment, absence of emotional responsiveness, a feeling that the experience isn't real, amnesia about important aspects of the trauma.

Dissociative Disorders:

- Essential feature = disruption in the usually integrated functions of the consciousness, memory, identity, perception of the environment.
- Extreme form = **dissociative identity disorder.** Traumatised person, in order to cope with stress, develops a number of distinct, autonomous / semiautonomous personalities.
- Kemp – 90% of people diagnosed have experienced extreme forms of child abuse, involving sexual abuse.
- **Dissociative amnesia** – complete and extreme loss of memory about the traumatic events
- **Depersonalisation disorder** – chronic feelings of being separated from one's mind or body, whilst still having a normal awareness of reality
- **Dissociative fugue** – person suddenly travels away from home & becomes confused about their identity and memory of their past.

Mood Disorders: depression to mania

Clinical signs and symptoms of a major depressive episode are referred to as vegetative symptoms:

- Depressed mood
- Loss of ability to experience pleasure
- Reduction of interest in activities
- Appetite changes
- Sleep disturbance
- Fidgetiness
- Lack of body movement

- Fatigue
- Loss of energy
- Inability to think and concentrate.

If these symptoms interfere with the person's normal level of functioning, then they are regarded as depression – and not related to other causes like physical illness.
Manic episodes – much livelier – on the other end of the continuum. Characterised by:

- Heightened and exaggerated, or irritable mood. Symptoms include:
- Grandiosity (inflated self-esteem)
- Decreased need for sleep
- Talkativeness
- Racing thoughts
- Easily distracted attention
- Increased goal-directed activity
- Excessive involvement in risky, or pleasurable activities.

Personality Disorders

- Usually develop in childhood or adolescence in an effort to cope with / adapt to overpowering and dysfunctional life circumstances.
- Behaviour becomes ingrained and carried into adulthood, even though not appropriate – causing social consequences that can include rejection / isolation.
- Kemp reports – abuse survivor's behaviour consistent with those associated with personality disorders.
- Clinicians working with personality disorders report a high rate of sexual abuse among patients.

3. The Feminist perspective

- Feminist movement drew attention to men's violence against women, and men's efforts to oppress woman. Male domination in the home and father- daughter incest exposed.
- Incest seen to be the manifestation of power imbalance in patriarchal families.
- "Rape Trauma syndrome" (Ann Burgess and Lynda Holmstrom) :
- Insomnia, startle responses, nightmares – resembling symptoms experienced by combat veterans.
- Male supremacy in patriarchal families, gives males power over woman / children.
- Sexual division of labour (woman nurture / are subordinate) persists through generations.
- Sexual division of labour also socialises men into not being able to ask for help – are expected to "fix it", "take care of it" - never nurtured to be empathetic or caring.
- Feminist movement responsible for improving legal and psychotherapeutic responses to rape; however political and cultural forces create power imbalance between men and woman that still has not been addressed.
- Woman & Children trapped by their economic dependence on men.

- Trapped by values of family honour and privacy.
- Sexually abused men also trapped as society emasculates them, therefore easier for them to remain hidden and silent.

4. The systems perspective

- Systems theory offers a broader, interrelated perspective, emphasising the dynamic nature of families, or family systems.
- The systems approach assumes that family problem arise as a result the manner in which the family system is organised or functions.
- Problem seen to be a response to dysfunctions in one or more of the significant relationships in the family. Problems can be resolved by addressing relationship issues.
- Attention paid to power structures of the family – favour a hierarchical structure of families, parents at top.
- Coalitions / subgroups exist within the family.
- Central tenet of systems approach = the whole is greater than the sum of the parts.
- Marriage is more than combining two lives of individuals. Partners bring their perceptions, which is their reality. Therefore more than one reality.
- Families are recognised as symptoms that are essential for providing the needs of their young and old.
- Systems are goal directed, and family members attempt to achieve and maintain homeostasis, stability, in the provision of love, belonging, acceptance, self-esteem.
- Individual family members find unique ways to adapt to troubled family systems.
- Can assume role of "identified patient" – develop issue / illness in an attempt to keep family together – therefore maintaining family homeostasis.
- Incest can fulfil a particular function in the family system.
- A complex series of interactions between family members in order to keep their family system afloat.
- Incest is more than sexual contact between an adult and a child. It is a complex effort by different family members to meet the needs of different family members.
- Theorists believe perpetrators actions are connected to the dynamics within the family, but they do not absolve them of their responsibilities for sexually violating their offspring.

Family History

- Family – "place of learning" for its members. Children learn who they are, what to expect from the world and socialised to accept the nature of inter-generative boundaries between family members and diff. roles ascribed to each of them.
- Unique boundaries that have to be respected.
- Each spouse brings with them his / her own background history – which is the accumulation of many of their personal experiences and those of their family of origin; this influences their new family life.

System theorists believe:

- Parents who commit incest may themselves have been sexually abused.
- Adults who have been sexually abused as children may accept abuse as a valid family rule, and may transfer it to their own family
- Parents who commit incest tend to originate from families who functioned in isolation – where parent-child relationship was poor. Little love, affection and communication – sexual topics would have been regarded as taboo
- Sexually abusive parents are most likely to have been rejected by their parents in one way or another. The relationship would not have met the child or the parent's expectations.
- Significant patterns of behaviour may be transferred from one generation to another.

The quality of the marital relationship in the incestuous family

- Distant, poor, unsatisfying marital relationship in the incestuous family.
- Disengaged, no intimacy,
- Violation of inter-generative boundaries occurs – child is propelled into the role of partner.
- Systems perspective proposes that it is usually the mother that is `absent' in the marital relationship, or frigid towards the father, as a result of a combination of:
    - The father cannot understand the sexual functioning of his wife / mother can't meet sexual demands of father – and withdraws from the sexual relationship altogether.
    - Mother had unpleasant experiences in childhood – therefore avoids sex; husband finds alternative methods to keep the marital relationship intact.
    - Father confuses intimacy and sex.
    - Mother leaves the home - leaving daughter to run the home – father moves into relationship with daughter.
    - Mother may be `frozen out" or side-lined as father becomes preoccupied with his sexual relationship with his daughter.
    - The mother doesn't know who to turn to for help
    - Father uses incest to "punish" the mother.
- The marital dyad so close that couple fails to address the needs of other family members.
- Children, whose emotional needs for love and affection not met within the family, are vulnerable to exploitation by others outside the family. This pattern = enmeshed relationship.

Role Reversal and Shifting boundaries

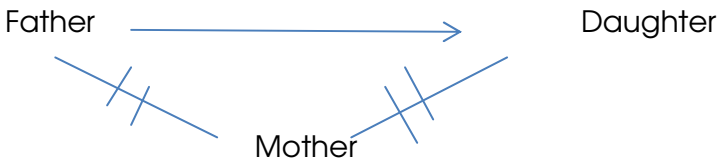
- Incest = violation of inter-generative boundaries.
- Chaotic shift takes place in the family's interactional patterns.
- Boundaries no longer clearly defined; role-reversals take place

i. A dominant father and a passive/dependent mother

ii. A dominant mother and passive/ dependent father

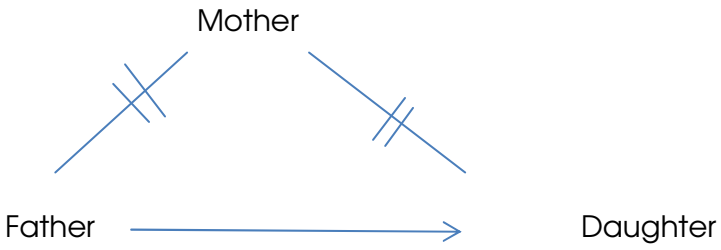
i. A dominant father and a passive/dependent mother

- Father is introvert with few friends.
- Strives to present himself as ideal father, family man, and churchgoer.
- Keeps people at a distance, avoids attention.
- Mother is aloof – emotionally and physically – therefore cannot fulfil role of mother and daughter is coerced into taking on her tasks and fulfilling her duties.
- Relationship between mother and daughter becomes one of peers with an element of competitiveness and conflict.
- Mother avoids facing the reality of what is happening in order to protect herself.
- Father moves out of the parental role – away from wife, into a spouse role towards his daughter.
- Mother moves to child position, making her powerless to do anything about the incestuous relationship.
- Daughter assumes mothers responsibilities, incl. sex.



ii. A dominant mother and passive/ dependent father

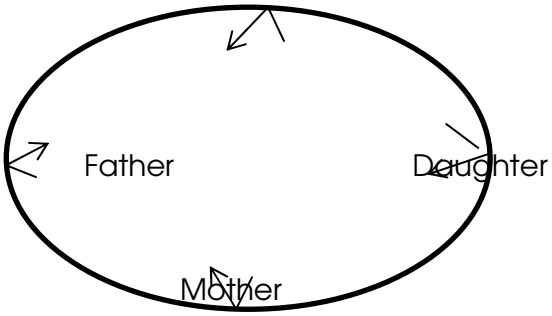
- The female fulfils the role of mother towards her spouse.
- Male withdraws from marital relationship to establish marital relations with his daughter.



- Daugther becomes spouse to the father who has found an alternative relationship to fulfil his needs.
- In most cases, father experienced insufficient nurturing from his own mother and is dependent upon a mother figure. He expects his partner to fulfil this role.

The boundary between the incestuous family and the community

- The boundary between family and community is rigid and closed.
- Isolation of the members of the incestuous family ensures secrecy persists.
- Family fear community rejection, and keep to themselves.
- In systems terms – they want to protect the family's homeostasis.
- The family system in which incest occurs may be represented:



Incest as a family Secret

- "Secret" is a component of a incestuous relationship
- Systems perspective proposes – each member has his or her own reason for maintaining the family in its current form:
  - It is taboo to discuss sexual issues within the family
  - Little sexual guidance is given to family members and the children lack criteria to enable them to judge whether right or wrong is being committed.
  - Family fear community reprisals. Stigma associated with abuse will lead to ostracism.
  - Disclosure may lead to losses for the family – likelihood of offender being imprisoned – loss of breadwinner, accommodation, education etc.
  - Emotional blackmail, physical threats used to the child.
  - Child may enjoy the bond between themselves and the abuser. May fear losing the relationship that meets his needs for affection and closeness.
  - To maintain the homeostasis of the family, the child does the non-perpetrating family member a favour by assuming the role of sexual partner.
  - Eldest child protects the younger children, believing that their own abuse will prevent the abuse of younger siblings.
  - Attempts by children to disclose abused status not taken seriously
  - Systems perspective shows how the family is a living system of complex interrelationships, making practitioners mindful of the needs of each family member, and the way each family member interacts and deals with each other's needs.
  - It shifts the blame of social problems from one individual to the way the family relate to one another, as a whole.

Criticisms of the systems approach:

- It may unfairly view victims as participants in abuse, rather than acknowledge that, mostly, they have been coerced into participating.
- A concern is that this perspective may lead to 'mother blaming' for child sexual abuse, as it holds the mother responsible for failing to fulfil the perpetrators needs.
- It appears to minimise the perpetrators responsibility for taking a conscious decision to break the law.
- It infers that males have such an overwhelming sex drive that they cannot help but compromise the psychological safely of their children in order to satisfy this drive
- It overlooks the reality that many incestuous abusers simultaneously abuse others outside the family.

Perpetrators must accept responsibility for their actions before family counselling can proceed.
Family counselling is only considered when there is absolutely no risk of further abuse of children.

Mothers struggle to deal with:

- their guilt when abuse is uncovered.
- Disclosure may lead to the disintegration of the family, a huge threat.
- Live in fear of the abuser
- Are economically dependent on the abuser.
- Nowhere to go

5. Child Sexual Abuse Accommodation Syndrome. (Not listed in the DSM-IV, therefore should not be considered as a disorder)

Survivors engage in much behaviour; they may withdraw allegations of abuse after initial disclosure. Summit (1983) recognised two of the reactions
1. Reluctance to report victimisation
2. Later recantations.

Five categories in the syndrome:

i. **Secrecy** – inherent symptom of child sexual abuse.
ii. **Helplessness** – imbalance of power. The adult consciously abuses the child's trust
iii. **Entrapment and accommodation** – abused child cannot control their abuse, so the learn to adapt to survive, physiologically, emotionally, physically – which reflects the resilience of the human psyche.
iv. **Delayed**, **conflicted**, **unconvincing disclosure** – in the wake of family conflict, or a breakdown in the victims coping strategies.
v. **Retraction** – victim becomes aware of the ramifications of their disclosure, feel guilty, regret, and try to save their family from disintegrating. This internal pressure causes withdrawal of accusation.

These are normal responses from resilient children to an abnormal situation of abuse by adults.

6. Abuse related accommodation model (Briere)

Respect, positive regard and the assumption of growth
Central principal of abuse-related accommodation model is that people who have been sexually abused must be considered survivors (not victims)
Survivors persevere despite extreme trauma.
Each survivor develops unique symptoms in their efforts to cope or mange emotional turmoil.

Briere – 7 areas of psychological problems common to survivors of child sexual abuse:

i. Post-traumatic stress
ii. Cognitive / thought distortions
iii. Altered emotionality
iv. Dissociation
v. Impaired self-reference
vi. Disturbed relatedness to others
vii. Avoidance

Abuse focused therapy sends the following message to survivors:

"you have spent much of your life struggling to survive what was done to you as a child. The solutions you've found for fear, emptiness and memories you carry represent the best you could do in the face of the abuse you experienced. Although some others, perhaps even you, see your coping behaviours as sick or 'dysfunctional', your actions have been the reverse: a healthy accommodation to a toxic environment. Because you are not sick, therapy is not about a cure – it is about survival at a new level, about even better survival. Your job is to marshal your courage, to go back to the frightening thoughts and images of your childhood, and update your experience of yourself and your world. My job, the easier of the two, it so engineer an environment where you can do this important work, and to provide in your sessions the safety and respect that you deserve"

The phenomenological perspective

- **Phenomenology places more emphasis on the survivor's personal experiences and perceptions than on theoretical notions of the frames of reference of experts.**
- Empathetic stance, as it considers the helpers most powerful tool is their ability to understand and experience the survivor's inner world; to perceive indirectly what the survivor perceives.
- Helper focuses on issues critical to the survivor and allows he survivor to decide how fast / slow treatment should be paced.

- Survivors are recognises as having the inherent ability within to make sense of their trauma and develop an individualised, coping response that will lead to the abatement of their suffering and enable them to take control of their lives.

Functionality of 'symptoms' and defences

The abuse-related accommodation model proposes three main implications for understanding survivors.

1. Their behaviour is active and practical rather than passive and symptomatic
2. Their attempts to use their own coping strategies provide them respite from their abuse-related memories and experiences. For them, these responses and functional and difficult to give up.
3. The survivor's behaviour is their attempt to adapt and cope to a real life event. To understand the experiences of a survivor, the helper must try to understand their behaviour.

- Each behaviour actually serves a psychological purpose, making it very difficult for the person to give them up.
- When the survivor begins to understand the functionality of these, this insight leads to change.
- By both the helper and survivor understanding both the defensive and adaptive aspects of these 'symptoms' they are able to map out what the actual targets of treatment should be.
- Substance abuse- survivors attempt to self-medicate to escape unpleasant thoughts / memories
- Self-mutilation – an attempt to mask the intense unbearable psychological pain by inducing physical pain.
- Trauma-induced amnesia – a way of avoiding dealing with reality until the survivor has energy to do so.
- The helper must understand the functions the problem behaviours serve.

Awareness and integration

- This approach assumes greater awareness of the past and present allows survivors to discover and address the basis of their unhappiness and inner psychological tension.
- They re-work their trauma related experiences by beginning to understand the 'whys' and 'whats' of what happened to them.
- They start to begin to accept themselves and reject previously held self-ideas that they are bad / damaged.
- Use counselling to develop a new relationship to these internal experiences – therefore no longer managed by their symptoms.

This model proposes that survivors adapt to their experiences in three stages.

1. **Initial reactions to traumatisation:** experience traumatic stress reactions which shatter the originally help assumptions about the world in which they live. May experience PTS, cognitive distortions, painful affect.
2. **Accommodation to on-going abuse**: survivors instinctively find methods of coping. Goal is to find some form of safety and / or to decrease pain
3. **Long term elaboration and secondary accommodation:** survivor integrates the new way of coping in order to survive. This tends to get in the way of enjoying a more fulfilling life later on.

THEME FOUR – SEXUAL ABUSE OF CHILDREN

Helpers cannot make generalisations about child sexual abuse / abuse survivors.

- No universal definition of child sex abuse. The definitions of sexual abuse are intricately linked to cultural constructions of sexual actions that are socially and legally considered acceptable.
- Sexual abuse definitions are based on values and belief systems, bound by culture and time.
- Definitions must be contextualised.

- In ancient times – emphasis placed on procreation as early as possible.
- Middle Eastern Tribes – permitted sex with girls of three years and one day.
- Ancient greeks regarded sex with young boys normal. Some boys castrated to keep them looking youthful.
- USA allowed marriage of 13yr old children in 20th Century.
- Pitcairn – pacific island – woman's lover could be her father, son or husband. A young girl should lose her virginity when she reaches puberty (11/12). New Zealand / Australia – would call this rape – but Pitcairn's call these culture- appropriate acts.
- Female circumcision - from 5 years and older, condoned by African culture (female genital mutilation)

Child abuse is committed not to satisfy sexual needs, but a misuse of offender's power and authority.

- Inappropriate exposure of adult's sexual parts to a child for the adult's sexual excitement (exhibitionism)
- Inappropriate sexual interest in watching a child undress, bath – in order to excite his/her own sexual feelings (voyeurism)
- Use of sex talk for own sexual arousal (verbal molestation / crimen injuria)
- Sexual touching of child's body for the purpose of sexual gratification of the adult.
- Stimulation / penetration of the penis and scrotum / vagina, clitoris, anus with the mouth – oral sex
- Indecent exposure by adults in front of children – molestation – due to negative psychological effect on the child.
- Penetration using fingers, objects. Anal intercourse = sodomy / buggery = indecent assault.
- Exposure to sexual acts / porno / using children to act.
- Child prostitution – may occur with the consent of the parents who benefit financially.
- Genital mutilation of girls – not done for sexual gratification of the person who undertakes the ritual – but it severely impacts girls sexuality and sense of powerlessness later.

Definitive characteristics of sexual abuse.

- The abuse of power and authority by the offender, who takes advantage of the child's lack of knowledge and understanding of sexual matters.
- The act is carried out purely for the gratification, immediate or delayed, of the offenders needs.
- Consent from the child is non-existent.
- Children lack the emotional, cognitive, social 'wherewithal' to make sense of sexual experiences, and should not be placed in a position where they have to decide whether or not to have sexual relations.
- The act exploits the child because it denies his/her rights and feelings.
- Sexual abuse is a violation of children's right to normal healthy trusting relationships.
- Male adults may be charged with **rape** if penetrative sex occurs with a child of 12 or younger.
- Under 16 consenting to sex = **statutory rape** and carries a lesser sentence
- Sexual abuse that do not involve penetrative sex, but touching = **indecent assault.**
- When activities do not involve sexual touching = **crimen injuria.**
- Sexual intercourse unlawful between male of 16 + years and female under 16 yrs.
- Sex without consent = Rape

"Child sexual abuse is any form of sexual activity with a child by an adult or another child who has power over the child. It includes, but is not limited to, showing a child pornographic materials, placing the child's hand on another person's genitals, touching a child's genitals and / or penetration of any orifice of a child's body (mouth, vagina, anus) with a penis, finger or an object of any sort. Penetration does not have to occur for it to be sexual abuse"

Infant Rape

- Unique to SA.
- Intra-racial
- Offenders known to mothers' of the babies
- Alcohol /substance abuse involved (mothers / and or perpetrators)
- Mothers and offenders living in degrading socioeconomic circumstances.
- Offenders were members of ethnic groups where virgin-cure myth as a prevention/cure for HIV/AIDS was well entrenched within the cultural believe system.

Does Sex Damage a Child?

- *"….repeated trauma in childhood forms and deforms the personality" (Herman)*
- Child sexual abuse cultivates abnormal states of consciousness that allow for the development of an enormous array of symptoms, both somatic and psychological.
- Sexual abuse is a highly individualised experience.
- Children develop a range of coping strategies to survive abnormal situations.

Sex play between peers

- Interest in own/bodies of others is normal part of development.
- Sexual experimentation is part of a growing child's quest for identity.
- Mutual curiosity, discovery, based on equality of developmental level, power and choice, unspoken knowledge and awareness of how far the game will go – makes the activity harmless.
- Should one child use force, threats a young child – then it becomes abusive.

Common feelings related to sexual abuse

- Being sexually abused leads children to have confusing / overwhelming feelings about themselves and their world; feelings which affect children's perception of themselves.
- Due to myths surrounding sexual abuse "*victims ask for it*" "*only bad girls get sexually abused*" "*children fabricate stories of sexual abuse*" - children realise they will not be believed and may develop ways of dealing with their life – secrecy, blaming themselves when things go wrong.
- This leads to reinforce their negative feelings and beliefs about themselves.
- Coping mechanisms:
- Block out / deny abuse experience
- Develop numbing defence mechanism that enables them to go through the motions of living without being aware of their feelings.
- Children may experience fear / anxiety in relationships because intimacy is one of the strongest associations of the abusive pattern.
- Depression is a common reaction, often overlooked and misdiagnosed.

Sexual abuse engages the child in behaviours that are inappropriate for children and this engagement leaves the child feeling bad and guilty.

- By introducing a child to sexuality before the child has developed sufficiently to explore their own sexuality, is a blatant invasion of their privacy and amounts to disrespect for them.

Sexual abuse denies children the right to decide what is right for themselves and their bodies.

- Children are trusting and dependent on adults, making them vulnerable to sexual exploitation. Children are taught not to question authority.
- Society disempowers children.
- Abuse disempowers children, as they are coerced and manipulated. Helpers should not plan things without the consent of the children they are working with – and disregarding them in the decision making process further increases their sense of powerlessness.
- Due to loss of power – they seek to regain their sense of personal autonomy; by trying to disempower others (bullying, challenging teachers, parents, refusing to accept discipline)

Sexual offenders may be defensive about their actions and blame their victims for the abuse.

- Secrecy and silence are the offender's first line of defence.

Sexual abuse is an exploitation of the child's basic needs for affection and acceptance.

- Abuse involved intricate weave of intimacy and betrayal.
- Person most trusted by the child can be the abuser – leaving the child confused about intimacy and closeness, and betrayed by those who failed to protect them from the abuse.

Sexual abuse introduces the child to sex according to the adult's timetable and this impacts his / her sexuality later on

- Children's physiological response to sexualised contact may have been experienced as pleasant, but be left with feelings of guilt about being a willing participant in something they sensed was bad.

Sexual abuse weighs the child down with enormous feelings of responsibility for others

- "Your mother will have a breakdown if she finds out" etc. The implicit message given to children is that their feelings don't count and they should put others feelings first. This may become a habitual pattern in interrelationships with others later.

Children's bodies are physically immature and penetration of the vagina and anus may result in physical injuries.
The stigma that society attaches to sexual abuse inflicts as much trauma on the victim as the sexual abuse itself.

- Misconceptions about sexual trauma often result in apportioning blame to the wrong person, the child rather than the perpetrator. They are accused of being provocative and inviting.

Betrayal of trust

- Offender uses the child's need for love / affection to their own advantage.
- They use the child's needs to satisfy their own need for power. In the process they provide the child with an explanation that normalises the sexual contact, which distorts the reality of the situation – misleading the child. Their trust is betrayed.

Distorted power relationships

Sexual abuse is an abuse of power. Offenders use the following to bribe, coerce, threaten children:

- Age,
- Nature of relationship to the child (parent, teacher)
- Their status in the community
- Physical size / strength
- Cognitive skills, access to resources that the child needs

This coercion takes away the child's right to decide what is good for them, and they realise they have no power to avoid the abuse.

Factors that impact on the severity of the child's response to abuse

Age of the survivor at the time of the abuse. The younger, more dependent child is likely to have greater damage, particularly when abuser is parent / caregiver.

The gender of the child survivor.

- Misconception that girls are more vulnerable to sexual abuse.
- Infancy to latency – males more vulnerable
- Adolescence – girls more vulnerable.

Previous history of an emotional disorder

- Children exposed to situations of high levels of anxiety, physical abuse, marital conflict, suffered from depression prior to the abuse = less resilient

External factors that impact on the severity of the effects of sexual abuse:

The child's relationship with the abuser.

- Abuse by father / stepfather causes greater trauma than abuse committed by those unrelated to the survivor.
- Abuse by mother leaves the child with no safe attachments.
- Both parents – double traumatisation.
- Guilt is less intense when the abuser is a stranger because the consequences of disclosing the abuse are less impacting on the family as a whole.

The number of offenders involved:

- Effect of abuse more severe if child abused by more than one person.
- When children are abused within their families, they are more prone to being victimised by others – and risk of further sexual abuse is increased.

Continuous versus single episodes of abuse

Longer, more frequent abusive episodes result in more intense effects

The method of entrapment

- How the offender gets the victim into their power impacts the way the child experiences abuse.
- Threats of physical harm, emotional blackmail – exacerbate the child's sense of powerlessness, guilt and fear.

Post-disclosure support

- When children are not handled with sufficient sensitivity, they may be re-traumatised. (secondary trauma)
- Secondary trauma occurs when the child does not feel as though they are believed by others, when they are blamed and punished for the abuse, when they are removed from the home and placed in temporary custody (where there are juvenile offenders) , when parents response to disclosure is intense and the child feels afraid and responsible for the abuse.
- Professionals who deal with child abuse cases must be properly trained to sensitively cross-questioning child victims.

Intra familial (incest – parent, sibling, relative) and Extrafamilial Sexual abuse (offender is unrelated to their victims – teacher, caregiver)

Intrafamilial Sexual Abuse

- Bowlby – **attachment theory** – safe attachment and a secure base is necessary for healthy development of a child. Within these relationships, children learn what kind of person they are.
- The perceptions they gather about themselves impact greatly on their developing attitudes towards themselves, others and the world.
- Thus – long term impact and considerable damage on a child abused by parent.

Types of Intrafamilial molestation

1. Father-daughter
2. Mother-son

(More prevalent where no father figures in the family) Mother seduces son to fulfil her own needs. Boy's sexual curiosity is satisfied and he seeks no other relationships.

3. Homosexual Intrafamilial sexual abuse Occurs between mother and daughter / father and son.

- Mother / daughter – most likely to occur early in childhood – leads to love/hate bond. Child loses out on emotional nourishment and security. Child becomes frustrated by invasion of her identity by her mother, projects her loathing of her mother's body onto herself, end's up loathing her own body.
- Father / son – act of dominance by the father (no history of homosexuality necessary) Abuse of father's power leads to boy feeling robbed of self-determination and masculinity.
  Can lead to identification with homosexuality, when in reality they are heterosexual. In adulthood – survivor may become violent and aggressive, high-risk behaviour in a bid to prove masculinity.

4. Grandparent-grandchild incest

- Grandfathers are mostly responsible.
- Sexually abused themselves, abused daughters then grandchildren.
- No such thing as being too old to be an abuser.

5. Sibling incest

- If close in age – may be sexual exploration that is part of normal development – even though considered socially unacceptable.
- Related by birth, marriage, foster placement.
- Sibling sexual abuse different from sexual exploration – in that there are five year differences in age with the older child manipulating the younger one. The coercion involved makes it abusive – it is a misuse of trust, power and authority.
- Sex offenders start offending in their teens; younger siblings become the targets.
- In families where there is:
  - a lack of understanding of the necessary boundaries relating to sexual behaviour,
  - an inability to differentiate between normal sexual curiosity or experimentation and sexually inappropriate acts
- The risk of these acts being overlooked is great, and incidences are unreported. There is a conscious decision to keep the abuse a secret: fear consequences of social condemnation.
- Family may become preoccupied with finding ways to protect the sexual offender from being prosecuted; therefore overlook the survivor's needs. This is perceived as the ultimate betrayal by the survivor.
- Living under the same roof as the abuser, sibling survivor is likely to be subjected to multiple acts of abuse by the perpetrator over a period of time. Becomes a "life script", and results in them being powerless to defend themselves from being re-victimised by others throughout life.
- Victim usually begins by trusting the abuser because they are siblings – then betrayed by them.
- Sibling abuse is confusing for survivors. Perpetrators often abused themselves so whilst survivors understand the actions of the offender, they still have to deal with their own pain, shame, fearfulness.
- Probable cause for sibling to sibling incest is that they are emotionally vulnerable because parents can't see their needs, which aren't being met due to:
  - Economic / financial problems
  - Marital discord
  - Parent-sibling rivalry
  - Drugs and alcohol abuse
  - Poor Intrafamilial communication

Factors contribution to older siblings abusing:

- Neglect by parents
- An older sibling is given too much responsibility for caring for younger siblings

- Children have witnessed or experienced sexual abuse.
- Children who have access to pornography
- Inadequate socialisation

Characteristics of the incestuous family

1. Emotionally isolated and place little emphasis on respecting the individual needs of their members
2. Closed families, with few supportive relationships outside the family
3. Poor communication between family members, with little info about sexual matters.
4. Characteristically patriarchal and authoritarian – fathers have attitudes of ownership and rigid definitions of gender role and duties.
5. Father demonstrates high need to control and dominate family members.

Disclosure

- Children can't turn to people they are dependent on – as these are the same people who are abusing them.
- Disclosure can lead to disintegration of whole family – divided loyalties within members.
- Child caught between – preserve the relationship with offender and stop the abuse – preserve the family or preserve themselves.
- The longer the abuse occurs, and the less support given to a child after disclosure – the more long-term and severe the effects of the abuse will be.

Extrafamilial child sexual abuse

- 80% of time – sexual abuse is known and trusted by the victim.
- Occurs in familiar environment when offender has control.
- Grooming occurs - offender spends time developing a relationship with the victim so that they may use their knowledge of victim's needs, interests, desires to their advantage.
- The more the abuser (teacher, priest etc) is revered / feared by the child's parents, the more entrapped the child will feel.
- Child assumes that abuser outranks parents.
- Abuser uses power in the community to deny allegations.
- Some child offenders design their lives to fulfil sexual yearnings – teachers, work in children homes – where they have access.

Recognising the signs of a child in trouble

Signs do not confirm the existence of abuse, but provide a point of departure for further exploration of the possibility.

1. **Problems at school** – sudden decline in performance that cannot be attributed to a specific cause
2. **Personality changes**

3. **Isolation** - child avoids company of others, withdrawing
4. **Destructive and violent behaviour.**
5. **Self-destructive behaviour** – self-mutilate, stealing, running away, eating problems, no care for personal hygiene, substance abuse
6. **Regression** – act younger by resorting to comforting behaviours like thumb sucking, bed-wetting
7. **Sleep difficulties** – nightmares, trouble falling asleep

Indicators that signal that the problem may be sexual abuse

- Sudden lack of trust in / avoidance of well-known adult
- Avoidance of familiar place/s
- Fear of being bathed, clothes or nappy changed
- Exhibition of sexual behaviour inappropriate to the child's developmental phase.
- Awkward posture
- Inappropriate expression of affection towards another; kissing with tongue, undressing, touching or hugging a relative stranger
- Serious rebellion against mother, whom the child blames for failing to protect him
- Reporting abuse
- Unwillingness to undress
- Negative body image

Physical Signs and medical problems.

- Stains on underwear
- Irritation, itching
- Infections of urinary tract
- Sexually transmitted infections
- Discharge from genitals
- Bruising
- Psychosomatic pains

Remember that children's responses to abuse need to be individualised.

Dealing with Sexually abused children

- Early intervention important, check child is safe from further abuse
- Adult must not act hastily, forcefully or sensationalise the child's story – which will constitute secondary trauma for the child.
- Insensitive handling makes it easier for the child to deny abuse
- Develop a relationship of trust with the child
- Don't allow personal values to interfere
- Provide safe context for children to tell their story, in their own time, in their own way (playing, drawing, writing)
- Set child's mind at ease – they can talk about what happened, you are not angry / shocked

- Reassure child that this has happened to others
- Reflect the child's feelings in simple words "that hurt", "it made you feel bad"
- Acknowledge that it's brave of the child to talk, explain this is the start of making it better.
- Reassure the children of confidentiality, with the limits.
- Remind child they have done nothing wrong, no-one is angry with them
- Children should be engaged in making as many decisions as possible to restore sense of personal power.
- Don't make promises that cannot be kept or false reassurances.
- Show on-going concern – don't withdraw after disclosure.

Reporting child sexual abuse

- Report to child welfare society
- CPU – child protection unit of SAPS. Child friendly (plain clothes, playrooms)
- Police officer
- takes report
- arranges for child to be examined by medical practitioner and referred to social worker
- Get the child to district surgeon ASAP if necessary.
- District surgeons role is to collect evidence (not treat)
- Child must be treated by medical examiner – another examination – lead to further trauma.
- Child must be accompanied by trusted adult who should stay with the child, if the child wants them.
- Doctor should spend time before the investigation reassuring the child about what will happen.
- Doctor should conduct comprehensive medical investigation
- Positions for examining children – foetal position (knees to chest) and frog position (leaning against trusted adult)
- Child MUST be examined within 72 hours after abuse as signs of abuse can heal very quickly and this is the only way to collect evidence.
- Child mustn't bath until after examination to preserve evidence.
- Underwear removed and kept
- If no visible signs of assault, doctor must take a swab to look for signs.
- Speculum should only be used if there is obvious genital injury
- Doctor must record any observations – no matter how minor.

Court and Court preparation

- Greatest consequences in sexual abuse are psychological and emotional. Physical signs hard to detect.
- Occurs in secret, perpetrator wont' tell what happened, so victim needs to.
- Child protection services, social worker use interviewing and assessment skills to establish if sexual abuse has occurred.

Guidelines of accuracy in investigatory interviewing

Setting:

- in a place where child feels comfortable

Interviewer behaviour and attitude:

- Approach interview with open mind
- Be friendly and build rapport with the child before exploring for sensitive material.
- Clarify your expectations
- Emphasize being truthful and not pretending
- Be sure to tell the child you don't know much about the facts of the case
- Encourage child to admit being confused rather than guessing
- Encourage child to admit to not knowing, or not remembering rather than guessing.
- Tell the child that when you repeat a question, it doesn't mean his or her previous answer was wrong
- Give the child permission to refuse to answer questions that are too hard
- Encourage child to disagree with you and correct you when you make mistakes.

Be thoughtful about how you ask your questions.

- Keep in mind that you can mislead in any direction, depending on the nature of your suggestions.
- Make your questions developmentally appropriate
- Avoid highly leading / coercive questions
- Avoid repetitive suggestions and interviews
- Begin with open-ended questions and free narrative, then focused questions when appropriate
- Document relevant questions and responses.

Attempt to corroborate

- When law enforcement is involved, every effort should be made to collect whatever material evidence there might be that might corroborate the child's testimony.

Overview of legal process, once alleged offender arrested and charged:

- Their constitutional right to apply for bail.
- Magistrate assesses whether the alleged offender has a stable home, employment, considers threat to the victim of abuse
- Court case may be postponed several times before being finalised – making it difficult for child who has to re-live the trauma.
- Cases heard in the regional magistrates court or Supreme court
- Magistrate is in control in the court and will pass sentence
- Prosecutor represents the state to present evidence against the perpetrator
- Child is the complainant and becomes a witness for the state.

- Child has the right to give evidence in a separate room "in camera" – literally, "in a vault" – responses are relayed to the courtroom via video camera.
- Intermediary asks child questions in a simple way
- Intermediary usually a social worker – protects the child from feeling intimidated by court process.
- Accused as the right to be present in court, right to a defence lawyer to represent them.
- Prosecutor reads the charge at the outset of the trial and accused must plead guilty / not guilty
- Defence lawyer tries to prove no abuse / case of mistaken identity.
- Evidence heard and magistrate sums up evidence and gives a verdict.
- Case may be dismissed due to lack of evidence or guilty / not guilty charge.
- If either party believe there has been a wrong interpretation of the law, or sentence too harsh, lenient, then case may be reopened – an appeal made

Crime committed
↓
Crime reported
↓
Investigating and building of case
↓
Arrest of alleged perpetrator
↓
Alleged perpetrator is charged and a bail hearing is held
↓
Trial: Plea, evidence in chief, cross examination, re-examination
↓
Verdict (Guilty, not guilty, sentenced)
↓
Accused set free / sentences
↓
Possibilities for appeal

Preparing the child for court

- Trial stressful – makes the child relive the trauma in great detail.
- Court process must be explained to children in great detail in a simple language
- Child given an overview of sequence of events
- Courtroom scene may be role-played or practiced in *Tots and teens testify program*
- Children helped to understand the roles of the different professionals – misconceptions can contribute to quality of evidence
- Some children afraid of policeman and magistrates and carry an inaccurate perception of them.
- Older children need to understand some of the legal terms

- Guided tour of the court before the trial can help the child to orient themselves. Be shown the room where they will sit – the camera process explained to them.
- Children encouraged verbalising any fears about what is going to happen in the trial.
- Time should be spent dealing with child's emotions regarding his role as witness. Fears, embarrassment about what happened should be spoken about before the hearing.

Aftercare

- Follow up procedure to assess if child will benefit from on-going individual or group counselling.
- Explain the outcome of the trial (if perpetrator released, not because the child was not believed etc)

Group therapy

- Result of abuse is child feeling dirty, damaged, different, and child will withdraw further into themselves.
- Involvement with others may offer relief from their sense of aloneness.
- Group therapy = discussions, games, play, art, movement, music

THEME FIVE – THE ADULT SURVIVOR OF SEXUAL ABUSE

As a result of abuse, tasks of early adulthood = establishing independence and intimacy – are burdened by major impairments in self-care, in cognition and memory, in identity and in capacity to form stable relationships.

- Not all survivors are affected in the same way.
- Critical determiner of outcome is the way the child was treated at the time of disclosure; if met with compassion and effective intervention, healing beings immediately. If not – damage may be compounded.
- Process of healing is an abstract guide, to enable the practitioner to map the process of recovery in survivors.

Myths about the adult survivor

1. **Incest only happens to bad girls:** women "ask for it" – myth projects men as powerless over their sex drive which minimises their responsibility for their actions. Frames the survivor as being the guilty party.

2. **Woman and children get sexual enjoyment from abuse:** suggests that if the abused had not enjoyed the abuse, they would have removed themselves from the situation. Overlooks that sexual abuse is not an act of sexual pleasure, but a sexual expression of violence, an abuse of power
3. **Damage to a child after sexual abuse is irreparable:** effects of sexual abuse, whilst being traumatic, don't' have to be permanent. Abuse can be turned around into a meaningful opportunity for growth. Mental health intervention not always necessary.

4. **Survivors of child sexual abuse become deviant adults, involved in crime, drugs and prostitution:** Abuse may create anger, bitterness and feelings of worthlessness, but people direct and channel these feelings differently.

5. **Survivors of abuse will abuse their own children**: this is a misinterpretation of studies - `cycle of abuse'. Many adults abused have never been identified, and are therefore not visible as a group for research purposes. Research focuses on high-risk parents and their children – very narrow group.

6. **All the adult survivor's problems arise from the abuse:** Helpers need to acknowledge that survivors have the inherent capacity to resolve issues relating to their abuse. Not all difficulties are related to the abuse.

7. **There must be signs of a struggle to prove that the offender sexually abused the child:** due to shock and disbelief of the sexual experience, the child is likely to submit quietly, with little / no protest. Children are immobilised by their abuse. They are taught to obey and respect adults, who are the providers of food, shelter, love and food – they

have the power to make the child suffer serious consequences if that child does not listen to them.

Reasons for an adult disclosure

- Child sexual abuse is an activity committed in secret – which makes it impossible for us to have a reliable or accurate picture. It's an iceberg.
- *Tip of the iceberg* – known, reported cases to CPU and reflected in official statistics
- *Just under the water* – Cases known to other professionals, not included in statistics.
- *Deep under the water* – Cases known only to the victim, perpetrator and selected others. Some never disclose their abuse; some may not be heard / believed.

Factors that impel survivors to disclose their abuse:

1. **Problems in their close interpersonal relationships:** Survivors consciously / unconsciously fear that a partner may perceive them as being tainted by abuse and reject them. Intimacy becomes a challenge for them – fear sexual relationships – generates a crisis that leads to disclosure.

2. **Pressures of dealing with developmental and life crises:** Stress during adulthood may precipitate disclosure. By entry into new developmental phase of life (new career, intimate relationship, birth and growth of child) survivor feels thrown by feelings of unworthiness, self-doubt – precipitates disclosure. They are overwhelmed with memories of abuse – see themselves in their offspring and fear for their safety; in order to deal with fears, they talk about the abuse.

3. **Disclosure precipitated by loss**: loss of a loved one (or death of offender, the non-protecting parent, survivor's children leaving home) during adulthood may precipitate the mourning of losses associated with abuse as a young child. The deprivation of a loving, protective family

4. **Persistent depression precipitated by low self-esteem:** Feelings of never being good enough distort survivor's ability to recognise their achievements. Feeling of never succeeding wears the survivor down – resulting in deep depression. Exploration of the low self-esteem can lead to examination of childhood and abuse.

The effects of sexual abuse on the adult survivor

- The development of a person's personality is greatly determined by the quality and nature of their relationships with significant others.
- People we form attachments with, or look to for approval, exert powerful influence over our lives.
- They convey strong injunctions (messages) to us about the way to behave, which we internalise in our sense of self. (Calling a family member black sheep. His actions will confirm their belief)

- Injunctions regulate a person's thoughts about themselves, their feelings, actions in situations.
- Sexual abuse confronts the survivor with affects and meanings that become very difficult to manage which impact on areas of survivors functioning – having long term effects.

1. **Loss of sense of self and personal boundaries**:
   - Core of sexual trauma is the sense of being out of control of one's personal life and having physical and psychological boundaries violated.
   - Offender abuses their power "all father do this – why are you upset?" or with intimidation or violence, which destroys the survivors sense of self.
   - The experience of acute powerlessness is a highly regressive experience that carries the threat of nonbeing.

2. **Poor self-esteem:**
   - Survivors told 'you are ugly, useless, only good for sex' – making is hard for them to believe in themselves.
   - Adult survivor feels ashamed, dirty, that there is something wrong with them inside and when this is discovered they will be deserted. Such thoughts influence how they feel / treat themselves.
   - Survivor report having a hard time nurturing and taking care of themselves. Easily give up, even when encountering success – don't believe that what they achieved is good enough.

The most common one liners:

- *I hate myself*
- *I don't deserve it*
- *I can't do it*
- *It has to be perfect*
- *Whatever I do, it'll never be enough*
- *It's not worth trying*
- *What I want doesn't count*

3. **Stigma:**
   - sexual trauma is outside the range of normal experiences - and people whose situations are outside the norm and are judged. Their suffering not understood.
   - Society has a preconceived idea what abuse is and how a victim out to respond, and this influences survivors who begin to doubt themselves and their actual experiences.

4. **Feelings:**
   - As children, adult survivors could not afford to feel the full extent of their pain and rage – this would have been devastating. In order to survive, they have learned that they

should never rely on their feelings. Feelings expressed that might have been underplayed, disregarded or mocked.

- Being unable to deal with the intensity of their anger and pain – they may have suppressed their feelings.
- Sexual trauma counselling stresses the importance of helping survivors to identify the complex kaleidoscope of their emotional reaction to their trauma.

5. **Dissociation:**
   - Self-protection – the psyche numbs itself against emotional pain, to protect the self from further injury.
   - Survivors put aside their feelings in order to survive, as feeling the intensity of their emotions could be overwhelming.
   - Deadening / shutting down of emotions = psychological / emotional numbing = dissociation = critical defence mechanism. Survivor can go through the motions of functioning in other areas of life.
   - It happens involuntarily. Four kinds of dissociation:
     i. **The senses and the emotions disconnect**. Survivor sees something but does not react as expected, or no reaction. (children watching TV while parent is being beaten by spouse)
     ii. **Depersonalisation** – survivor feels inanimate, like a robot or thing – feel more like an object, not a human and don't feel physical pain. Not uncommon for survivors to try to hurt themselves physically in order to feel 'real' or 'alive'
     iii. **Floating, distant feeling of detachment** from events and emotions that accompany them; or a total or partial amnesia surrounding events. Survivor has no feelings at the time of abuse – may see, hear, touch, smell in part. The full realisation of the experience is blocked.
     Survivor left feeling vague about the course of events.
     iv. **Complex: survivors memory becomes compartmentalised in distinct states**. Different memories are stored in different personalities within the person – creating multiple personality disorder.

   - Dissociation not four separate states – but ranges from one end of the continuum (pathological mechanism – multiple personality disorder) through to a healthily and normally adaptive defence.
   - "going on auto pilot' feeling numb, experience a sense of non-reality. Short lived responses that decline as the survivor integrates them into the self and the trauma subsides.
   - On-going trauma – split in self becomes apparent – 'out of body, looking down on the self, becoming an object.

6. **Intimacy:**
   - Building blocks of intimacy – giving and receiving, trusting and being trustworthy – learnt in childhood.

- Abuse skews survivor's natural trust and is left with confusing messages about the relationship between sex and love, trust and betrayal.
- Survivors describe intimacy as suffocating and invasive. As children – handled feelings on their own and taking care of themselves – therefor unfamiliar and scary to be in close committed relationship.
- Physical closeness experienced as a threat / confusing – therefore adult survivor struggles to establish intimacy with lovers. Past becomes confused with present.
- Thought of intimacy can be threatening – leading to 'escape behaviour' to 'run away from intimacy'
- Escape behaviour manifests itself in the following behaviours:
- Survivor moves from one place to another, can't settle, or get comfortable. When dwelling becomes home – they start to feel unsafe.
- Survivor develops long distance relationships as a way of avoiding, reducing intensity of relationship
- Survivor works long hours / travels often.

7. **Sexuality:**
   - Abused children are introduced to sex according to abusers timetable and needs. Sex drive becomes linked with shame, disgust, pain.
   - Sexual pleasure tainted
   - Sex associated with powerlessness, dangerous due to emotional pain it inflicts
   - Where abuse has been coupled with affection, survivors may begin to sexualise need for closeness. Intimacy and sex become confused and they sexualise their demonstration of attraction early in the relationship.
   - Sex may be regarded as a means to securing things that the survivor wants.
   - Some may become anxious about being hurt when they feel aroused – they have faulty patterns of arousal that interfere with normal sexual adjustment.

8. **Self-harming behaviour:**
   - Initially children learn about the world and themselves through their body. Hunger, fear, love, rejection, anger etc. All emotions begin on a bodily level.
   - As children, survivor's bodies were the means by which they learnt the world was not a safe place, where their needs were not met. They therefore learn to do things to adapt. Numbing, addictions, self-mutilation are all attempts to survive.

Eating disorders: May reflect disgust with femininity and sexuality.
Lack of eating / over eating = bid to disguise these aspects of the self.

- **Food restricting (anorectic)** obsessed with not eating, revolted by food. Obsessed with body image and weight. Asserting control over eating is an attempt to assert control over themselves.
- **Non-food restricting (bulimic)** binge and purge with laxatives / exercise to maintain substandard weight. Relief / power when able to vomit the food out – throwing up is a

subconscious act of eliminating reminders of the penis, fingers, objects being forced into their body.

- **Compulsive overeating –** binging, eating, even when survivor does not feel hungry. Find it difficult to stop eating, realising a problem, secretly binges / lies about it. It's an escape – it brings relief and is a way of nurturing the self at a time of hurting. Food becomes substitute for other needs.

Substance abuse: Alcohol / drugs serve as self-medicating for trauma, they eventually create financial, interpersonal social problems.
Abuse prevents the survivor from being in touch with his or her pain, prevents other from getting too close; is the survivor's expression of both the anger towards the abuser and helplessness of the abused child – and reflects the lack of restraint and boundaries experienced by the survivor during their time of abuse.

Self-Mutilating behaviour: Physical pain seems to alleviate the unbearable feelings. Cutting, burning, banging the head, hair pulling.
Not a means of manipulating others, nor a suicidal gesture.
Feelings of depersonalisation and anaesthesia, feelings of unbearable agitation and compulsion to attack the body.
Wounding actions release "feel-good chemicals" that are morphine-like substances on which survivor becomes addicted.

Mixing in the wrong crowd: survivors have a deep sense of being different, alienated and marginalised – therefore may be attracted to groups / activities that don't fit in with the mainstream of the world. Within social milieu – survivor feels equal.

Children and parenting

- Adult survivors have not benefited from the positive influence of healthy role models.
- Parenting becomes a challenge because they have not experienced parental nurturing first hand.
- Child abuse is not genetic – but it can multigenerational.
- Not true that abused children grow up to be abusers themselves.
- Some are scared of children being born into a dangerous world
- Some place themselves under pressure to be the perfect parent.
- Often overprotective parents, too restrictive – bad for children who need to develop autonomy and independence.
- May feel shy to discuss sexuality and then fail to give appropriate sex education.
- Dynamic interaction between parent and child provides the adult survivor with a chance to reconnect with the 'child within'.

The impact of abuse on a partner

- Partner has been robbed of a partner with a healthy attitude towards sex.
- Partner might not understand what is wrong.

- If partner sensitive to sexual matters, they are likely to recognise the survivors unusual or unpredictable reactions during lovemaking, but can't make sense of them. Numbing, dissociating will be unnerving.
- Partner may not understand the complexities of healing and may expect immediate recovery.
- Partner may struggle with unfairness of being target of survivor's pain. Their reaction makes the survivor feel that partner blames him
- Partner can be over protective and over sensitive to survivors pain – then try to take charge of the recovery at their own pace, in their own way – serves to disempower the survivor.
- If not part of therapy, partner unlikely to understand the emotional impact of healing process. Don't understand that things get worse before they improve.
- Survivor's sexual reactions may confuse partner.
- Partner personalises responses received from the survivor – doesn't understand they are rooted in past.

THEME SIX – THE HEALING PROCESS OF THE ADULT SURVIVOR

- Phenomenological and strengths-based approach in working with survivors.
- Survivors are people who have inherent strengths and abilities to survive and overcome the harmful effects of their ordeal.
- We should not judge coping responses as good / bad – but rather as more / less helpful. J
- Coping efforts may be observed in many aspects of the survivor's life: way in which they conduct interpersonal relationships, emotional patterns, defences, assumptions about the world and people who live in it.
- Coping responses that exist indefinitely fail to equip the survivor well for the rest of their lives and this prompts them to come for therapy.

Healing is regarded as a process.
Healing means "*confronting what you haven't yet confronted, integrating what you have yet to integrate, and binding up your emotional wounds*"

The nature of the healing process

In order for healing to really begin, survivor must demonstrate a willingness to sort out thoughts, feelings and memories from their past.

Helping Relationship in the healing process

- Central features of psychological trauma = helplessness, loss of personal control and detachment from others.
- Recovery is based on empowerment of survivors, helping them to reconnect with their strengths and providing genuine relationship where they feel respected, understood and have their personal power returned to them, by being encouraged to take their own decisions. Abraham Kardiner: *"An assistant to the patient, whose job it is to help the patient to complete the job that he is trying to do spontaneously…"*

- Sole purpose of the relationship = promote healing of the survivor
- Helper becomes the survivor's ally.
- Understanding between helper and survivor regarding the use of power. Survivor perceives himself committing to an unequal relationship because helper is assumed to have superior status and power.
- Helper must therefore resist all attempts to dominate, control, and manipulate survivors.
- Helper is a collaborative partner who does not direct, advice or educate the survivor.

Popular notions about the healing process

Process implies a series of steps or stages that are progressive in nature.

1. **Healing can only begin with the survivor at the steering wheel:** others can support, assist and care, but none can 'cure' the survivor. Recovery is dependent on their

ability to regain power and control over their lives; they need to be recognised for doing it themselves.
Survivors should be offered choices and consulted about their wishes.

2. **Healing takes time and hard work:** It's not an overnight process, may be lifelong, depending on how deeply the survivor was harmed by the abuse and the extent and quality of the support available.
   Each survivors healing process unfolds in its own course of time. They must make sure they understand each of their experiences and reactions to their experiences.

3. **Stages of the healing process are abstract:** Experts have tried to simplify the complexity of the process so that they have common terms of reference to understand and follow during the survivors responses during healing.

4. **Healing is a non-liner process**: healing process consists of different components that do not necessarily follow a particular order or sequence. It's more of a spiral

5. **Healing does not imply recovering to the survivor's state of being before the abuse**; it implies something better: the objective is for the survivor to be stronger and wiser than they were before the abuse. By claiming talents and wellbeing that are theirs by right, survivors actually can turn disadvantages into advantages.

6. **Healing requires safety:** survivors sense of being in control of their emotions and behaviour so that they can handle and regulate their pain (Internal) and having a safe haven to seek comfort from, that is free from emotional and physical abuse (external)
   Survivor needs to feel safe with their thoughts, feelings and behaviors before they can contemplate the trauma.

7. **Healing happens in fits and starts:** the transition from one stage to another is gradual. Survivor might drop out of counselling when they believe they have dealt with as much as they are willing to. They manage until the trauma reoccurs – triggered by life, a dream. The trigger allows him or her to proceed to the next stage of healing. Helper must respect the autonomy of the survivor and expect breaks in between.

The healing process is described differently, according to each theorist's perspective:

Herman's model = 3 stages. (NOT NEEDED FOR EXAM)

- 1st stage, primary concern is re-establishing survivor's safety.
- 2nd stage, involves facilitating the survivors remembrance and mourning
- 3rd stage, reconnecting the survivor with ordinary life

At each stage, survivor must be helped to address biological, psychological and social consequences of their trauma.

Matsakis's three stages of healing (NOT NEEDED FOR EXAM)

1st Stage: Remembering the trauma and reconstructing it mentally

- Cognitive part of recovery
- Regardless of type of trauma – important that they eventually recall as much as possible.
- This enables them to understand the connection between current symptoms and past experiences.
- Help survivor to view the trauma objectively, not judgementally
- Through processing experience, lead to four gains:
    i. A clearer assessment of the choices that were available during the traumatic event
    ii. A greater understanding of how the trauma influenced their thoughts, feelings, actions
    iii. Reduced self-blame
    iv. Sharper understanding of whom they feel anger or rage towards

2nd stage: Experiencing feelings associated with the trauma

- Emotional stage of recovery
- For healing to occur, survivor must rework experiences on emotional level
- Suppressed emotions must be identified and experienced, at a gut level.
- Survivor needs `courage to feel'

3rd stage: The empowerment of the survivor

- The mastery stage
- Survivor finds meaning in the trauma and develops a `survivor' rather than `victim' mentality
- Regain strength and able to:
    i. Recognise their PTSD symptoms more quickly
    ii. Comfort themselves in non-destructive ways when experiencing symptoms
    iii. Manage the symptoms without harming themselves or others
    iv. Develop a growing self-respect that comes from taking care of themselves physically and emotionally
    v. Develop meaningful relationships
    vi. Derive some meaning from their trauma

- Matsakis's model emphasises that healing does not run in a straight path – it involves occasional regressions; regressions are inevitable as survivor takes on more emotional material then they can handle.
- They have to retreat to absorb the emotional shock and make sense of this highly emotive material before they can move forward again.

The six stage model of healing (Petty & Spies 2005)

1. Denial
2. The emergency stage
3. Consciousness
4. Exploration of emotive content
5. Bottoming out and acceptance
6. integration

1. Denial

- Thought of trauma are painful and distressing, therefore survivors engage in conscious and unconscious ways of blocking the experience from their everyday lives.
- In an effort to move on/ regain control of their lives – they pretend the abuse never happened, or they have not been negatively affected.
- Resort to avoidance behaviours, but cannot avoid emotional pain and therefore experience stress related symptoms
- Denial:
- Provides a respite during moments when survivors cannot align themselves with the memories of their trauma / abuse.
- Is a natural response when memories become too much to bear.
- Indefinite denial harmful because if the survivor never acknowledges the abuse, they will never get to grips with the effects the abuse has had on their lives. It prevents them from taking remedial action to correct their negative /harmful assumptions that regulate their decisions about surviving.
- Cannot demand that survivors let go of all their defences – that would be violation of respect regarding their autonomy.

Denial behaviour:

- **"Running away"** – changing jobs frequently, being in and out of relationships, changing therapists
- **Dysfunctional eating patterns**
- **"I'm fine now"** – know they have been sexually abused, but don't believe it's necessary to deal with it. Survivor unable to identify the pervasive impact the abuse has had on their lives.

Levels on which believing takes place:

- Believing abuse definitely happened
- Believing that abuse affects their adult life negatively
- Believing that, despite the abuse, they remain an acceptable and worthy person, entitled to respect.

2. The emergency stage

- Having acknowledged the abuse occurred; survivor goes onto emotional roller-coaster.
- Supressed emotions come flooding back with such intensity that survivor struggles to manage to control all the memories.
- Survivor fears they will not be able to manage to unpack the experiences and yet realise that they cannot pack them back into their unconsciousness.
- Inability to regulate the emotional expression of the sexual trauma due to:
  i. Trauma and secondary trauma experiences, by their nature, are physically and emotionally powerful events.
  ii. The feeling of being overwhelmed by emotions recreates the emotional climate of the original sexual trauma.
- The commencement of the "re-experiencing of feelings" associated with sexual abuse marks the emergency phase = earthquake = immobilising and intense. Later emotions are more like earth tremors.
- Emerging feelings may interrupt survivor's routine at first due to being constantly confronted by the reality that the abuse happened.

Dangerous symptoms to watch out for, and then refer to prof. for medication:

- Fainting spells
- Hallucinations
- Feelings of being out of touch with reality
- Urge to hurt themselves
- Suicidal / homicidal thoughts
- Being unable to function for more than a day
- Physical immobilisation for more than 2/3 hours

To minimise suffering during emergency phase, survivor must:

- Remind themselves that this is normal, temporary phase that marks the process of healing
- Enlisting support / assistance from others
- Spoiling themselves and building treats into their daily routines – as this cultivates self-nurturing habits
- Constantly rewarding themselves for demonstrating the courage to move forward
- Finding skilled professional support
- Keeping a journal

3. Consciousness

- Important for survivor to recall as much of their story as possible
- Having experienced flashbacks an emotional intensity in the emergency stage, survivor needs to understand causative factors.

- Survivor must piece together clues about what actually happened – which helps the survivor develop a cognitive understanding of the context in which the sexual abuse occurred.
- Powerful step – brings about concrete validation of the memories.
- Survivor challenged to break the silence and speak to significant others – who can help them make sense of what happened.
- This stage is about discovering the content of the abuse and disclosing it.
- Detective work should only start once the survivor has a network of support and a self-care program in place. Survivors must not rush to move on without ensuring their safety.
- Survivor should only discover and share the information about the abuse at their own pace and in a way they can deal with it. Increasing knowledge can bring additional pain.

Memory aids to trigger recall of traumatic incidents:

- Photographs
- Revisit the scene
- Speak to others who were in their lives at the time
- Talking to other survivors and reading literature may prompt memory
- Write the story / record it / telling a trusted person
- Physical expression through paint / dance /sculpture

- Memory process might get stuck - too painful to go on. Then survivor must stop and revisit the memory later.
- After processing all the feelings, survivors begin to focus on the trauma objectively, rather then being judgemental about it and themselves. They develop a clear picture of the pressure they were under and the choices available to them at the time.

4. Exploration of emotive content

- Survivors start to see connections between current symptoms and their past.
- People fear losing control of themselves and experiencing further suffering.
- *Five common emotions that survivors need to address are:*
  i. Anger
  ii. Grief,
  iii. Guilt,
  iv. Fear,
  v. Asexuality

May not deal with all the emotions – some may never surface and some might not disappear.
Survivor's goal is to tolerate the intensity and duration of feelings, without their interfering with and derailing them from daily functioning.

i. Anger:

- Closely connected to grief.
- Natural response to injustice where a person feels their rights have been violated.
- A functional emotion that energises people – making them feel powerful. Energy enables them to take action to deal with unresolved issues
- Motivates them to work through feelings of shame and tear down secrets that keep them locked into pain.
- Converse of anger is grief and loss – leaves survivors feeling weak and helpless
- Anger manifested in different ways:
  - Directed at offender
  - Directed at mother for not protecting them
  - Inwards – at themselves
  - Some fear anger will overwhelm them, endanger them.
  - Towards those who were not helpful in the aftermath – family, friends, helpers.
- At first – survivor might not be fully in tough with anger – it spills out in overreactions in daily lives.
- Children may turn anger inwards as perpetrator can convince them that abuse is their fault, resulting in self-blame and anger.
- Survivors might not verbalise their anger due to:
  - Fear of the offender
  - A belief that anger is unacceptable / dangerous emotion
  - A fear that the same pattern of abuse will occur in their own families

Focusing anger on the offender and away from the self clears the way for self-acceptance, self-nurturing. Venting rage is cathartic.

ii. Grief and mourning:

- Grieving hardest part of the healing process
- Emotionally intense – people try to avoid it – which is inherent dangerous. Avoidance can result in rage, restlessness, depression, addiction, anxiety
- Inability to grieve can aggravate medical conditions.
- Three levels of grieving:
  1. Grieving the loss of a specific thing taken by the trauma: virginity, belief in the integrity of people, loss of home.
  2. Grieving for the loss of power and control. Survivor has a deep sense of defeat when they realise they can't turn back the clock – nothing can undo the abuse.
  3. Grieving their mortality – Trauma triggers awareness, they will die one day, and will not be able to get any control over this event. This is ultimate expression of powerlessness.
- Potential for dysfunctional grief is high due to there being no rituals that recognise mourning.
- Specific rituals to facilitate mourning will offer mourners comfort, support, hope.

- They will move from a problematic situation to a new status by consciously celebrating resolution of difficulties, their awareness of new identified resources and strengths, the movement towards healing and wholeness. They mark their accomplishments.
- Celebratory dinners, cleansing rituals, writing letters to the abuser.
- Survivors need to be helped to take stock of their losses (innocence, peace of mind, safe relationships, and abandonment by non-abusive parent)
- Intensity of mourning depends on depth, length and meaning of their losses, their cultural background, personality, amount of energy available to deal with demands placed on them
- By identifying losses and grieving them – survivor can use the knowledge of what they have lost to empower them. By allowing themselves to mourn they are making space for new feelings and relationships – they become stronger and move onto a life without the pain.

iii. Guilt and self-blame

- Survivors being to believe that they were, in some way, responsible for the abuse. This self-blame is pervasive, impacting many aspects of their lives.
- Reflection on the survivors responses during the abuse event, helps survivors understand that their responses were comprehendible and part of fight, flight, freeze reaction.
- Must learn to evaluation actions against the backdrop of emotional shock, specific pressures operating during the trauma.
- Alert to patterns of all-or-nothing thinking, must ask: "is the self-blame based on a general pattern of unacceptable behaviour or just one or two mistakes?" – they then come to realise they have generalised their guilt to other areas of their lives.

iv. Fear

- **Explicit or Implicit**
- Fear for their lives, during the event or as consequence of breaking the silence, fear of abuse being repeated
- May be deeply embedded fear, nonspecific, fear of world as dangerous place.
- Fear can be monitored in survivors avoidant, phobic, self-protective behaviour.

Darkest fears:

1. Will I become a child abuser?
2. Will I always loath sex?
3. Will I be able to stop sabotaging myself?
4. Will I always feel compelled to have sex with whoever wants me?
5. Am I homosexual?
6. I enjoyed sex when I was young – does this mean it was my fault?
7. When I was little I tried to have sex with other children, does this mean I am an abuser?

v. Asexuality

- Instead of survivors recognising sexuality as being an integral part of their humanness and healthy functioning, they tend to develop distorted perceptions of themselves as pathological sexual beings.
- During this stage of the healing process, survivor struggles to make sense of feelings of shame, disgust, explores how these are associated with sexuality.
- Through introspection, survivor examines and challenges his misconceptions about relationships, intimacy, and sexuality.
- They separate from their imprinted experiences of trauma and start assessing or evaluating each relationship according to strength / weakness.
- Survivor makes a conscious effort to nurture themselves and validate themselves (caring for physical appearance)
- Healing brings with it the knowledge that they have the right to choose their sexual partners, expect their partners to be patient and supportive.

5. Bottoming out and acceptance

- Stage of taking stock
- Survivor evaluates the extent to which abuse has impacted their lives.
- Feelings start to stabilise as understanding of how abuse has distorted their way of thinking and feeling.
- Patterns need to change, and they develop a sense of control over their future (despite having no control over the past)
- Start to incorporate lessons learnt in life.

6. Integration

- The stage where survivors have learnt all they can about their experience of abuse – and it no longer has the same intense impact on their life as it once had.

Indicators of recovery:

- Developing a more positive self-image
- Set goals to maximise happiness – education, relationships, careers
- Increase in self-acceptance results in fewer difficulties with entering and maintaining positive relationships.
- Find it easier to tolerate own mistakes and those of others
- More self-aware and able to recognise abuse distorted thoughts, feelings and behaviours – and act on them before they create problems.
- More realistic – recognise present day difficulties need not become disasters.

- Recovery does not imply a complete reduction of symptoms – as symptoms are triggered by anniversary dates, entering into new relationships, life's losses and disappointments.
- Recovery implies survivors appreciate their emotional and spiritual growth, take greater control of their lives, forgive and reward themselves, work through emotional and psychological scars as they appear.

- Recognise their own resilience and make peace with those things that are beyond their control.

THEME SEVEN – RAPE

Rape is defined as a sexual act – but is primarily an expression of violence, anger or power. Underreported, unpunished crimes.

Definitions of rape

Legal definition in SA "Intentional, unlawful sexual intercourse with a woman without her consent. This includes rape within a marriage as well as the rape of a woman by the man she is going out with"

- "**Intent**" – man must have wanted to commit rape
- "**Unlawful**" – offender must be over age of 14yrs
- "**Sexual intercourse**" – penetration beyond the opening of the vagina by a penis. The offender does not need to achieve an orgasm. (did society gender roles create rape??)
- "**without consent**" – sexual act took place against a woman's will.

Statutory rape

Consensual intercourse that takes place between an adult male and a girl who is younger than 16yrs

Present problems with the legal definition of rape

- The definition undermines the harmful effects of other sexual assaults such as oral / anal intercourse, penetration using objects.
- Definition ignores the fact that violent sexual acts between people of the same sex may be traumatic when one of the parties does not consent to participate in these acts.
- Female offenders are not legally recognises as rapists. They may only be convicted as an accessory if they are involved in helping another person rape someone
- The Act does not acknowledge that boys under the age of 14yrs should be found guilty when committing sexual acts with someone else, under coercive circumstances.

The amended definition of rape

1. Rape should be recognises as gender-neutral statutory offence.
2. Any sexual penetration that takes place in coercive circumstances should be recognises as unlawful.
3. Acts compelling one or more individuals to engage in sexual acts with another / others should be unlawful
4. Sexual penetration should be defined more broadly and should include simulated sexual acts.
5. Oral and anal penetration, under coercive circumstances, should be considered rape.

6. Previously victims had to prove that they had not consented to sex. New act proposes that the onus is on the offender to prove that the victim consented to sexual acts, as a justification for their sexual acts. Perpetrators have to prove their innocence.
7. No marriage / relationship shall be recognised as a defence against any charge of rape.

Different forms of rape

1. **Friend Rape:** common form of rape committed by someone know and trusted by the victim. Rapist interprets refusal as sex play "playing hard to get"
   When victims assert themselves, rapist gets angry and forceful.
2. **Date Rape:** back of a car, deserted place, hotel room – carefully chosen. Victims voluntary presence is misconstrued as consent to sex.
   Victim not physically marked, due to threats – no struggle – then difficult to prove that sex did not take place mutual consent.

Because victims of friend and date rape tend to remain silent about the abuse – they are more likely to be trapped into their feelings of self-blame and guilt than survivors who have been raped by a stranger.
Their assumptions about the world and perceptions of others are destroyed. It is difficult to disclose this abuse, for fear of being labelled as naïve / stupid.

3. **Drug rape**: rapist finds a means of drugging victim, rendering them incapable of independent action and choice.
4. **Medical abuse:** doctors, dentists, physiotherapists have a unique quasi-legitimate access to intimate touching. Some practitioners have been known to target young, naïve patients and pass off sexual activity as part of treatment. Abuse is disguised in such a way that victims become unsure of their own perceptions of the situation and then fail to report the experience.
5. **Gang rape:** peer group, school mates, military colleagues
   - "Jack Rolling" – township saying that refers to violence directed at young woman by armed youth gangs.
   - 75% of gang rape in townships is gang rape.
   - Schools in townships vulnerable to attacks.
   - Gang rapists are between 10 and 17yrs
   - Trauma of victims extended as they have to continue facing rapists at school, on the streets.
6. **Opportunist rape:** happens in isolated or deserted places such as bus shelters, public toilets, road sides. Townships and similar that have poor lighting and lack of public transport may increase likelihood of rape. Rapist mostly unknown to the victim.
7. **Premeditated rape:** committed by people with obsessive mental disorders. Victim is perceived as prey and stalked over a period of time. Offender takes pride in outwitting, humiliating and terrorising the victim – which may occur over minutes or years

8. **Political rape:** rape of prisoners of war, as part of breaking them in. Pain, humiliation and disorientation are induced together with sleep deprivation and isolation. Done to shatter their identity.
   The rape of elderly people: severe physical injuries because of aging body. Nervous system no longer able to cope with the stress. Sense of safety shatters and loose independence.
9. **The rape of sex workers:** due to emotional deprivation / extreme poverty - prostitution. Sex workers are exploited.

Common Rape Myths

Lewis: *"Rape myths give a man silent permission to rape a woman because they help him to excuse his behaviour and escape responsibility for his violent action"*

"Blame the victim" beliefs about rape – allowing society to shield itself from having to assume responsibility for initiating change and addressing inequalities and misuse of power.
Rape is committed by both men and woman. But statistics suggest more men then woman commit rape.
Rape myths:

- teach survivors to blame themselves for their own victimisation.
- Transform rape by acquaintances, friends, intimates into "no rape at all'
- They keep survivors quiet and controlled.

Myth 1: Only bad girls get raped: attitude that betrays a double standard of sexuality. Sexual feelings and expressions acceptable for men, but unacceptable for women.
Woman provoke rape by behaviour and appearance. Participate voluntarily and then cry rape later.
First world woman expected to look attractive, but if raped then damned and scorned.
Society shifts blame from man to woman, making woman feel guilty of her rapists crime.

Myth 2: All women enjoy a little rape now and then: rape has nothing to do with sexual pleasure, but is used as a means of overpowering victims. Victim has not control and are at the mercy of rapist.

Myth 3: Men rape for sexual relief: rape is mostly not sexually motivated. It is a pseudo-sexual act. Committed to fulfil non-sexual needs such as power, domination and need to prove masculinity.
Power Rape: rape by a disempowered person, frustrated by life situations like poverty, unemployment – therefore rape to assert power over another person.
Anger Rape: Person with unresolved feelings of anger, resorts to sexual assault to vent anger.
Sadistic Rape: the rapist intention is to humiliate and hurt – includes mental and physical abuse that involves sexual and non-sexual torture.

Myth 4: Rape is as sign of male virility: *"in our country, rape is part of a virility mystique in which maleness is equated with sexual aggression"* SA has the highest rape statistics in the world. In some societies – men who rape are not considered masculine. (Italy, Greece, Spanish speaking – men who use physical force are mocked – they are expected to use charm and wit, sex appeal to win woman)
In some segments of SA – rape is glamorised or interpreted as a form of initiation.

Myth 5: Men rape because they cannot control their sexual lust: man has a natural sexual desire that he can't control – which causes him to rape. Research findings that disprove this believe (Lewis):
This belief projects men as not being accountable for their actions, yet research shows that rape is planned in advance, happens in a woman's home, and involves a man known to the victim. This belief is a social construction to vindicate men from taking responsibility for their actions.
All types of women are raped, including those not seen by society as "sexy", like babies and old woman. Rapist targets the helpless – therefore shows that rape is act of power rather then lust.
Rapists rape despite having no / little sexual feelings for their victim.

Myth 6: Date rape isn't really rape: women raped by friends or dates have been found to be fearful for longer periods, suffer more self-doubt, question their ability to take care of themselves more, doubt their ability to judge people.
Myth 7: Rapists are usually strangers: up to 50% of victims know their rapists. Often from same school, work, family – often the person least suspected.

Myth 8: Only attractive women get raped: rape has little to do with the appearance of the victim, more to do with the rapists state of mind.

Myth 9: A woman was not really raped if she does not fight back: it is rape when a person has sex with another person without his or her consent. A rapist does not need to use physical force or a weapon, nor does the victim need to fight back. Intimidation always used in rape. Survivors may be passive (due to lack of strength, intimidation, don't know how to fight back, cultural norm).

Myth 10: Men don't get raped: but they are raped more often than commonly thought.
They are less likely to report it due to the shame and humiliation they feel. They fear the scorn they will get for being unable to defend themselves, and worry about being labelled homosexual.
Society's intolerance of 'unmanly' men forces male victims of rape to keep abuse a secret.
Most male victims raped by other men. Intense fear can cause erection, making it possible for adult females to rape younger boys.

Myth 11: If I have a pre-existing relationship such as a marriage, then I have a right to sex:
Some societies promote a sense of entitlement in marriage – they see the satisfaction of male's sexual needs as the women's responsibility, and this evokes aggressive sexual acts by the male.
Woman has no economic means to manage on their own and is therefore prisoners in the relationship.
Healthy sexuality contains an implicit respect for a partner's needs.

The effects of rape

- Rape increases a victim's sense of depersonalisation, mistrust and alienation in society, as a whole, and even in themselves.
- Matsakis: Rape wounds – psychological wounds that exert great power over a person's life. *"Sadly, psychic wounds are not well respected in a society that better understands broken bones than broken spirits"*
- Being raped changes the way a survivor sees her life. Integrating the experience into her life may take months or years.

Every rape is different and victims respond to rape in a personalised unique way. Response is shaped by many factors:

i. Demographics – age, gender, religion, class, culture and ethnic group
ii. Victims personal history – previous psychiatric history, life experiences, manner in which they have transcended normal development crises
iii. The rape itself – the nature of the violence or force used; the circumstances of the rape, the sources of help available to the victim at the time
iv. Factors relating to individual rapists - who they are, their relationship with the victim, the behaviour towards the victim during and after the rape
v. The availability of post-rape support – the response of the police and medical staff immediately after the event, support of family and friends, trauma counselling.

Consequences of the rape may be worse if the survivor is *"physically or mentally handicapped, raped by more than one person, or on more than one occasion or by someone trusted"*

<u>Survivors have two distinct groups of reactions to their trauma:</u>
Acute symptoms: Those responses that present immediately after the rape and responses for a limited period (six months) after the rape.
Chronic symptoms: include all long0term unresolved issues stemming from the trauma six months or more after the rape.

Acute Symptoms:

- Survivors struggle to deal with their vulnerability and confronted with their loss of control and power.
- They feel unsafe in their bodies and emotions, and in relation to other people.

- Unsure of themselves and ability to manage emotions

Feelings: Intense fearfulness, anxiety, bouts of crying, blunted emotions (flat, expressionless)
Cognition: poor concentration, faulty memory or recall
Physical: sleep problems, nightmares, insomnia, nausea, headaches, constant fatigue, disrupted menstrual cycle, prolonged bleeding, STI.
Social: Paranoia, disruption of personal relationships, inability to handle certain situations with others at work, school, restricting social activities to feel safer, change jobs, home, telephone number in attempts to feel safe.
Arousal Responses: physiological arousal symptoms – shortness of breath, dry mouth, palpitations, jumpiness, hyper-alertness

Chronic Symptoms:

- PTSD
- Rape Trauma Syndrome (Burgess and Holmstrom) – symptoms resemble the more modern classification of symptoms of PTSD listed in the DSM-IV.
- Each person response is unique.
- Chronic symptoms are generally more subtle and develop into other syndromes that mask the initial and underlying rape experiences.

Feelings

- Numbness, loss of feelings "flat"
- Shame – despite not being responsible
- Anger due to the unfairness of the event, senselessness of the event, lack of understanding from others Feelings spur the need for revenge.
- Fear of recurrence of event, being alone, losing control over emotions.
- May develop phobia about men, strangers, leaving homes – become aware of their own vulnerability.
- Sense of loss of many things – dignity, control, peace of mind, hope for the future, physical wellness, faith in others.

Cognition

- Assumptions of the world and people in it are reconsidered
- Can't concentrate, easily distracted

Physical

- Cope with pregnancy, STI, HIV, headaches, eating disorders

Social

- Neglect themselves and others or become preoccupied with cleanliness as a result of feeling defiled by the rapist.
- Will not socialise, or socialise all the time

- Interpersonal problems are common – more irritable / argue
- Capacity for intimacy impacted – therefore left feeling emotionally separate.
- Two relationship patterns: becoming overly dependent upon others or over independent of others.
- To regain control – may make sudden changes in work, home, town.
- May lose interest in sex, aggravated by partner who blames them.

Arousal responses

- Avoid anything that reminds them of the rape
- Easily startled, hyper-alerted, flashbacks.

Intervention

Acute intervention

- Purpose is to address practical matters that have been caused by the rape such as health, safety, violation of privacy.
- Raised levels of adrenalin will impact survivor for a while and observation of reality may be affected.
- They fail to make sense of the connection between their symptoms and their experience.
- To minimise long-term impact on the survivors functioning, they should be offered high levels of support.
- Given the opportunity to relate their experience repeatedly since this enable them to make sense of what happened, and understand why they react to various things (on guard for danger, flashbacks,) during their daily lives.

The role of the helper (CRISIS INTERVENTION – supportive and task oriented)

- Listen, provide support and reassurance
- Words should acknowledge the seriousness of the offence.
- Communicate that you are glad survivor is alive and reassure them they did everything possible at the time of the rape.
- Reflect that the rape was not the survivors fault and her / his story is believed.
- Demonstrate a deep willingness to understand the survivors experiences, (not use their own frame of reference)
- Allow survivor to express their feelings, which will help them to make sense of their emotional trauma and confusion which facilitate healing and restores their sense of control over their lives.
- Primary objective is to secure safety of the survivor
- Refer victim to police / medical facilities
- Offer to be with them – or get someone they trust to be with them.
- Give priority to protecting their confidentiality – survivor can choose who they want to disclose to.
- Respecting their right to confidentiality will facilitate trust building

- Survivor should be encouraged to make all decisions as to what actions they wish to take – so as to empower them. Critical step towards restoring their sense of control over their lives again.
- Survivor helped to express immediate feelings – fear, anger, shock – so they can be worked through.
- Give support and education to prepare them for legal and forensic procedures that have to be followed should they decide to prosecute.
- Help assists survivor in practical ways to "get them back on their feet"

Addressing Medical issues after rape

- See a doctor as soon as possible – even if he / she has not sustained serious injuries, even if they don't plan on reporting this to the police.
- Survivor that lays a charge of rape, they are expected to see a district surgeon first before consulting a doctor for treatment.
- Tetanus for any cuts or grazes
- Throat irritations and soreness are common after forced oral sex.
- Rape brings on menstruation and periods are heavier and more painful thereafter
- Females not using contraception should be given the post-coital pill. This involves taking two oestrogen pills every 12 hours, within first 72 hrs of being raped.
- Treatment to prevent vomiting is recommended at the same time
- This treatment is unsuitable for pregnant woman
- Alternative method of preventing pregnancy = intrauterine device fitted in the first 5 days following the rape.
- Effects of STI's can be minimised by prescribing medicine
- Avoid possible contraction of HIV by ARV's. which are offered by the state.
- Baseline test taken after rape to establish if the survivor had HIV. If not – then they have to wait for a three month window period to pass to establish if they have contracted HIV or not.
- Hepatitis more infectious than HIV. Immunoglobulin injections administered in five injections, after one, two and six weeks and then again after three and six months. Not offered by the state.

Helping survivors who plan to prosecute

- Secondary victimisation is common, making survivors choose not to report rape so as to avoid further possibility of humiliation and stress.
- *Two main reasons for pressing charges:*
    i. Survivors choose to take legal action out of a sense of duty to themselves and other potential survivors
    ii. Legal action affords them a legitimate opportunity to deal with their anger, which leads them to regain a sense of power and control over their lives.
- Successful prosecution depends on factors beyond survivors control
    - Meticulous preservation of evidence by the forensic team
    - Speed with which the police respond to their call for help

- Ability of police to secure the scene of the crime in order to find evidence
- Extent to which the investigating and forensic teams follow procedures
- Personal attitudes of investigating and forensic teams
- Attitudes of legal representatives and presiding judge

At the police station

- Survivor should be accompanied to the police station
- If under the age of 18, then Child Protection Unit should be notified immediately

Procedure:

1. Police officer introduces himself
2. Police staff offer the survivor a quiet office, separate from charge office, to protect privacy
3. Police officer explains the procedure to be followed, being specific about the people who will need to interview the survivor.
4. Survivor should be given the option of speaking to a same gender police officer.
5. Survivor cautioned about giving a statement at this stage as they are considered to be in a heightened emotional state that may lead to them contradicting themselves, which could compromise their case if it goes to trial
6. Police officer obtains brief version of what happened, focus on description of offender and location of rape
7. Police officer informs survivor of importance of preserving evidence on her / his body. Given detailed reasons why they must avoid swallowing liquids after oral sex, refrain from washing and retain all sanitary material that they used during urinating and cleaning themselves, and preserve underwear worn during the rape
8. Police officer arranges for detective to investigate the case
9. Team of investigators dispatched to the scene to collect evidence
10. Police officer arranges for survivor to see a medical examiner ASAP

The medical examination

1. Victim not allowed to bath or shower until the samples have been collected from their bodies
2. Procedure:
3. Swabs taken from vagina, mouth and anus
4. Glass smears are prepared from samples from each of these areas
5. Pubic hairs are combed and those that fall free are placed in soft paper envelope
6. Samples of hair with roots are removed from the survivors head
7. Nail scrapings are taken from the survivors fingernails
8. Blood samples are taken from the survivor
9. Survivor asked to identify all persons they've had sex with in the 72 hr period prior to the rape.
10. Blood samples taken from these identified people in order to make DNA comparisons

11. Medical examiner informs survivor of the importance of taking pregnancy and HIV tests
12. Under no circumstances may the samples collected from the survivor of rape be handled by the person who has dealt, or is dealing with, the suspect's specimens. Survivor and suspect samples should never be allowed to be stored on the same surface as this may result in contamination.
13. Survivors underwear is collected and placed in fresh paper bag

The identity parade

Identify suspect from behind a one way mirror, but most police stations don't have this facility. Survivor should be accompanied and will not have to touch their suspect.

Medical treatment

- Not offered at the same time as the medical examination
- After the examination, survivors asked to choose his/her own treatment facility
- If financial restrictions, then SAPS have the responsibility to take the survivor to the nearest state hospital.
- Prophylactic treatment for STI's, HIV and pregnancy should be given as early as possible.
- Doctor should refer survivor for counselling at Rape Crisis or Life Line, or trained counsellor.

Preparation for court

- Rape is a capital offence.
- It is a crime against the state
- Rape survivor becomes the witness in the state's case against the suspect.
- State has to prove the suspect is guilty
- State lawyer is the public prosecutor who assists the survivor prepare for the court case
- Lawyer can be consulted, but not allowed to represent them in court
- Survivor is the plaintiff = expected to tell the story in detail, under cross-examination from suspects (defendant) legal counsel
- Suspect is the defendant
- Conviction is not guaranteed
- Courts are overworked and many delays and postponements
- Court may be traumatic, as defence may try to convince court that survivor consented to sex, and try to discredit them.
- Supportive helper should address the following:
  - Helping survivor familiarise themselves with the court procedures
  - Prepare survivor for long waiting periods, often in close proximity to the suspect
  - Assist survivor to understand the legal terms and laws and common defences used
  - Help survivors to clarify their expectations in terms of the outcome they expect.

- *Positives of proceeding with legal process:*

- Survivor regains sense of control over their life by bring justice to the rapist
- Affording them opportunity to deal with their rape, rather than denying it happened
- Protecting others by making rapist responsible for their action

Post-Court Issues

- Rapist might not be found guilty, or receive a sentence that does not reflect the crime. This can result in survivor feeling victimised all over again.
- Survivor should be reminded that even if the accused is not acquitted, it does not mean the survivor was not believed.
- Court did not find enough evidence to convict.
- Survivors should be reminded of the following at the outset:
- They are not to be blamed for things that happened before, during and after the rape
- It will take time to rework feelings and thoughts about being raped. They will, in time, blend the experience into their world and live healthy, happy lives again
- Their safety is important. Help them take practical steps to increase their protection against further attacks.
- Survivors family and friends are also likely to be affected, and may also feel victimised.

Chronic Intervention

Treatment issues for rape survivors during chronic symptomatic presentation are complex.
Therapeutic relationship is of paramount importance
Individual survivor must feel respected by helper, experience the helper and genuine and willing to relinquish control to the survivor to pace their own healing process.
Helper's role is to:

- assist the survivor to link their past trauma with their current symptoms;
- help them to re-engage with their strengths and coping skills;
- motivate them to challenge any misconceptions they have about themselves and their rape;
- teach them new coping skills – like assertiveness, relaxation, stress management;
- Supports the survivor during flashbacks.

The process of Integration

- The emotional process of healing may be likened to the six step model of the process of healing (Petty & Spies)
- Recovery does not occur in a linear fashion, it is a lifelong process
- Individual survivors experience the stages of healing in their own unique way
- There is a strong sense that, within 6 months to a year after rape, survivors who receive qualified help regain much of their emotional equilibrium and are more confident about restoring their lives to the previous levels of functioning, than those who don't.

THEME EIGHT – MALE RAPE

Three main reasons why male rape is not recognised as a social reality (Mezey and King)

1. The male sexual stereotype emphasises men's superior strength, physical size and role as initiators of sexual activity. It is more difficult to imagine a man being victimised than a woman.
2. There is a failure to appreciate the nature of sexual assault as primarily an aggressive act, rather than one which is motivated by sexual need
3. For far too long, rape has been too narrowly defined as non-consensual vaginal penetration by a penis

Male Rape: Myths and Facts

Myth 1: Men cannot be raped: any person can be sexually assaulted. Rape may be defined as sodomy, buggery, indecent assault – in all cases victim experiences sexual violation committed against their will.

Myth 2: The rape of men happens only in prisons: it can occur at anytime, anywhere, to any person in any social standing

Myth 3: Only homosexual men rape other men: the majority of men who rape other men identify themselves as heterosexual. Rape is an act of violence and abuse of power, not sexual passion or lust.

Myth 4: Males who are raped are boys or weak adults: it is more difficult for us to believe that men may be sexually violated by others. Men traditionally expected to defend their boundaries and limits whilst maintaining control. Society tends to silence them rather than acknowledge the vulnerability of masculinity and manhood in today's world.

Myth 5: If a man experiences an erection or ejaculates whilst being raped, it suggest that he is actually enjoying it: states of intense pain, anxiety, panic or fear may result in spontaneous erection and ejaculation. They are unrelated to sexual arousal and pleasure – but are physiological responses to fear

Myth 6: Very few men, if any, are raped: Male rape is an unreported crime of violence. Incidents go un-reported because victims fear being scorned and are ashamed of their failure to protect themselves.

Forms of Male Rape

- Assumption of sodomy (anal sex) – but there are many forms
- Forced Fellatio (oral sex)
- Masturbation of victim
- Forcing victim into their own anus

- Forcing victim to penetrate other victims
- Use of objects in the victim's anus

Who are the perpetrators of male sexual assault?

Homosexual male offenders

- There is usually some kind of interpersonal relationship between the perpetrator and victim before the rape occurs
- Statistically speaking, higher percentage of homosexual offenders target victims less than 25yrs of age, and appear to have known them for some time before sexually assaulting them.
- Rape of young males is more likely to be committed by authority figures that have access to them, schools, sports, youth movements, foster care.
- With children – modus operandi of offender is gentle seduction, and sexualising touching for a period of time before committing rape. They are multiple offenders, who choose times and places for the abuse when they know help is not easily available to the victims.
- There is a higher level of psychological manipulation, than physical control
- High proportion of incidents of male homosexual rape parallel date rape.

Heterosexual male offenders

- Attack strangers of all ages
- More typically operate in gangs
- Modus operandi involves intimidation and humiliation of their victims
- Attacks usually take place out of doors and involve a degree of violence – which initially serves to subdue the victim but then seems to enhance the pleasure of the rapist by "feeding their primitive need to dominate other males" (Wade)

Work of Groth and Burgess – studies on offender and victim characteristics

- 75% of offenders sexually assaulted strangers
- They gained control over their victims through three methods:
  i. Entrapment - using deception and cunning means
  ii. Intimidation – use of threats or violence to coerce their victims
  iii. Physical force – strength, sometimes with a weapon

Groth and Burgess Study – analysed 22 cases of male sexual assault

- 75% of offender sexually assaulted strangers
- Five motivational components behind stranger attacks:
  i. Conquest and control – perpetrators need to assert power by defeating victims.
  ii. Revenge and retaliation motivated by anger – they have something they want to avenge and their victim reminds / represents them of what that is.
  iii. Sadism and degradation – motivated by perpetrator's need to inflict suffering and humiliation on his victim

iv. Conflict and counteraction involving issues of unresolved sexuality – rape that occurs because of an intrapersonal conflict experienced by the rapist. Rape is the rapist's way of trying to escape from an inner personal dilemma, or rape committed to give them an opportunity to prove something to themselves and others.
v. Status and affiliation – usually present in gang-related sexual assaults where peer pressure is intense.

Finding of the study cannot be generalised as it was conducted on a very specific group of offenders.
Small samples that are randomly chosen.

Hodge and Canter's study used bigger samples and more empirically stringent research methods
Their findings:

- male sexual assault by heterosexuals may be more common than sexual assault by homosexual offenders.
- The sexual assault of homosexual victims tended to be more violent than that of heterosexual victims

Female perpetrators of sexual abuse

- Research evidence about sexual abuse perpetration on male children at hands of female teenagers and adults.
- Sexual molestation by females tends to be less physical and more coercive – therefore more difficult to monitor.
- Female perpetrators commit fewer and less intrusive acts
- Tend to use more foreign objects
- Engage in mutual masturbation. Oral, anal, genital sex acts, showing child pornography, sex games
- Teachers, baby sitters, day-care workers
- More likely to be involved with co-abusers, typically male.

Problems associated with sexual trauma in males

- Difficult to separate out immediate and short-term reactions from those likely to be long enduring
- Difficulty of separating the impact of sexual abuse on children and youth from the impact of other forms of child abuse that they have experienced.
- Generalised statements about impact that applies to all victims are impossible because male survivors of sexual abuse are not a homogenous group – they are individuals whose family environments and developmental and cultural contexts differ widely.

Reactions that overlap and intersect:

- Self-blame
- Anger
- Questioning of sexual orientation
- PTSD

Factors contributing to the enduring, harmful outcome:

1. Duration and frequency of abuse
2. Nature of sexual abuse
3. Degree of force used
4. Relationship to / with perpetrator
5. Amount of post-trauma support available at time of victimisation
6. Personal history
7. Male survivor's ability to deal with other crises in their lives.

Stigma and Shame

- Males seem to have a harder time disclosing their abuse for fear of being labelled `gay', `a weakling'.
- Society tends to attribute more responsibility to male victims of sexual abuse than to female.
- When males abused, they feel a sense of guilt, embarrassed and feel somehow responsible for their victimisation.

Guilt

- Feel some action on their part provoked the rape
- They did not effectively resist
- Self-blame not totally internally situated – early in self-development men have learned that they are expected to be strong and self-reliant and self-protectors, and when they fail at this they begin to self-doubt.

Post-Traumatic Stress Disorder (PTSD)

- Symptoms vary depending on the circumstances surrounding the assault and aftermath.
  There are no specific outcomes that are more common for male rape survivors
- Embarrassment
- Shock
- Rape-related phobias
- Increased anger
- Irritability
- Flashbacks
- Intrusive thoughts
- Fear of being alone,
- Sleep difficulties
- Avoidance of triggers

- Depression
- Anxiety
- Guilt
- Somatisation (converting psychological stress and conflict into physical symptoms)
- Emotional numbing
- Lowered self-esteem
- Anxious need to please others

Anger

- Heightened feelings of hostility after rape
- More outwardly aggressive and display more anger than depression. This could be due to gender socialisation, it becomes difficult for men to recognise and express feelings such as hurt, embarrassment, inadequacy, for fear these suggest weakness and vulnerability "*anger seems to be the most available emotion to men"* and it therefore might be used to disguise other emotions associated with abuse.

Depression

- Patriarchal society – men who have been traumatised are expected to 'get over it' and given less permission then woman to express feelings of depression, so their depression may manifest in different ways.
- Men are socialised to mask their feelings with Bravado, aggression or act out to overcompensate of incapacitating feelings of powerlessness
- Self-medicate with alcohol etc. to numb the pain
- Probability for alcohol abuse estimated to be 80% in men who have been sexually abused, as compared to 11% in men who haven't
- High-risk behaviour (acting out) after sexual abuse.
- Adolescent male survivors develop social problems – sex offending, assault, conduct disorders. More prone to health-damaging behaviour such as smoking, drug abuse, promiscuity, running away.
- Hyper-masculine behaviour typical of male survivors trying to mask vulnerability. Macho behaviour like multiple female partners, dominating, argumentative.
- Self-Mutilation provides relief from feelings of shame, self-loathing, anger. "Feel good" chemicals provide temporary relief.
- Survivor can become psychologically dependent upon pain – self-mutilation becomes regular coping mechanism.

Sexual Identity conflicts

Sexual abuse of males tends to call into question the survivors sexual and personal identity as "a man".

Confusion relating to sexual preference:

Men who have been raped confuse the act of violence with the act of sex, and may conclude they have had a homosexual encounter. If they are heterosexual, they might

question their sexual identity due to physiological responses of having an erection, ejaculating.
Lack of knowledge about the functioning of the male body allows a misconception that the must have enjoyed it. Homosexual survivors may feel targeted due to their sexual orientation, and then might deny or hide their sexuality to safeguard against future assault.
Confusing relating to male roles:
Male survivor shattered because of inability to take control of the situation and assert their strength and manhood. This shatters their assumption about who they are and the power they have – due to stereotyping of gender roles, most men are not prepared for the reality that they are also vulnerable victims.

Sexual victimisation
Early abuse may have a disinhibiting effect on children's sexualised behaviour.

- Playing with genitals too often
- Thinking and talking about sex more often

Young children do not have the emotional, cognitive or social orientation with which to make sense of adult sexual experiences.
Behavioural responses unique to young male victims (Rogers and Terry):

1. **They experience confusion and anxiety over their sexual identity**: seek an explanation for why he was selected; self-blame for attracting abuser. If he does not physically resist – then begins to challenge his view of himself as masculine
2. **They engage in inappropriate measures to reassert their masculinity**: Aggression, manifested in fighting, hostile, disobedience.
3. **They often demonstrate recapitulation (imitation of the acts) of the victimising experiences**: they act as the perpetrator and someone else the victim.

Early experiences of pervasive violence are responded to with aggressive fantasies, which are acted out under the pressure of puberty / hormonal factors. This might explain why premature sexual encounters may lead a vulnerable male to becoming the victimiser.

Physical consequences and somatic complaints

- Anal penetration – abrasions / lacerations leading to difficulty and pain during bowl movements.
- Somatic complaints – sleep disturbances, nightmares, phobias
- *Phenomenological perspective* when counselling – allow survivors to raise the issues that they consider to be relevant and appropriate, and individualise their abuse.
- Abuse- accommodation model postulates that the quality of the helping relationship can be severely marred by providing survivors with untimely information, directing and controlling the process of recovery and generalising the survivor's experience.

Treatment of the male survivor

- Main difference in dealing with male and female survivors of sexual abuse embedded in the ways in which men and woman are socialised, as well as basic physiological gender differences.
- Patriarchal cultures raise boys to denounce feelings of sensitivity and vulnerability – therefore sexual trauma results in their assumptions about themselves, the world, shattered.
- Shattered assumptions need to be clarified and resolved after sexual trauma
- Due to societal expectations to be strong and in control of feelings, a traumatised boy / adult more like to deny or avoid addressing pain. Issues are masked by anger. Reactions such as these must be acknowledged as the survivors attempt to control his emotional field again.
- Under-reporting of male sexual abuse makes it more difficult for them to present themselves for counselling. They see themselves as different and responsible for what happened.

Main focus of treatment for male survivors should cover helping the male survivor to do the following:

i. **Giving expression to feelings associated with the abuse:** which will minimise the psychological tension.

Letter writing, journals

ii. **Recognising and altering abuse-distorted thoughts, beliefs and perceptions**: challenge faulty beliefs and negative self-statements. Survivors need to learn to place the blame for their abuse on the perpetrator.

iii. **Regaining control over thoughts, feelings and actions:** survivors need to rediscover their strengths and unused resources to manage invasive thoughts that undermine their self-esteem and functioning.

Helper to assist the shift in perceptions from being a victim to a survivor

iv. **Learning new skills such as stress management, relaxation, thought stopping, assertiveness**: Male survivors to identify which skill they want to learn – allowing their participation demonstrates respect.

v. **Establishing a network of support:** few gender-specific facilities for male survivors. Books, stories of male survivors account of rape, supportive relationship

vi. **Formulating an understanding of past and present relationships and interactions with significant others:** unresolved issues from past / present relationships might impede recovery from abuse. Helper should try to understand some of the survivor's reactions to his rape against backdrop of other issues.

The Helper

- High levels of respect and support and never undermine survivor's sense of autonomy.
- Rogers – in order to offer gender-specific intervention for male survivors of rape, helper should extend their repertoire of relationship skills to include:

- specialised knowledge about different forms of male rape,
- socialised stereotypes about masculinity and homophobia
- a basic understanding of male sexuality and biological functioning.

Developing a gender-specific response to survivors of male rape

1. **Education:**
   - ♦ When people have access to reliable information about sex and sexual violence, the stigma and shame of male rape will be reduced.
   - ♦ Information will help to develop a public understanding of rape as an act of violence, not to be equated with gay male sexual behaviour.

2. **Provision of services:**
   - ♦ More services available for survivors, the more comfortable male survivors will feel about asking for help. (counselling, law enforcement, medical care)
   - ♦ Services need to address male rape openly and guarantee confidential assistance.
   - ♦ Advertising, bill boards must clearly advertise they serve all people who have been sexually violated and use gender inclusive language and adverts.

3. **Research and publications:**
   - ♦ There is a lack of quantitative information about male rape – which can be misinterpreted as an absence.
   - ♦ There are few writings on the topic of male rape

4. **Prevention:**
   - ♦ **Macro prevention:** aimed at bringing about drastic social and cultural changes that would prevent people from ever attempting to commit sexual abuse acts on others.
   - ♦ Socialisation from an early age not to stereotype others, not to dominate and oppress, devalue physical aggression as preferred method of dealing with anger / resolving conflict.
   - ♦ Patriarchal attitudes need to be dismantled.
   - ♦ **Macro change** suggest people's needs should be met (poverty, unemployment, labour exploitation- render people vulnerable)

   - ♦ **Meso prevention:** ensuring all males have life-skills training such as assertiveness training, self-defence classes

   - ♦ **Micro prevention:** addresses aftereffects of rape – ensuring survivor has adequate resources such as medical attention to prevent HIV/AIDS, counselling to lessen degree of PTSD, well trained law enforcement officers who respond sensitively

5. **Legal reform:**
   - ♦ Sexual assault statutes should be gender-neutral or rewritten in a way that the rape of a man is a crime that is recognised and equal to the rape of a woman.

- Police officers should receive sensitivity training in regard to all forms of sexual violence. Investigative techniques should include proper collection of evidence from male bodies

THEME NINE – FIGHTING SEXUAL ABUSE, A MULTIFACETED APPROACH

A holistic model of dealing with sexual abuse sees intervention happening at three levels:

1. **Macro (Primary)** - "large" / social and cultural – target the wide population
2. **Meso (Secondary)** – aimed at middle level. High risk groups, families, communities
3. **Micro (Tertiary)** – small part – dealing with survivors & offenders with intent of minimising negative consequences or avoiding re-incidence

Preventive versus protection strategies

Preventive – activities taken in order to guard against those things that might cause harm, disease or decay. Societal responsibility

- Society has to dismantle harmful practices and implement controls to safeguard people; members of society must have their basic needs fulfilled and be enabled to self-actualise.
- Prevention implies critical thinking and strategic planning
- Families must develop children who feel happy, contented, able to identify, express and channel emotions properly, who feel safe and protected. Etc.

Protect means to safeguard against from injury, to keep safe, to preserve.

- Protection means taking action to reduce likelihood of the self / others experiencing unpleasant events.
- A well-functioning society has certain measures in place to protect it's members from harm such as responsive police, effective trauma centres, efficient health services.
- Individual protect themselves. Woman take self-defence classes, carry condoms,

Children cannot prevent sexual abuse, but parents can teach them measures to protect themselves in some situations.

Macro-Level Interventions

Primary prevention of child abuse (as opposed to macro prevention)

1. The child can be prepared to avoid abuse: protective strategies; sexual abuse can happen to anyone and we all need to protect ourselves form being abused.
2. Adults can create a safe environment for the child: prevention; Administrators of a country must ensure safe conditions prevail for all citizens. Parents need to ensure children are nurtured.

Macro Level issues: Widespread poverty, unemployment, inadequate access to health care and education. Cultural values about the authority and status of males, females, children, adults, sexuality.

Sexual abuse awareness programmes

Public awareness must be developed by introduction of education programs to alert children and adults to the reality that sexual abuse happens to all people from all types of backgrounds.

Problems with early programs aimed at preventing child abuse

Early child protection programs had main objectives to teach children:
The difference between good, bad and questionable touching
Body ownership
Rights of children to control who touched their bodies, and where they may be touched.
Encouraged children to disclose
Alerted children to range of resources.

Programs failed due to shortcomings:

- Failed to acknowledge children cannot prevent themselves from being abused; they are powerless due to age, cognitive abilities and physical strength. They must be protected from abuse by society
- Programs did not take into account the disempowering influence of child's inner feelings – guilt, shame, loyalty to family.
- Confusing messages; good vs. bad touching created unnecessary anxiety for children as their bodies might have responded to 'bad' touching, and therefore they felt guilty. Program should acknowledge natural sexuality of children.
- Program did not anticipate the disclosure would not always bring relief to children. Their experience with CPU, welfare system, medical procedures, legal processes cause secondary trauma due to insensitive handling.
- Programs failed to consider the dynamics of sexually abusive relationships. Abusive relationships, while stressful, do fulfil some of the needs of the children (acceptance, affection, food, education which cannot be provided by family). The relationship, the rewards received, or physical touching reinforced their participation in abusive acts and minimises their ability to say "No"
- Teaching a child to say "No" defied traditional norms of respect and obedience. Offender has more strength, greater cognitive abilities to persuade child victim, and greater control over resources that the child needs / wants. Child sees the adult not the abuser, and doubts they have the right to challenge.
- Programs failed to protect the child from the physical harm that could result from their disclosure
- Did not anticipate that disclosure would not always be in the best interest of the child. Child may be placed in place of safety with juvenile offenders. While offenders are released on bail, left at home. This leaves the child feeling like a criminal.
- Programs allowed parents / caregiver to become complacent. Sex education is a lifelong process and primary educators should be the parents. In response to programs, children:

    - Had greater difficulty accepting that greater chances of abuse would occur by the hands of someone they know
    - Concept such as secrets and dealing with ambivalence was not understood.
    - Children did not retain information.
- Programs should provide children with the behavioural rehearsal of prevention strategies necessary – and provide feedback to them
- Need to have a more balanced perspective. Training materials should take into account cognitive characteristics and learning abilities of the children they are aimed at. Content should be simple enough for children to use.
- Presentations need to be lively, interesting, varied, stimulating, to keep children attentive.
- Children should also be taught life skills – assertive behaviour, decision-making skills, communication skills – which make children more confident and in control.
- Longer programs should be integrated into school curricula. Progressive learning model more successful than a once-off, one-or –two day program.
- Programs should be interactive, learning should be participatory. Children should be listened to.
- Programs should communicate the need for adults to accept responsibility for the problem of sexual abuse. More formal and extensive parent / teacher training need to be developed.

Intervention at a macro-level should not place emphasis on how children should be taught to protect themselves, but on how we can create a greater awareness of the social reality and society's failure to meet their needs of protection.

Identifying and addressing factors contributing to sexual abuse at a macro level

- Children will always be vulnerable for as long as broader social issues such as sustained economic uncertainty, limited access to housing, inadequate security, inferior education and medical care, exist.

Patriarchal society

- The less power people have, the greater their vulnerability to sexual exploitation.
- Society places pressure on men to be omnipotent (powerful and in control) - this must be challenged.
- Permission to own sensitive emotions.
- Acknowledgement of woman's rights - men are less likely to commit violent crimes against woman if they see them as equal human beings, rather than property.

Women's economic dependence on men

- Women's position in SA economy weaker than men's due to earning less and being economically dependent on men. Men believe they "own" woman and children and therefore enjoy the right to use violence on them.

- Unless woman can be economically dependent, they are forced to remain in abusive relationships.

Racism

- People victimised by racism are left feeling powerless and try to overcome this feeling by dominating those who are weaker than they are. Victims of displaced aggression are usually woman, children and elderly.
- Racism leads people to see others as less important, making it easier to perpetrate violence against members of diff. races.
- Children need to be taught to be tolerant of differences

Unemployment

- This threatens a person's sense of self, and often interpreted as failure.
- Discontent with work conditions, not being able to find work – ads to feelings of powerlessness and anger – which is vented on nonthreatening targets – partner, children, stranger.

Relative deprivation and poverty

- Structural deprivation, unemployment, underdevelopment work in combination with other factors and contributes to increased levels of crime.
- Bad living conditions make people feel powerless
- Great differences in wealth, development and access to resources operate as incentives for criminal activity.

Alcohol and drug abuse

- Use of substances to escape stress, make a person feel better, and to act out and express feelings such as anger.

Culture of violence

- Many people in a society think that violence is the most effective way of solving problems, and use violence to achieve their goals

Problems with the criminal justice system

- Insensitive, judgemental behaviour can prevent victims from reporting.
- Sense of futility at police inability to convict and arrest offenders
- Victims feel unsupported
- Offenders are released, only to offend again
- Poor police treatment due to lack of training

Social change, as in the transition to democracy in SA

- Social change leads to stress, insecurity, helplessness.

- Government institutions cannot cope with the volume of traumatised survivors requesting services. Victims lose faith in government to control situations, which worsens their level of fear.
- Legal reform will be a powerful initiative that may be used to combat harmful effect of sexual offences. New Sexual Offenses Bill will tighten control and offer victims greater protection. Onus is on the offender to prove sex was consensual, not on the victim to prove it was non-consensual.

Meso-Level interventions

Social and Family relations are factors that increase or decrease the risk of sexual abuse. Unhappy families, with regular conflict don't meet member's needs for acceptance and affection. They are the breeding ground for vulnerable members of society, who are usually targeted for sexual victimisation – they turn to others for unhealthy attention.

Working with parents:

- Building a happy marriage between parents teaches children about loving, caring relationships, increases sense of emotional security.
- Parents / caregivers are providers of affection and acceptance in their children.
- Communicating regularly provides children with the message that everything can be talked about in the home
- Parents need to be educated about what constitutes as sexual abuse, what are the indicators of abuse including PTSD. Children seldom lie about abuse.
- Parents and caregivers need to be aware of options available for reporting sexual abuse and for obtaining help. Childline, life Line, CPU, social workers.
- Parents / caregivers should scrutinise their attitudes and values regarding relationships and sexuality. Most powerful teaching method is modelled desirable behaviour. Be mindful about the messages they pass on about sexual responsibility, gender issues.
- They need to share age-appropriate info. About sex and healthy sexuality with their children. Being honest about sex is important. Teach them about body parts, offer rules and guidelines for sexual behaviour.

The White Paper = A SA document proposes changes to SA welfare policy, and reshaping social work to be more developmental, empowering and community based as opposed to remedial model geared to working with individuals and their families.

- Early intervention and preventive services – using visitation services to pay postnatal visits to young families
- Comprehensive system that ensures basic needs of families and children – food, clothing, health and shelter. This relies on Macro sphere acknowledging and providing infrastructure for this to happen.
- Intervention in abuse cases must move beyond investigation and placement to include assessment and services.

- Community systems of care will be developed where schools, courts, mental health, law, social services work together.
- Service systems must be more culturally competent

General Safety Rules for children

Reduce risk of child abuse by instilling rules:

1. Children never left unattended / unaccompanied in public places
2. Taught to go to shop / crowded place to ask for help if lost.
3. They should know address / telephone number
4. Encouraged to leave any situation they feel uncomfortable in and inform adults of this
5. Reassured it's permissible to offend people when feeling scared
6. Discouraged from visiting public toilets alone
7. Should always report where they are going and provide contact numbers
8. Encouraged to travel in groups when using public transport
9. Parents should know who friends are and their parents. No sleep overs at unknown families
10. Never open door to strangers when alone at home.
11. Not allowed to play in dark deserted places, or outside property alone
12. There are good and bad secrets and the difference.
13. Know they have the right to privacy; certain parts of the body that only they can touch.

- Age of offender is getting younger and younger.
- Juvenile offenders struggle with low self-esteem. Social isolation, poor social skills. May come from families you failed to meet their needs for care, nurturing and protection. May be sexually victimised themselves.
- Failing to intervene increases the risk of young perpetrators developing into habitual sexual offenders

Micro-Level Interventions

Intervention for offenders:

- Difficult as there has been no success in finding consistent profiles that characterise them.
- Traditional approaches – social casework, group work and psychotherapy.
- Incestuous family interventions – training in parent-child interactions, child management techniques, better stress management
- Punishment in the form of incarceration does little to enable offenders to modify their behaviour as it does little to make them conscious of the reasons why they engage in abuse behaviour, or how they can correct their behaviour.

Main elements of offender treatment:

- Confronting offenders with the reality that their actions were abusive, by breaking down their defence mechanisms such as denial, rationalising, minimising – that prevents them from accepting the full responsibility of their actions.
- Identifying risk factors that could threaten safety of victims, or society at large, to minimise chances of reoffending.
- Decreasing any cognitive distortions that they entertain so that they can't justify or rationalise their abuse actions.
- Increasing their empathy for their victims so that they begin to see how their actions may have impacted victim's lives.
- Assisting offenders to develop skills that enhance social competency
- Decreasing offender's deviant arousal responses by carefully planning and manipulating the environment.
- Providing offenders with opportunities to review and rework their own experiences of abuse if applicable.

To be rehabilitated, offenders need to recognise that their actions were abusive and harmful. Legal processes have the power to make offenders admit that they have committed a crime that is punishable

- Demonstrate remorse and willingness to be rehabilitated – directed to formal offender program
- Jail sentences might be suspended on condition they don't re-offend and cooperate with treatment program developed for them
- Community service / house arrest – alternatives to incarceration (keeps breadwinner earning)

Treatment programs necessary to make offenders accountable for actions, and acknowledge their abusive actions, to prevent them from becoming multiple offenders.

Interventions for survivors:

- Micro level intervention aims to minimise the effects of abuse on the survivor and their family.
- Controlled research into helpfulness of psychotherapy for maltreated children moderately to highly effective in helping them, with long lasting gains.
- Counselling of adult survivors considered effective.
- Service for sexual abuse victims are specialised - psychologists, psychiatrists, social workers, nurses, theologians.
- Individual counselling provides survivors with an opportunity to relook the abuse and rework faulty assumptions about themselves, the world they life in and meaning they attribute to life that trauma might have caused. It's a short term process involving between 8 – 10 sessions.

- Counselling of parents, partners also necessary – they provide caring support that has an important influence on the outcome that the trauma has on the survivor – may increase survivor's sense of security and self-worth.
- Group therapy beneficial - work together supportively
- Some survivors don't get counselling and work through trauma on their own.