ARTICLE ONE

THE DYNAMICS AND IMPLICATIONS OF SEXUAL ABUSED CHILDREN IN FOSTER CARE PLACEMENTS

H.J. Galloway is a PhD student at the School of Psychosocial Behavioural Sciences Division Social Work at the North-West University (Potchefstroom Campus) and social worker at the therapy unit of Christelike Maatskaplike Raad: Mpumalanga.

C.C. Wessels is a lecturer at the School of Psychosocial Behavioural Sciences Division Social Work at the North-West University (Potchefstroom Campus).

C Strydom is a lecturer at the School of Psychosocial Behavioural Sciences Division Social Work at the North-West University (Potchefstroom Campus).

Abstract

The aim of this article is to determine by means of a literature study, the dynamics of sexual abuse and the implications the placement of a sexually abused child in foster care, have for the foster care placement. The impact of child sexual abuse depends on various factors like the age of the child, the amount of force used, the relationship between the child and the perpetrator, and the period over which the abuse took place. The impact of sexual abuse on the child also varies depending on the individual child. In order for the foster parent to assist the foster child to heal from the trauma of child sexual abuse, it is necessary for the foster parent to have knowledge of the dynamics of sexual abuse and insight into the impact on the child.

KEY WORDS: Child sexual abuse; foster care; foster children; foster care; social work empowerment program.
1. INTRODUCTION

The impact of sexual abuse on children can be devastating and long-lasting. Sexual abuse of children is a reality and happens to children of every class, culture, race, religion and gender. Spies (2006a:45) is of opinion that any kind of sexual abuse damages the child “the trauma caused by the abuse does not end when the abuse stops” (Spies, 2006a:45). Healing from sexual abuse is an on-going process in the life of the abused child.

Often children who are abused are removed in terms of the Children’s Act, Act 38 of 2005 (SA, 2008a & 2008b:72) and placed in foster care to protect them and initiate a healing process. Because of the impact of sexual abuse on the functioning, development and behaviour of children, it has certain implications for foster parents of sexually abused children. These implications will be discussed in more detail in this article.

2. PROBLEM STATEMENT

There is an increase in the numbers of sexual abuse reported to social workers. South Africa has amongst the highest incidences of child and baby sexual abuse in the world. Rape and sexual assault of children was reported at 67 000 in 2000 (Cape Gateway, 2009:1). Welfare groups believe that the number of unreported incidents could be up to ten times that number (Rape Statistics, South Africa and Worldwide, 2011). Many of these children are placed in foster homes, but data on how many is not available.

Children who have been sexually abused display certain typical perceptions and behavioural patterns (Earl-Taylor & Thomas, 2003:1; Potgieter, 2000:33). The devastating effects thereof are conveyed in the following way by Lodwick and Meyer (2006:1): “Sexual abuse is a profoundly disruptive, disorienting and destructive experience; the long-term aftermath can last a lifetime.” This aftermath will necessarily have implications for foster care. When sexually abused children are put in foster care, it would place extra responsibility on the foster parents to cope with the challenges of the on-going healing process. It is therefore of the utmost importance that foster parents have
knowledge of and understand the dynamics and implications of sexual abuse for foster care, before they can effectively contribute towards the child’s healing process.

Researcher has further experienced that social workers often expect screened and generally trained foster parents to be able to handle all foster children effectively. In practice this has proved not to be the case. Foster placement of sexually abused children might fail because the foster parents do not feel equipped to handle the upbringing of the foster children effectively and ask the social worker to remove and place the foster children somewhere else. Social workers often hear the following statement from prospective or new foster parents: "No, I don’t want children who have been sexually abused. I can’t handle that." Foster parents make this type of response for several reasons. They may refuse to accept sexually abused children into their homes because they recognize that they are uninformed or unequipped to meet the needs of this type of child (Gillespie, 2000:1).

Due to repeated removal, the foster children (apart from them being traumatised by sexual abuse) might experience secondary trauma as well as rejection. The foster parents experience that they have failed as parents and refuse to foster any more children. This entails that foster parents who take care of sexually abused children will also have specific needs due to the implications of sexual abuse on the child and the foster care situation. To prevent the failing of foster placements it can be useful to have advanced training for foster parents with sexually abused children in their care. The provision of training and support for foster parents is crucial to the continued development of the foster care service. This will enable foster parents to deal with special needs or more difficult problems (SA, Department of Social Development, 2011:26).

In order to enable foster parents to effectively foster children and especially children who have been sexually abused; they need to have knowledge and understanding of sexual abuse and the impact thereof on children, as well as on the foster care situation in general (Gillespie, 2000:1; Spies, 2006a:45). It
is necessary for foster parents to have a clear understanding of the special needs of the sexually abused foster child in order to create a safe and secure environment that promotes the healing process. In order for social workers to empower foster parents to deal effectively with the implications that sexual abuse has for foster care it is necessary to establish in detail what these implications are.

From the above discussion it can be derived that sexual abuse has certain implications for foster care. This will be linked to the needs of foster parents of sexually abused children. What these implications are will be investigated in this study.

Based on the above description of the research problem, the following research question can be formulated

**What are the dynamics and implications of sexual abused children in foster care placements?**

3. **CENTRAL THEORETICAL STATEMENT**

A theoretical statement or a proposition is described by De Vos and Strydom (2011:34a) as a “relationship expressed in a theory. A theoretical statement need to be tested against reality (through empirical study) before it can be accepted as a valid theory or part of a valid theory”.

The central theoretical statement for this part of the study can be formulated as:

**The placement of a sexually abused child has implications for the foster care placement.**

This statement is in line with the recommendation of Bak (as quoted by Fouché & Delport, 2011:108) that the central research problem must be one problem stated in one single sentence, question or hypothesis.
4. **AIM AND OBJECTIVE**

According to De Vos (2002:404), aims (or goals) refer to the broad conditions or outcomes that are desired by the study. A goal can thus be seen as what will be achieved with a certain action or effort.

4.1 **AIM**

The aim of this research is: **To develop, implement and evaluate a social work empowerment programme for foster parents of sexually abused children to improve their psychosocial functioning and their knowledge and skills regarding the dynamics of sexual abuse.**

4.2 **OBJECTIVE**

The objective for this part of the study can be formulated as follows:

**To establish through a literature review, the dynamics and implication of sexual abused child in foster care placements.**

5. **RESEARCH METHODOLOGY**

5.1 **RESEARCH DESIGN**

Research methodology generally refers to techniques a specific discipline uses to gather knowledge. The methodology of this article involves a literature review.

“A review of literature is aimed at contributing towards a clearer understanding of the nature and meaning of the problem that has been identified” (Fouché & Delport, 2002:127).

The intervention research model was utilised for this study. It consists of the following six phases (De Vos & Strydom, 2011b:476).

1. Problem analysis and project planning
2. Information gathering and synthesis
3. Design
4. Early development and pilot testing
5. Evaluation and advanced development
6. Dissemination

This article forms part of the first step in the second phase of the intervention research model (De Vos & Strydom, 2011b:480). According to De Vos and Strydom (2011b:480) a literature review would entail an investigation into empirical research done, reports of applicable practice and relevant innovations. They are further of the opinion that computerised databases can be very valuable to find the applicable information.

For the purpose of this literature review, various textbooks on a multi-professional level, including psychology, education, forensic social work, clinical social work, legal professions, medical professions, occupational therapy, therapy and assessment were consulted. It included national and international resources. A comprehensive internet search was done in order to be updated on the latest research done in this specific context. Various databases were consulted including EBSCO Host, ERIC, Psychinfo, Lexis Nexis. Literature available at the libraries of the North-West University and UNISA were consulted as well as Questia website.

Interviews were conducted with experts in the field of sexual abuse and foster care (Delport, 2010; Erasmus, 2010; Grobler, 2008; Petzer, 2010). All the information was used to form the basis of this article.

5.2 PARTICIPANTS
There were no participants in this part of the study.

5.3 MEASURING INSTRUMENTS
No measuring instrument was used in this part of the study.

5.4 ETHICAL ISSUES
According to Strydom (2011a:123) the researcher has to ensure that he/she is competent, honest and adequately skilled to undertake the proposed investigation. Researcher fulfils these requirements.
Plagiarism is also an aspect that is a very important ethical issue in this part of the study (Babbie, 2007:505). It is important that researcher be aware of and carefully executes the literature study, acknowledge all resources when and where it is necessary in order to avoid any form of plagiarism.

6. DEFINITIONS

Before a more comprehensive overview of relevant literature can be done, and to provide a foundation for this study, definitions of the basic concepts of child sexual abuse, foster care and foster parent, will be discussed.

6.1 CHILD SEXUAL ABUSE

Child sexual abuse refers to: “sexual abuse of a child by an adult, or some other person significantly older or in a position of power or control over the child, where the child is used for sexual stimulation of another person” (American Humane, 2008:1; O’Connor & Schaefer, 1994:319). The sexual activities may include all forms of sexual contact including oral-genital, genital, or anal contact by or to the child or abuse that does not involve contact, such as exhibitionism, voyeurism, or using the child in the production of pornography, also humiliation, and sexual torture (New Hampshire Coalition against Domestic and Sexual Violence, 2008:1; Orton, 1997:90; Townsend & Dawes, 2004: 55).

Barker & Hodes, (2007:393) defines sexual abuse as follows: “The exploitation and mistreatment of children and adults in ways that provide erotic gratification for the abuser. Abusers tend to have serious psychological problems such as a personality disorder, paraphilia or another sexual disorder, or psychosis. Victims often cannot or are unwilling to understand or resist the advances of the abuser. Sexual abuse can include sexual intercourse without consent (or when the victim is younger than the age of consent), the fondling of genitalia, frotteurism, the taking or showing of pornographic pictures, and other forms of sexual acting out. Some social workers also include rape, seduction, sexual harassment and sexual coercion as other forms of sexual abuse.”
Giardino (2007:33-34) specify some activities that are considered sexually abusive, and include the following:

- “An abuser sexually touching and fondling a child.
- Having the child touch the abuser’s genitals or perform oral sexual acts on the abuser.
- The abuser having vaginal or and sexual intercourse with a child, whether in a forced or unforced manner.
- Purposefully showing the child adult sexual activity, pornographic movies, or photos.
- Having a child pose, undress, or perform in a sexual manner.
- Spying on a child while he or she is undressing in a private setting such as a bathroom or bedroom.”

Child sexual abuse can thus be summarised as any act with sexual connotation that takes place between a child and another person significantly older than the child or who has power over the child for reason of sorts. A child is viewed as a person under 18 years.

### 6.2 FOSTER CARE

The Children’s Act, Act 38 of 2005 as amended (SA, 2008b:12) describes foster care as follows: “*foster care* means care of a child as described in section 180(1) and includes foster care in a registered cluster foster care scheme.” Section 180 of the above mentioned Act, Act 38 of 2005 (SA, 2008a:72) states:

“(1) A child is in foster care if the child has been placed in the care of a person who is not the parent or guardian of the child as a result of –

(a) an order of a children’s court; or

(b) a transfer in terms of section 171.

(2) Foster care excludes the placement of a child-

(a) in temporary safe care: or

(b) in –
(b) in the care of a child and youth care centre.

(3) A children’s court may place a child in foster care –

(a) with a person who is not a family member of the child:

(b) with a family member who is not the parent or guardian of the child; or

(c) in a registered cluster foster care scheme.”

Cape Gateway (2009:1) defines foster care as “the placement of a child, who needs to be removed from the parental home, into the custody of a suitable family or person willing to be foster parents”. This is done by order of the Children’s Court.

Foster care can be summarized as the care of children by some one other than biological parents, appointed by the children’s court to act as foster parents.

6.3 FOSTER PARENT

The Children’s Act, Act 38 of 2005, (SA, 2008:12) provides the following definition of a foster parent: “‘foster parent’ means a person who has foster care of a child by order of the children's court, and includes an active member of an organisation operating a cluster foster care scheme and who has been assigned responsibility for the foster care of a child.”

For the purpose of this study a foster parent will be a single person or a couple who has a foster child in his/her care by order of the children’s court, and excludes cluster foster homes.

7. INCIDENCE OF CHILD SEXUAL ABUSE

Incidence refers to the number of new cases recorded within a certain period of time (Van Niekerk, 2004:263). How many children are affected? Various authors confirm that it is not possible to give a precise answer (Kirstner, et al., 2004:15; Richter & Higson-Smith, 2004:24-25; Cape Gateway, 2009; Rape Statistics, South Africa and Worldwide, 2011:v). There are various reasons for
this of which the most important one is underreporting (Kirstner, et al., 2004:15). “As in all contexts it is difficult to obtain accurate figures on child abuse in South Africa due to the conspiracy of silence that surrounds violence against children” (Vermeulen & Fouché, 2006:14).

On 15 May 2002, the following figures were announced in South African Parliament for the period January to September 2001: 15 650 cases of child rape were reported to the South African Police Services. Of these, 8 559 children were under 12 years of age and the rest were 12 to 17 years of age (Van Niekerk, 2004:263).

Rape South Africa and Worldwide (2011:1) reports that there is an increase of 36,1% in sexual offences against children during the period 2006/2007 to 2009/2010. It is further reported that 27 417 cases of sexual offenses against children were reported during 2010, 60% was against children below 15 years and 29,4% was against children 0-10 years.

It is evident that high numbers of these children would be placed in alternative care, which will include foster care, in order to protect them. It can thus be expected that ever increasing numbers of sexually abused children will be placed in foster care and that high demands will be placed on the foster parents to contribute to the healing of these children.

As the symptoms of child sexual abuse will have implications for foster care, it will be discussed next.

8. SYMPTOMS OF CHILD SEXUAL ABUSE

It is important to acknowledge that there is no single set of symptoms which automatically indicates that a person was a victim of childhood abuse (American Psychological Association, 2008:2). Symptoms should thus be only used as a vague guideline for the identification of possible sexual abuse.

Often there are no obvious physical signs or symptoms of child sexual abuse and some signs can only be detected on physical exam by a physician (AACAP, 2008:1; Kellogg, 2005:4). It is also important to acknowledge that
not all children who experienced sexual abuse exhibit major overt symptoms. This may be related to once-off trauma, which does not uniformly lead to long-term consequences or some children may be more resilient to recover from difficult events.

Gold (2000: 210) refers to symptoms of sexual abuse as “the ‘intricate web’ woven by past deprivations or maltreatment, current adversities and disadvantages, and current conflicts”. This quote excellently summarises the intertwined complexities and of child sexual abuse in the past, present and future.

Townsend and Dawes (2004:58) are of the opinion that child abuse symptoms may be divided into two general categories: sexual symptoms and nonsexual indicators of possible sexual abuse. Dunn (2004:61) quotes Kendall-Tackett who discern between above mentioned categories by stating that sexual symptoms includes sexualized behaviour (overt sexual acting out toward adults or other children, compulsive masturbation, excessive sexual curiosity, sexual promiscuity, and precocious sexual play and knowledge). He describes nonsexual indicators as Posttraumatic Stress Disorder symptomatology, which includes nightmares, fears, feelings of isolation and an inability to enjoy usual activities, somatic complaints, symptoms of autonomic arousal (easily startled), and guilt feelings.

It is important to take note that even if a child does not show any of the symptoms that it doesn’t imply that the child has not been sexually abused. Neither does it imply that a child has definitely been abused should some of the symptoms be indicated. Some children don’t show any symptoms of any abuse, and these children are referred to as A-symptomatic children (Berliner, 2002:206; Faller, 2003:51). According to Barker and Hodes (2007:39) it is easy to take it for granted that these children are not affected by the abuse. Faller (2003:51) is of the opinion that it is more likely that the effects are subtle or are delayed or that the child has been well socialized by the offender, and in some cases by the family, not to reveal signs of her or his distress.
It is further important to differentiate developmentally normal behaviour from that which is more likely to be indicative as a symptom of sexual abuse. An example can be mentioned of children aged three, four or five who generally discover not only that touching themselves feels good but also that other people have genitalia, some of which are different from theirs (girls and boys are different). However, children who demonstrate specific age-inappropriate sexual behaviour or knowledge, or who make sexual statements, need to be evaluated for sexual abuse (Smit, 2007:78).

It is often difficult to differentiate between the symptoms of child sexual abuse and the impact of sexual abuse on a child as they are intertwined. Researcher is of the opinion that symptoms are an overt manifestation of the covert impact of the abuse on the holistic functioning of a child.

The following table was originally compiled by Dunn (2004:59-60, 66, 72, 73) and adapted by researcher to incorporate information from Fergusson, et al. (2008:609); Gill and Johnson (1993:27); Kellogg (2005:3); Killian and Brakarsh (2004:367); Miller-Perrin and Perrin (1999:124-125); Potgieter (1996:96-97); Spies (2006a:53); Stien and Waters (1999:20). It summarises the possible symptoms of sexual abuse in the different developmental phases namely, pre-verbal, toddler and pre-school, middle childhood and adolescence. It also divides the symptoms according to the four different developmental functional modalities of the child who has been sexually abused namely behavioural/social, emotional, cognitive and physical. These symptoms might be used in the identification of possible abuse.

Table 1.1: Symptoms of sexual abuse

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<tr>
<th>Behavioural/social</th>
<th>Emotional</th>
<th>Cognitive</th>
<th>Physical</th>
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<td>Pre-verbal, Toddler and Pre-school</td>
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<td>Regression/immaturity</td>
<td>Anxiety</td>
<td>Learning and or development difficulties</td>
<td>Bruises</td>
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<td>Social withdrawal</td>
<td>Clinging</td>
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<td>Genital bleeding</td>
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<td>Sexualised behaviour</td>
<td>Nightmares</td>
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<td>Genital pain</td>
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<td>Sexual preoccupation</td>
<td>Fears</td>
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<td>Genital itching</td>
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<td>Precocious sexual knowledge</td>
<td>Depression</td>
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<td>Genital odours</td>
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<td>Seductive behaviour</td>
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<td>Excessive masturbation</td>
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<td>Genital odours</td>
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<td>Problems walking</td>
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<td>Possible immune system</td>
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<td>Dysfunction</td>
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<td>Sleep disturbance</td>
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<td>Bruises</td>
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<table>
<thead>
<tr>
<th>Middle childhood</th>
<th>Adolescent</th>
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<tbody>
<tr>
<td>Sex play with others</td>
<td>Anxiety</td>
</tr>
<tr>
<td>Sexual language</td>
<td>Phobias</td>
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<tr>
<td>Genital exposure</td>
<td>Nightmares</td>
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<td>Sexual victimisation of others</td>
<td>Fears</td>
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<tr>
<td>Family/peer conflicts</td>
<td>Obsessions</td>
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<tr>
<td>Difficulty separating</td>
<td>Tics</td>
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<tr>
<td>Hyperactivity</td>
<td>Hostility/anger</td>
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<tr>
<td>Masturbation</td>
<td>Aggression</td>
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<tr>
<td>Problems sitting</td>
<td>Depression</td>
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<tr>
<td>Sleeping problems</td>
<td>Guilt</td>
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<tr>
<td>Eating disturbance</td>
<td>Suicidal</td>
</tr>
<tr>
<td>Enuresis</td>
<td>Low self-esteem</td>
</tr>
<tr>
<td>Encopresis</td>
<td>Learning difficulties</td>
</tr>
<tr>
<td>Stomach-ache</td>
<td>Poor concentration</td>
</tr>
<tr>
<td>Headache</td>
<td>Poor attention</td>
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<tr>
<td>Eating disturbance</td>
<td>Declining scholastic achievements</td>
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<tr>
<td>Abdominal pain</td>
<td>Dissociation</td>
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<td>Headache</td>
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<td>Genital pain</td>
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<td>Bruises</td>
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It can be seen that because of the difference in development in the three developmental levels, symptoms in especially the behavioural/social, emotional cognitive sphere might differ, but generally the symptoms are similar in all the phases. The same child might react differently in the middle age to sexual abuse than she would when she moves into the adolescent phase.

The abovementioned symptoms will have implications for foster care therefore it is important that foster parents have knowledge of these symptoms. It should be seen as part of the trauma experienced by the child, and the foster parent should be prepared to address it accordingly. It is further important that foster parents should keep in mind that these symptoms will not necessarily seize after therapy, but that it may manifest in a next developmental phase. The impact of sexual abuse on the child will be discussed in the following paragraph.

9. IMPACT OF SEXUAL ABUSE

The term ‘impact of child sexual abuse’ is seen by researcher as the intensity and duration of trauma that is caused to the functioning of child, by the sexual abuse. This includes the degree of trauma as well as the influence it has on the behaviour, feelings, thoughts, of the child on short as well as long term.

The impact of child sexual abuse is not the same for every child and it needs to be understood in terms of the parameters of abuse. Several aspects of the sexual abuse situation will have an influence on the extent of symptomatology in both child victim and the adult survivor. Crosson-Tower (2005:128), Dunn, (2004:61-62), Killian and Brakarsh (2004:368) and Spies (2006a:49-52) mention that the degree of trauma a child experiences, depends on several variables. These variables include: the frequency of abuse, the duration of the abusive relationship, the relationship of the perpetrator to the child, the type of sexual act, whether or not force was used, the age of the child at the onset of the abuse, the age of the offender, whether or not the abuse was disclosed, and the first reaction of the significant others to the disclosure (Giardino, 2007:48-49; Grosz, et al., 2000:10; Kirstner, et al., 2004:25).
Single events, whilst being extremely distressing, are not as likely to produce impact as powerful as those caused by repeated abuse within the context of a relationship in which the child sexual abuse is evidence of a betrayal of trust (Killian & Brakarsh, 2004: 368). It is the set of individual circumstances that needs to be considered in order to understand the degree of impact on the child. These include the child’s circumstances and range of subjective responses, both at the time of these experiences and later, in retrospect. A wide range of emotions needs to be considered, including possible feelings of warmth and affection towards the perpetrator (Killian & Brakarsh, 2004:369). Literature reviews of research studies (Finkelhor and Brown, 1994:28) have indicated that sexually abused children are more likely than non-abused children to exhibit emotional distress such as anxiety, phobias, depression, embarrassment, anger and post-traumatic stress disorders (Righthand et al., 2003:20). The behaviour patterns of a sexually abused child tend to change drastically after abuse due to the impact of the trauma (Kistner, et.al., 2004:24).

10. MODELS TO DELINATE THE IMPACT OF CHILD SEXUAL ABUSE

The impact of sexual abuse is further discussed within the framework of the traumagenic model, the internalizing model and the Child Sexual Abuse Accommodation Syndrome (CSAAS).

10.1 TRAUMAGENIC MODEL

Finkelhor and Browne (1994:27-39) developed an eclectic but comprehensive model that suggests a variety of different dynamics to account for the variety of different types of child sexual abuse symptoms. This model incorporates some elements of the Post-Traumatic Stress Disorder model, but is also broad enough to explain sexual abuse of the non-post traumatic Stress Disorder variety (Finkelhor, 1995:178; Naylor, 2006:230-233). These symptoms also correlate with the findings of Grosz, et al. (2000:10).

The model proposes four traumagenic dynamics to account for the impact of sexual abuse: traumatic sexualisation, betrayal, stigmatisation, and
powerlessness. Finkelhor and Browne (1994:27-39) argue that the traumagenic dynamics alter a child victim’s cognitive and emotional orientation to the world and create trauma by distorting the child’s concept of self, world view and ability to show emotion. This creates ongoing trauma for the child throughout lifespan, especially if not treated (Fergusson, et al., 2008:608; Van der Merwe, 2007:15-16). These distortions often result in the behavioural problems that are commonly noted in victims of child sexual abuse (Dunn 2004:71: Muller & Hollely, 2000:117). The impact of these factors that are mentioned as part of the traumagenic model, are divided into seven categories by the American College of Obstetricians and Gynaecologists (2010:2). These categories are: emotional reactions, symptoms of posttraumatic stress disorder, self-perceptions, physical and biomedical effects, sexual affects, interpersonal effects and social functioning.

Each of the traumagenic dynamics will be described to show what it includes and the impact it has on the child and the implications for foster care.

- **Traumatic sexualisation**
  Traumatic sexualisation refers to the conditions in sexual abuse under which a child’s sexuality is shaped in developmentally inappropriate and interpersonally dysfunctional ways (Muller & Hollely, 2000:117-120; Naylor, 2006:234).


- Sexually abused children are often rewarded, by offenders, for sexual behaviour that is inappropriate to their level of development.
- Because of the rewards, sexually abused children learn to use sexual behaviour, appropriate or inappropriate.
- Because of the attention they receive, certain parts of sexually abused children’s anatomy are given distorted importance and meaning.
- Children become confused and acquire outright misconceptions about sexual behaviour and sexual morality as a result of things that offenders tell them or ways that offenders behave.
- Finally, a child’s sexuality can become traumatised when frightening and unpleasant memories become associated in the child’s mind with sexual activity.

Traumatic sexualisation (aversive or overvaluing feelings about sex, sexual identity problems), self-reproaches (also termed ‘damaged goods syndrome), involving feelings of guilt and responsibility for the abuse or the consequences of disclosure, often reflected in self-destructive behaviours such as substance abuse, risk-taking, self-mutilation, suicidal acts, or provocative behaviour designed to elicit punishment (Kirstner, et al., 2004:26).

Foster parents can have difficulty to cope with some of these behaviours – mostly if they don’t understand the reason for this behaviour. Foster parents of the opposite sex of the foster child can experience feelings of fear when a foster child shows provocative behaviour towards him/her. They can be fearful that the child might say that the foster parent abused him/her.

- **Betrayal**

In betrayal, children discover that someone on whom they were vitally dependent has caused them or wishes to cause them harm (Finkelhor & Browne, 1994:27). Sometimes the betrayal occurs at the time of the first abuse, as children realise that a person they trusted is treating them with callous disregard for their wishes or well-being. In other cases of abuse, children experience the betrayal belatedly, in the realization that they were tricked into doing something bad through the use of lies or misrepresentations. Children can experience betrayal not only at the hands of offenders, but by family members they believe should have protected them from the abuse or do not believe them (Dunn, 2004:74).

A sense of betrayal (experience of undermining of trust in people who are expected to act as protectors and nurturers) is reflected in lack of trust in others, manipulative behaviour, re-enacting the trauma through involvement in

A child victim whose feelings of betrayal are intense, often show signs of grief and depression over the loss of a trusted person (Muller & Hollely, 2000:122). Finkelhor and Browne (1994:28) argue that these reactions are defined by feelings of deep disillusionment; an intense need to regain trust and security expressed through extreme dependency and clinging. Foster parents would need to have knowledge of these feelings of the sexually abused child in order to be able to provide for these needs to be fulfilled. Disbelief and rejection by potential adult caretakers increase the helplessness, hopelessness, isolation and self-blame that makes up the most damaging aspects of child sexual victimization (Garrison, 1998:1).

Adolescent victims tend to show aggressive behaviour in response to anger due to feelings of betrayal. This could have a very negative impact on foster child and foster parent relationship if not understood by the foster parent and handled in a sensitive way (Fouché & Yssel, 2006:245-246).

- **Stigmatisation**
Stigmatisation refers to the negative messages about the self (evilness, worthlessness, shamefulness, guilt) that are communicated to the child around the experience, either by the abuser or by the attitudes of other persons in the family or community (Finkelhor & Browne, 1994:27-39; Righthand et al., 2003:20; Fowler, 2008:19). These messages are communicated in several ways - abusers say it directly when they blame the victim (‘you seduced me’) or denigrate the victim (‘you bitch’). But much of the stigmatisation comes from the attitudes the victims hear or the moral judgments they inform from those around them. Victims are likely to know, or discover at some point, that sexual abuse and incest are regarded as deviant (Dunn, 2004:73).

These inferences are often reinforced by the specific comments the child may hear in the wake of disclosure; for example, that they, or other abuse victims,

This sense of inner badness and stigmatisation has an effect on the foster parents because the child who was sexually abused doesn’t receive positive messages from anyone. They feel that they are bad and worthless and foster parents might struggle to change these messages.

- **Powerlessness**

There are two main components to the traumagenic dynamic of powerlessness: A child’s will, wishes, and sense of efficacy are repeatedly overruled and frustrated, and a child experiences the threat of injury or annihilation.

Many aspects of the sexual abuse experience can contribute to powerlessness or disempowerment (Finkelhor & Browne, 1994:30). One form of powerlessness central to sexual abuse is the experience of having one’s body space repeatedly invaded against one’s wishes, whether this occurs through force or deceit. A second core form of powerlessness is the experience of violence, coercion, and threat to life and body that occur in some types of sexual abuse. Both of these forms of powerlessness – invasion and life threat – are exacerbated when children resist by fighting back, running away, or trying to outsmart the abuser and are frustrated in their efforts to end abuse (Muller & Hollely, 2000:123-126).

Sense of powerlessness can manifest in the perception of vulnerability and attempt at mastery, often through identification with the aggressor, reflected in dissociation, anxiety, phobias, sleep and eating problems, and revictimisation (Kirstner, et al., 2004:26-27; Naude et al., 2003:11; Righthand et al., 2003:21).

The foster child’s feeling of powerlessness may have an impact on the relationship between the child and the foster parent. The foster parent may
expect something from a foster child (to tidy his/her room) and the foster child may not be able to do it, because of their feeling of powerlessness. If the foster parent doesn’t understand these feelings from the child, they might just feel that the foster child is just disobedient.

The traumagenic dynamics described are not limited to one part of the process of child abuse. They operate before, during and after the sexual contact. The four dynamics are ongoing processes and the impact of sexual abuse always needs to be understood in context to the child’s life beforehand. The four traumagenic dynamics can therefore be used to analyse child sexual abuse as a process, rather than simply an event (Dunn, 2004:74). It is important for the foster parent and significant other in the life of the abused child to understand the impact of sexual abuse as a process and that the impact thereof continuously plays a role in the life of the abused child.

10.2 INTERNALISING MODEL

From infancy, a child internalises experiences of self and self in relation to others (Killian & Brakarsh, 2004:370, Potgieter, 2000:33-39). The internalisation process can be defined as the taking in and processing of the meaning of external experiences as they relate to the self and through which the self-concept develops. The child will internalise certain messages to create an internal working model, which will finally become the base from which a child will respond to or interact with the outer world (Killian & Brakarsh, 2004:370). As a result of the sexual abuse, a child is likely to have a damaged or distorted sense of self due to various messages that he has internalised about himself (Wieland, 1997:85; Fowler, 2008:19-20).

Internalisations commonly expressed by sexually abused children are: “It was my fault”; “I can’t trust people close to me”; “There is something wrong with me”; “If I am sexual, good things will happen to me”; “I am damaged/I am powerless”; “I am guilty/bad/an object to be used”; “I am responsible for…”; “memories of abuse/no protection”; “I feel chaotic”; “I am betrayed by people close to me”; “I have no boundaries”; “My sexuality means: no feelings, no control, negative feelings”; “What is said to me, is not what is meant”; “I have
The abovementioned internalisations that the sexually abused child has made about himself, will result in certain behaviours that will have implications for foster care. Foster parents need to have insight into these consequences of abuse and the resulting behaviour and feelings of the sexually abused foster child in their care.

10.3 CHILD SEXUAL ABUSE ACCOMMODATION SYNDROME (CSAAS)

In 1983 Dr Roland Summit developed the model of the child sexual abuse accommodation syndrome Garrison, 1998:1):

“Child victims of sexual abuse face secondary trauma in the crisis of discovery. Their attempts to reconcile their private experiences with the realities of the outer world are assaulted by the disbelief, blame and rejection they experience from adults. The normal coping behaviour of the child contradicts the entrenched beliefs and expectations typically held by adults, stigmatizing the child with charges of lying, manipulating or imagining from parents, courts and clinicians. Such abandonment by the very adults most crucial to the child’s protection and recovery, drives the child deeper into self-blame, self-hate, alienation and revictimization” (Summit in Garrison, 1998:1).

This model is based on Summit’s clinical experiences and has five stages (Giardino, 2007:50; Bruck et al., 2005:195; Fowler, 2008:23-25), namely secrecy, helplessness, entrapment/accommodation, disclosure and retraction. It is important to keep in mind that there are two separate aspects of this model, each with its own components. The first stipulates the psychological consequences of abuse (fear, blame & accommodation). The second aspects stipulate the consequences the psychological states have on behaviour (secrecy, disclosure and recantation) (Bruck et al., 2005:195).

The five stages will be discussed next:
• **Secrecy**

After being abused, a child may be forced to keep the inappropriate sexual contact a secret (Bruck *et al.*, 2005:195). The adult either covertly or overtly convinces the child that the sexual abuse is a secret. Overtly this may be reinforced by the use of verbal threats. Covertly this may be by the use of body language, signs and signals. The adult uses the child’s isolation and takes advantage of the child’s helplessness (Fowler, 2008:23).

For the foster care situation it has the following impact: the foster child is so used to keeping secrets as a way of survival that they tend to keep everything a secret; for example their feelings and if they are in trouble at school. The foster parents need to be aware of this fact and make the foster child feel safe in their environment to tell their secrets.

• **Helplessness**

According to Fowler (2008:23) the adult uses the ‘natural’ power they have over children, and this produces a relationship where power and control determine the interactions. The victimised child’s first reaction to the situation is often to feel trapped and helpless (Giardino, 2007:50).

Foster children that have been sexually abused tend to fear many adults. If the foster parents are very rigid in their ways of discipline, the child might have these same feelings of being trapped and helpless.

• **Entrapment/accommodation**

The adult lies about or distorts his or her actions towards the child, for example telling them this is what all fathers do. This behaviour is repeatedly used. Children who keep their abuse secret become locked into a process of helplessness and entrapment. The child may eventually begin to blame themselves for what is happening, believing they are responsible for provoking the abuse. They even sometimes see the abuse as a consequence of their bad behaviour (Fowler, 2008:24).
These children feel that they deserve to be abused. Foster children, who have been sexually abused, sometimes keep their abuse a secret. They can be placed into foster care because of other reasons, and not always because of the sexual abuse. Even after being in a safe environment they might still feel compelled to keep the abuse a secret and feel entrapped by their emotions. That is why foster parents need to be aware of the symptoms of sexual abuse and if there is any possibility of sexual abuse, it needs to be investigated.

- Disclosure

The victimised child informs others about the abuse that has occurred or is occurring (Bruck et al., 2005:195). If a child discloses after being placed into foster care, it is very important how the foster parent react to this disclosure. Wilcox et al., (2004:338) is of the opinion that “... sexual abuse is most damaging when it involves a betrayal of trust and the child is not listened to or believed in respect of the abuse.”

- Recantation/Retraction

If the child does disclose the abuse but fails to receive adequate support and protection from the people around him or her, the feelings of helplessness are reinforced and may lead the child to retract the disclosure (Giardino, 2007:50). That is why it is so important for foster parents to support the foster child that have been sexually abused.

As already discussed, the symptoms and impact of sexual abuse on the child (including the foster child) will differ from child to child. It will also depend on the developmental phase the child is currently in, as well as the phase he was in when the abuse took place. It is therefore necessary to have a look at developmental theories to gain a better understanding of the development of the child and the implications of the abuse for foster care.
11. DEVELOPMENTAL THEORIES

In order to investigate the implications of sexual abuse for foster care, it is necessary to firstly have a basic knowledge of normal development of the child. For this study it is done via Maslow’s theory of self-actualisation and the psychosocial theory of Eric Erikson.

11.1 MASLOW’S THEORY OF BASIC HUMAN NEEDS (SELF ACTUALISATION THEORY)

In order to anchor the needs and behaviour of sexually abused children in theory and to understand it better, it is also necessary to take Maslow’s hierarchy of needs into consideration.

According to Meyer, Moore and Viljoen (1997:438) Maslow believes that human behaviour can be explained in terms of need gratification. He presents the human being as a ‘yearning being’ who is seldom satisfied because sooner is one need gratified, then another surfaces. People have certain basic needs, which are hierarchically arranged. They are biological, safety, love and esteem needs. These must be satisfied before the need for self-actualisation, which is at the top of the hierarchy, becomes apparent (Dunn, 2004:69).

Maslow distinguishes between two general categories of motives, namely deficiency motives and growth motives. Deficiency motives refer to the first four levels of the need hierarchy, while growth motives refer to the actualization needs (Meyer, Moore & Viljoen, 1997:439).
Figure 1: Maslow’s hierarchy of needs

Maslow’s Hierarchy of Needs
(original five-stage model)

- **Self-actualisation**
  personal growth and fulfilment

- **Esteem needs**
  achievement, status, responsibility, reputation

- **Belongingness and Love needs**
  family, affection, relationships, work group, etc

- **Safety needs**
  protection, security, order, law, limits, stability, etc

- **Biological and Physiological needs**
  basic life needs - air, food, drink, shelter, warmth, sex, sleep, etc.

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Chapman, A. (2004:3)

The child in the abusive situation’s safety and acceptance needs are not met because he does not feel safe on a continuous basis. This child tends to confuse the difference between love/acceptance and sexual intimacy. As these needs are not met, or confused, the child in the abusive situation may have problems with the need of esteem. This refers to the need to evaluate oneself positively (Guishard-Pine, et al., 2007:29; 80). This leads to a feeling of confidence, competence, usefulness and that you are needed by the world. The child in the abusive situation does not experience these feelings. As this child is struggling with the basic needs, the need for self-actualisation and reaching optimal potential, will probably never be met (Dunn, 2004:70; Kruger & Spies, 2006:164-165).
11.2 ERIC ERICKSON’S THEORY OF PSYCHOSOCIAL DEVELOPMENT

Eric Erickson developed a theory regarding the psychosocial development of the individual. This theory is important to use as a baseline to compare how child sexual abuse affects the normal development of the sexually abused child and the implications it has for foster care.

Erickson divided the lifespan into eight stages (Dunn, 2004:66; Woolfolk, 2007:67) each stage is characterised by a crisis – a situation in which the individual has to orientate himself according to two opposite poles. Each crisis is brought about by a specific way of interaction between the individual and society. On the one hand, the maturation of individuals brings about new needs and possibilities in them (Hook, et al., 2002:283).

The solution of each crisis does not, however, lie simply in choosing the positive pole. Instead, it lies in a synthesis (combination of the two opposites at a higher level) of the two poles. This will result in a new life situation from which the two opposing poles of the next stage arise. When the crisis of one stage has been solved successfully, this will lead to the solution of the next crisis. However, when the crisis of one stage has not been solved successfully, it remains present and must still be handled (Meyer & Van Ede, 1998:51). This is very significant for the sexually abused child, because instead of utilising energy to accomplish normal emotional development, the energy should now be used to overcome the trauma of abuse. The emotional development is thus negatively impacted upon (Wikipedia, 2008:1). The implications this behaviour has for the foster care situation should be fully understood by the foster parent, because the foster parent need to support the foster child to overcome the trauma of the abuse, in order for the foster child to utilise his/her energy for normal emotional development.

For the purpose of this study only the first five phases of Erickson’s Theory will be discussed because the other three phases are more applicable to adults. The impact of sexual abuse in each specific phase will be discussed simultaneously. In table 1.2 a summary of Erickson’s psychosocial theory is done.
Table 1.2: Phases of Erickson’s Psychosocial theory.

<table>
<thead>
<tr>
<th>PSYCHOSOCIAL CRISIS STAGE</th>
<th>LIFE STAGE</th>
<th>AGE RANGE, OTHER DESCRIPTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Trust v Mistrust</td>
<td>Infancy</td>
<td>0-1½ years, baby, birth to walking</td>
</tr>
<tr>
<td>2. Autonomy v Shame and Doubt</td>
<td>Early Childhood</td>
<td>1-3 years, toddler, toilet training</td>
</tr>
<tr>
<td>3. Initiative v Guilt</td>
<td>Play Age</td>
<td>3-6 years, pre-school, nursery</td>
</tr>
<tr>
<td>4. Industry v Inferiority</td>
<td>School Age</td>
<td>5-12 years, early school</td>
</tr>
<tr>
<td>5. Identity v Role Confusion</td>
<td>Adolescence</td>
<td>9-18 years, puberty, teens*</td>
</tr>
</tbody>
</table>

(Chapman, 2012:4)

11.2.1 Pre-verbal - Phase 1: Basic trust versus mistrust (synthesis: hope)

During this stage, which coincides with the first year of life, the child must develop a feeling of basic trust. At the same time, he/she must overcome a feeling of basic mistrust (Meyer & Van Ede, 1998:51).

A healthy synthesis between basic trust and mistrust will equip children well in dealing courageously but carefully with new situations. This synthesis, which Erickson characterises with the word hope, is of great importance throughout life (Meyer & Van Ede 1998:52).

11.2.2 Toddler - Phase 2: Autonomy versus shame and doubt (synthesis: will-power)

During this stage, which covers roughly the second year of life, the child has the task of developing a sense of autonomy (independence) and, at the same time, overcoming a feeling of shame and doubt. This is a time of rapid physical maturation, so that the child is capable of greater self-control and movement than before (Meyer & Van Ede 1998:52).

Physical maturation thus allows children to have greater autonomy and to follow their own will. The excretory function, in which the children now acquire the ability to hold back or let go, is the prototype for a variety of actions. But greater autonomy and freedom bring children into contact with rules and standards of behaviour. This, in turn, leads to the possibility of failure and consequently shame and doubt about their own abilities. This conflict between freedom and discipline is, however, essential for the development of children’s moral conscience (Meyer & Van Ede 1998:52).
11.2.3 Pre-school - Phase 3: Initiative versus guilt (synthesis: purpose)
This stage, which lasts approximately from ages three to six years, is characterised by the task of learning to show initiative while at the same time overcoming a feeling of guilt. Children’s greater freedom of movement and autonomy enables them to act more independently than before so that they can now begin to explore their world with a new sense of purpose. They make contact with a wider circle of people and learn how to manipulate all sorts of things. Children begin to devote themselves to learning their gender role, in which identification with the parent of the same sex plays a major part (Meyer & Van Ede, 1998:52; Woolfolk, 2007:67-69).

11.2.4 Middle childhood - Phase 4: industry versus inferiority (synthesis: competence)
This stage, which lasts from the age of six until the beginning of puberty, more or less covers the primary school years. According to Meyer and Van Ede (1998:53; Woolfolk, 2007:69) children aim at mastering certain skills required for adult life and society assist them by providing schooling. Achieving success becomes important to the child. The child wants to play with and compete against friends, preferably of the same sex.

In modern societies, children's ability to move between the worlds of home, neighbourhood, and school and to cope with academics, group activities, and friends will lead to a growing sense of competence. Difficulty with these challenges can result in feelings of inferiority (Woolfolk, 2007:69).

11.2.5 Phase 5 - Adolescence: Identity versus role confusion (synthesis: reliability)
This stage, which lasts for approximately the age of twelve until twenty, has the central task of achieving and developing an identity. The individual must gain certainty about her own characteristics, her social identity and her own values and ideals. The internal cause of the identity crisis lies in the physical and psychological changes that begin with puberty, namely changes in the physique, the intensification of drives (particularly the sexual drive) and the
reproductive ability that comes with sexual maturity (Meyer & Van Ede, 1998:53).

12. PSYCHOSOCIAL FUNCTIONING OF THE FOSTER PARENTS

Although this part actually forms the next phases (phase 6, 7 and 8) of Erickson’s model of psychosocial development, it is discussed under a separate heading as it focuses on the psychosocial development of the foster parents. Foster parents normally falls within the frame of these two phases due to their developmental phases. This also forms part of the overarching problem statement of this research: “The psychosocial functioning of foster parents of sexually abused children and their knowledge of the sexually abused foster child, will improve if they took part in a social work empowerment programme.” In order to be able to investigate this statement it is necessary to conceptualise psychosocial functioning of the foster parent.

Psychosocial relates to a person’s psychological development in, and interaction with, a social environment. The individual does not have to be fully aware of this relationship with the environment. It is usually used in the context of "psychosocial intervention," which is often used alongside psycho-educational and points toward “solutions for individual challenges in interacting with an element of the social environment” (Wikipedia, 2012:3). In this research psychosocial functioning refers the foster parent’s interaction with the sexually abused foster child as an element of the social environment.

Erikson’s model can also be used to help explain what happens in Maslow’s theory when a trauma affects someone's life, which causes the person to revisit certain needs and internal conflicts (crises) which were once satisfied earlier but are no longer met. According to both Erikson’s and Maslow’s theories, anyone can find themselves revisiting and having to resolve needs (or crisis feelings or experiences) from earlier years (Chapman 2004:6). This also applies to foster parents because although foster parents might have been screened, previous trauma in their lives, might have an influence on their ability to understand the sexually abused child and any challenging
behaviour. Providing specific training on what to expect from the sexually abused child, might help to eliminate the negative impact on their psychosocial functioning, but might even help to improve it.

The following figure by Chapman (2012:4) explains the psychosocial development in phase 6 and 7 of Erickson’s model:

**Table 1.4: Phases 6, 7 and 8 of Erickson's model**

<table>
<thead>
<tr>
<th>Phase</th>
<th>Conflict</th>
<th>Positive Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. <strong>Intimacy</strong> v Isolation</td>
<td><strong>Love &amp; Affiliation</strong> (capacity to give and receive love - emotionally and physically, connectivity with others, socially and inter-personally comfortable, ability to form honest reciprocating relationships and friendships, capacity to bond and commit with others for mutual satisfaction - for work and personal life, reciprocity - give and take - towards good)</td>
<td>young adult / lovers, friends, work connections / intimate relationships, work and social life</td>
</tr>
<tr>
<td>7. <strong>Generativity</strong> v Stagnation</td>
<td><strong>Care &amp; Production</strong> (giving unconditionally in support of children and/or for others, community, society and the wider world where possible and applicable, altruism, contributing for the greater good, making a positive difference, building a good legacy, helping others through their own crisis stages)</td>
<td>mid-adult / children, community / 'giving back', helping, contributing</td>
</tr>
<tr>
<td>8. <strong>Integrity</strong> v Despair</td>
<td><strong>Wisdom &amp; Renunciation</strong> (calmness, tolerance, appropriate emotional detachment - non-projection, no regrets, peace of mind, non-judgemental, spiritual or universal)</td>
<td>late adult / society, the world, life / meaning and purpose, life achievements, acceptance</td>
</tr>
</tbody>
</table>
Erickson emphasised the significance of and ‘mutuality’ and ‘generativity’ in his theory. The terms are linked. Mutuality reflects the effect of generations on each other, especially among families, and particularly between parents and children and grandchildren (Chapman, 2012; Meyer & Van Ede). In this case foster parents will form part of this. “Everyone potentially affects everyone else’s experiences as they pass through the different crisis stages. Generativity, actually a named disposition within one of the crisis stages (Generativity v Stagnation, stage seven), reflects the significant relationship between adults and the best interests of children - own children, and in a way everyone else’s children - the next generation, and all following generations – also foster children” (Chapman, 2012:5). Generations affect each other. A parent obviously affects the child’s psychosocial development, but in turn the parent's psychosocial development is affected by their experience of dealing with the child and the pressures produced. The same applies to foster parents. This explains why parents (or teachers or siblings or grandparents) often struggle to deal well with a young person when it’s as much as to deal with own emotional challenges (Chapman, 2012:5).

Rhodes et al. (2003:138) refers to research that indicates the impact of the quality of parenting, family functioning, marital functioning, home environment and parent’s mental health (psychosocial functioning) on the child’s emotional and behavioural adjustment. This would also include the foster child’s adjustment, and it is therefore important that the foster parent’s psychosocial functioning is healthy because of it’s impact on the foster child. Rhodes et al. (2003:138) suggests that the foster family with fewer psychosocial problems will have less difficulty fostering the foster child with emotional and behaviour problems and are more likely to continue fostering.
13. **LONG TERM EFFECTS OF SEXUAL ABUSE AND ITS IMPACT ON THE FOSTER CARE PLACEMENT**

In previous sections the symptoms of sexual abuse, the impact of sexual abuse, the models to delineate the impact of sexual abuse, and normal child development were discussed. All these paragraphs will be linked in this paragraph, as the symptoms and impact of sexual abuse on children will be looked at and simultaneously the effect it has on normal child development as well as the implications thereof for foster care, will be discussed.

It is the responsibility of the foster parent to cope with the impact of sexual abuse as it manifests in the foster child (Carey 2008:1-3). These possible longer term effects, problems and symptomatology as compiled by Miller-Perrin & Perrin (1999:128) are provided in the following table. It will be utilized as a guideline for further discussions on the implications of sexual abuse for foster care. Only symptoms that bear implication for foster care will be included.

**Table 1.5: Longer term symptomatology associated with child sexual abuse**

<table>
<thead>
<tr>
<th>TYPE OF EFFECT</th>
<th>SPECIFIC PROBLEM</th>
<th>SPECIFIC SYMPTOMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional</td>
<td>Depression</td>
<td>- Depressed affect</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Suicidal</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Low self-esteem</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Guilt</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Poor self-image</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Self-image</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Self-blame</td>
</tr>
<tr>
<td>Anxiety</td>
<td></td>
<td>- Anxiety attacks</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Fears</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Phobias</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Somatic symptoms</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Migraine</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Stomach problems</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Aches and pains</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Skin disorders</td>
</tr>
<tr>
<td>Interpersonal (Social)</td>
<td></td>
<td>- Difficulty trusting others</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Poor social adjustment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Social isolation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Feelings of isolation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Insecurity</td>
</tr>
<tr>
<td>Sexual adjustment</td>
<td>Difficulty forming or maintaining relationships</td>
<td>Parenting difficulties</td>
</tr>
<tr>
<td>-------------------</td>
<td>-------------------------------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>Sexual adjustment</td>
<td>Sexual phobia/aversion</td>
<td>Sexual anxiety</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Promiscuity</td>
</tr>
<tr>
<td>Behaviour dysfunction</td>
<td>Eating disorders</td>
<td>Bingeing</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>Illicit drugs</td>
<td></td>
</tr>
<tr>
<td>Self-mutilation</td>
<td></td>
<td>Cutting body parts</td>
</tr>
<tr>
<td>Post-Traumatic Stress Disorder Symptomatology</td>
<td>Re-experiencing</td>
<td>Intrusive thoughts</td>
</tr>
<tr>
<td>Numbing/avoidance</td>
<td>Dissociation</td>
<td>Amnesia for abuse events</td>
</tr>
<tr>
<td>Associated symptoms</td>
<td></td>
<td>Out-of-body experiences</td>
</tr>
<tr>
<td>(Miller-Perrin &amp; Perrin, 1999:128)</td>
<td></td>
<td>Poor concentration</td>
</tr>
</tbody>
</table>

From the above table it is clear that child sexual abuse has a negative impact on every aspect of the child’s life namely emotional, social, sexual and also post-traumatic stress disorder due to the trauma experienced by the abuse. Specific problems are identified. Depression and anxiety are symptoms being experienced as part of emotional functioning problems. Under behaviour dysfunction, eating disorders, substance abuse and self-mutilation are specific problems often identified in sexually abused children. Re-experiencing,
numbing/avoidance and associated symptoms are problems identified as part of post-traumatic stress disorder in the sexually abused child.

The specific symptoms that will have implications for foster care as part of depression, are: depressed affect, suicidal affect, low self-esteem, guilt, poor self-image and self-blame. Symptoms as part of anxiety are: anxiety attacks, fears, phobias, somatic symptoms, migraine, stomach problems, aches and pains and skin disorders.

Symptoms as part of social functioning that might have implications for foster care are; difficulty trusting others, poor social adjustment, social isolation, feelings of isolation, insecurity, difficulty forming or maintaining relationships, sexual re-victimization. Sexual adjustment symptoms that will be focused on the older child or adolescent are: promiscuity and prostitution.

Behaviour dysfunction is evident in symptoms of bingeing, purging, overeating. Substance abuse by using drugs and/or alcohol. Self-mutilation that entails, cutting body parts, carving body areas, hitting head or body with or against objects. Post-Traumatic Stress Disorder symptomatology will include: intrusive thoughts, flashbacks, nightmares, dissociation, amnesia of abuse events, disengagement, emotional numbing, out-of-body experiences and poor concentration.

Although it is impossible in reality to delineate the implications of sexual abuse for foster care into clear categories, researcher will attempt to discuss it broadly under the four headings: emotional, social, sexual and behaviour dysfunction. It should be noted that there will be duplications or overlapping of issues.

14. EMOTIONAL SYMPTOMATOLOGY OF THE FOSTER CHILD AND ITS’ IMPLICATIONS FOR THE FOSTER CARE PLACEMENT

In this section the various symptoms as shown in table 2 will be discussed. It is also important to note that children in the various developmental levels may show different reactions due to the difference in emotional functioning.
14.1 ATTACHMENT

The development of infant-attachment and healthy socio-emotional functioning depends on the presence of consistent, responsive, attuned, and nurturing care givers (Blunden, 2005:41-43; Bowlby, 1988:102; Hook, et al., 2002:112; Hughes, 1997:11; Single, 2005:12). This might have lacking in the life of the sexually molested foster child, previous to foster placement. The basis for healthy attachment is trust, which has been broken during sexual abuse. This will require foster parents to be consistent, emotionally available and able to provide nurturing care on a continuous basis in order for the child to be able to trust and attach again.

Perry (quoted by Earl-Taylor & Thomas, 2003:2) is of the opinion that “…the cascade of problems that result from impaired socio-emotional functioning due to early life sexual abuse can impact on all domains of functioning and, more importantly, it will be a source of ongoing confusion and pain to anyone experiencing sexual abuse in infancy.” From this quote it is clear that healing is an ongoing process in the life of the sexually abused child. Knowledge of these facts is vitally important for the foster parent as it will have an impact on the child’s ability to bond with the foster parent. The foster parent should be able to provide opportunities to facilitate bonding with the foster child, even if the child is older.

14.2 OPPORTUNITY TO VENTILATE FEELINGS

The child needs to ventilate his or her feelings, ask questions, and replay abusive incidents in order to resolve issues. Children have been taught that caregivers and other adults in their lives act in their best interest and cannot understand that people who are supposed to love and care for them can also harm them. Their dependency on parents and other adults for care and security intensifies their conflict. Many children believe they deserve the punishment they receive and often see the foster placement as part of punishment. Children are initially hesitant to discuss the problem with the foster parents because of intense feelings of guilt; they believe that somehow they provoked the adult’s behaviour or could have done something to prevent
it (Thompson & Rudolph, 2000:439). They may feel worthless and ashamed of having been abused (Lodwick & Meyer: 2006:6). Foster parents can play an important role in ensuring children that it is not their fault and there is no need to feel shame.

### 14.3 UNDERSTAND BEHAVIOUR

Sexual abuse impacts the child’s impulse control and therefore influences his/her abilities to achieve success. Instead of feeling good about him/herself, the child experiences feelings of helplessness and inferiority (Potgieter, 1996:99). Wieland (1997:23) confirms that the intrusion causes the child to internalise that "I am damaged" and "I am powerless”. This may finally lead to behaviour reflecting helplessness or aggression. Inappropriate sexual behaviour and/or masturbation can lead to shame and feelings of guilt. This can also result in suicidal behaviour (Kirstner, et al., 2004:27). Foster parents need to understand that this behaviour is normal for a child that has been sexually abused. If the foster parent feels inadequate in handling this behaviour they must be emotionally mature enough to ask for the assistance of a social worker.

### 14.4 TRANSFER OF FEELINGS AND BEHAVIOUR

The child who knows and cares for the abuser becomes stuck between affection or loyalty for the person, and the sense that the sexual activities are wrong. If the child tries to break away from the sexual relationship, the abuser may threaten with violence or loss of love. When sexual abuse occurs within the family, the child may experience the anger, jealousy or shame of other family members, or be afraid the family will break up if the secret is told (AACAP, 2004:1). A child placed in foster care carries these feelings and experiences into the new situation and unless the foster parent is aware of it and able to handle it effectively, it may exacerbate problems. If the foster child feels in any way that his/her behaviour might have an effect on the foster placement, they might be confronted with this same feeling of being trapped in a situation that they are unable to control or handle. That is why it is so
important for foster parents to reinforce their commitment in taking care of the foster child and not to put the foster child in difficult emotional situations.

14.5 REGAINS CONTROL

Sexual abuse represents a situation where the perpetrator gradually takes control of the child’s own abilities. Because of this a form of learned helplessness and a fear to explore may result in the sexually abused child (Potgieter, 1996:99). The foster parent should be aware of this dynamic and be able to address it in a sensitive manner in order for the child to develop a feeling of independence and will-power to execute tasks.

14.6 RESTORE IDENTITY AND SELF-ESTEEM

Sexual abuse influences the child and adolescent’s identity as he/she feels emotionally damaged, fragmented and helpless. Sexual abuse contributes to an identity crisis (Phillips & Daniluk, 2004:2; Potgieter, 1996:100). The adolescent may experience excessive guilt because of sexual development, and feel shame because of sexual drives. Identity development is influenced by low self-esteem and the belief of self as damaged goods. There is a constant fear that others might discover past ‘sins’. Some children distort their thinking at the time of the abuse and subsequently. That can make them vulnerable to further abuse and the re-abuse of children, is something to which practitioners and foster parents should always be alert (Fowler, 2008:20). Some sexually abused children become child abusers themselves or prostitutes or develop other serious problems when they reach adolescence or adulthood (AACAP, 2004:1). It might also happen that the adolescent wants to rise above what happened and over compensate and over achieve.

14.7 GAIN BACK THE LOSSES

Children experience enormous loss through abuse. Loss of autonomy, loss of ownership of the body, loss of innocence, loss of childhood, maybe loss of the family or part of the family, loss of trust, loss of the capacity to make friends and deal with other children. And often the loss of the ‘monster’,
because many children love and miss their abusers (Cattanach, 1992:77). While experiencing these losses and not having the cognitive capacity to understand the underlying feelings and thoughts, children might exhibit various behaviour to cope with these feelings. Foster parents should be aware of these behaviours and the reasons for it, and be able to give the foster child opportunities to heal and where possible, gain back the losses especially the loss of control, by providing choices to the child. Foster parents should also be aware of the loss cycle and how it will influence the child’s behaviour and emotional development.

14.8 UNDERSTAND AGGRESSION

The foster parent should be prepared to cope with the foster child’s aggression and to provide alternative acceptable methods of expressing anger. Also focus on the various feelings that the child experiences regarding the self and the abuse. Foster parents’ urges to change the children’s behavioural patterns may affect these children adversely. They must be aware that when animosity is expressed towards the abuser, it may contribute to the child’s already low sense of self-worth, as the child often tend to accept responsibility for the abuse and regard his/her abuser as an equal (Spies, 2006b: 274).

15. SOCIAL SYMPTOMATOLOGY OF THE FOSTER CHILD AND ITS’ IMPLICATIONS FOR THE FOSTER CARE PLACEMENT

Sexual abuse results in certain symptomology in the social functioning area of the child. In this section the implications thereof for foster care will be discussed.

According to Spies (2006b:274) most substitute care placements (in this instance foster care) fail “because caregivers have little or no knowledge of sexual abuse to support them in responding successfully to the behavioural patterns of the sexually abused child in their care”. Foster parents indicate that they have an urge to nurture these children; to be very close to them; to try to change their destructive behaviour; and to speak out against the person
who abused them. However, when they respond according to these urges, they find that the children become aggressive and/or withdraw from the family system. This approach may cause sexually abused children further stress and pain as they may experience closeness and nurturing as traumatic owing to the strong association with the sexual abuse process. The foster parent might find himself/herself in the middle between the foster child and the foster family, due to anti-social behaviour by the foster child. This might have implications for the healthy social functioning of the foster family.

Foster parents should be familiar with the above mentioned symptomatology and understand that the foster children bring all the trauma related to the sexual abuse into the foster situation. Foster parents should be sensitive to the specific emotional, nurturing and closeness needs of the foster child. Isolation in terms of physical, emotional, social or psychological aspects results in the child thinking: “I won’t let anyone get close to me” (Lodwick & Meyer, 2006:6). The foster parent should be aware of the fact that this destructive behaviour won’t change unless the deeper psychological and emotional wounds have been healed. They need to accept the foster child unconditionally and be careful to not speak against the person who abused the child, as the foster child might have a strong emotional bond with the abuser and experience it as rejection of the self. This may result in social isolation or feelings of isolation.

Abused children have learned not to trust themselves, other people, or their environment. The world and the people in it are inconsistent and hurt them. Withdrawal from this painful world is safer than chancing relationships. Building friendships and trust may be difficult for the child (Smith, 1981:52; Thompson & Rudolph, 2000:438). Because abuse often comes from those who were to be trusted and often involves the misuse of trust, trust is an early casualty of abuse. Trust is almost always non-existent. Trust in many ways is the number one problem requiring time and effort to win and restore (Lodwick & Meyer, 2006:7). The child would also project this mistrust unto the foster parent until the latter has proved to be trustworthy. This behaviour will have an impact on the foster family and it is vitally important that they are aware of
this negative impact on the communication and relationships with the foster child.

Naudè, et al. (2003:15) discuss the impact of child abuse and trauma on the child’s brain. They conclude that traumatic stress associated with child abuse, may have a particular negative impact on audio-sensory functioning and memory processing. It also results in an inability to regulate behaviour, to make choices, to detect and restore mistakes, and to regulate emotional behaviour. Other significant results were the facts that the children have impaired verbal functioning. Although they have the desire to speak, they find it difficult. This might have an important negative impact on their social functioning.

16. SEXUAL ADJUSTMENT OF THE FOSTER CHILD AND ITS’ IMPLICATION FOR THE FOSTER CARE PLACEMENT

Symptomatology regarding sexual adjustment of the sexually abused child and the implications for foster care is discussed next.

When young children are sexually abused and show sexualised behaviour such as masturbating in public, or being flirtatious, they are doing what they have been taught to do. Many foster parents find this behaviour very confronting in a young child and sometimes get angry with the child in a way which reinforces blame. So the child thinks: "I must be bad if adults get so angry with what I do." (Cattanach, 1992:91; Wallace, 2002:73.) Foster parents should be aware of this and be aware that children are constantly re-abused by reinforcing their sense of shame.

Adolescents who have been abused may have difficulty differentiating between sexual and affectionate behaviour. Research has found a link between child sexual abuse and earlier age of first pregnancy which may reflect a search for love and affection (Children’s services practice notes, 2000:1). Spies (2006a:45) indicates that the exposure to sexual abuse leads to the possibility that children may subconsciously sexualise all their needs, even the non-sexual ones: “...when you want closeness, intimacy, or
communication, when you want to feel you are loved and worthwhile and cared for, when you’re happy, disappointed, or angry, you ask for sex instead”. Foster parents should be aware of this and the implications it might have on them and their family members as well as own children.

17. **BEHAVIOUR DYSFUNCTION OF THE FOSTER CHILD AND ITS’ IMPLICATIONS FOR FOSTER CARE PLACEMENT**

Behaviour as an overt reaction to emotions (covert) is often the most difficult to understand, because this is what is shown outwardly and what is seen by people. Although much of possible behaviour has been discussed under the previous sections, the behaviour of the sexually abused child and the possible implications for foster care will be looked at in more detail.

Sexual abuse victims learn certain responses or behaviour in order to survive emotionally or being able to cope. It can be seen as symptoms of the manifestation of a traumatic experience. It highlights the complex impact of sexual abuse on the functioning of a child victim (Muller & Hollely, 2000:109-116).

According to Ryan and Blum (1994:54) children’s first reaction whenever they are sexually abused, will be to ask the question: “Why did it happen to me?” Wieland (1997:24) elaborates when she states that the secrecy around the sexual abuse will create in the child the question “Why me?” this often leads to the answer: “Because of me.” Because of this answer the child blames himself for the abuse and has extreme guilt feelings. This can trigger a whole array of behaviour patterns which can have negative implications for foster care, and foster parents should be aware of this, and be able to manage it.

Anger as a normal emotion may result in aggression as inappropriate behaviour. Anger is a universal characteristic of abuse victims. Wherever there has been abuse there will be anger. Their anger is initially directed against the abuser. Their anger is ultimately directed against non-supportive parent (and God). Their anger is regularly expressed against innocent significant other and children (Lodwick & Meyer, 2006:7).
Eating disorders may also be part of behaviour dysfunctioning. The sexually abused child or adolescent may have the following thinking pattern: “I’ll eat any sexual features into oblivion so that he doesn’t find me attractive and will leave me alone.” Or “I’ll starve myself back into childhood features like before he abused me and he will leave me alone.” (Lodwick & Meyer, 2006:6.) Foster parents should be aware of any possible eating disorder and seek professional help as soon as possible.

The abused child may play a mind game to keep safe. The sexually abused child might learn to be aware of surroundings and to manipulate people or activities to keep the abuser out of his life. The thinking pattern behind this might be: “I won’t let anyone manipulate me, so I have to become a better manipulator.” (Lodwick & Meyer, 2006:6.) The foster parent should be very sensitive to any manipulative behaviour of the abused child as this might have severe implications for foster care and might end up producing negative consequences for the foster child as well as the foster family.

Sexually abused children are often perfectionistic. Often being a perfectionist is mentally, emotionally and physically demanding, victims turn to this to keep their mind occupied. If their world can’t be perfect at least they can make another part of their life perfect (Clean-freak, body has to be perfect – over exercising, hobbies, homework or work) (Lodwick & Meyer, 2006:6). Researcher experience this many times in therapy with sexually abused children. This also manifest as a way of regaining control back into their life, after being abused took away their control. The foster parent should be aware of this possible behaviour of the foster child in order to preventing it from developing into a disorder.

Because of the intense need of the sexually abuse child to be in control, it might have negative implications for the foster situation through undesirable behaviour. The child cannot handle being out of control of situations. The need to be in control of someone else can result in criticizing, nagging, yelling or controlling their lives by anger or threats (Lodwick & Meyer, 2006:7).
18. POST TRAUMATIC STRESS DISORDER SYMPTOMATOLOGY OF THE FOSTER CHILD AND ITS’ IMPLICATIONS FOR THE FOSTER CARE PLACEMENT

The sexually abused child might be severally traumatized due to various aspects. This results in Post-Traumatic Stress Disorder (PTSD) symptomatology which will be discussed next.

It is important to establish how foster parents are affected when a child who has been sexually abused is placed with them. They must care for children in emotional turmoil because of the abuse and the disruption of their families (Children’s Services Practice Notes, 2000:4). To support the sexually abused child during his or her healing process, it is necessary for foster parents to have knowledge of the possible post-traumatic stress symptoms.

According to Dominguez et al., (2008:1-2) the most commonly experienced effect of sexual abuse is PTSD. This disorder is a clinical syndrome which symptoms fall into three clusters: re-enactment of the traumatic event; avoidance of cues associated with the event or general withdrawal; and physiological hyper-reactivity (Dominiguez et al., 2008:1-2). This is often misunderstood by foster parents who have the inner wish to ‘rescue and protect’ the foster child from all harm and see this behaviour as disrespectful or not appreciating what is being done for them. Foster parents should be aware of the fact that this behaviour is not directed at them as foster parents, but is a result of the abuse.

Behaviour indicating that emotions are swinging between emotional numbing, anxiety behaviour and avoidance is typical of symptomatology of sexually abused children. Feeling nothing is better than feeling pain, humiliation or disgust. Feeling nothing helps eliminate having to deal with the abuse and its effects. Often significant dimensions of emotional development are stuck in relation to the time (age at) of the abuse (Lodwick & Meyer, 2006:7). Children who have been sexually abused often exhibit the polarity of anxiety/numbing behaviours. This might be difficult for foster parents to understand and to cope
with. Children should be scrutinized for such symptoms and professional help obtained as soon as possible.

Denial and/or memory suppression is behaviour that the sexually abused child may exhibit. The thinking pattern might be as follows: “This didn’t happen (to me).” “This wasn’t abuse.” Complete chunks of childhood memories are blank (Lodwick & Meyer, 2006:7). How sexual abuse trauma effect brain development is very important and has implications for foster care because of the way the sexually abused foster child behaves and reacts in foster care.

The vast majority of brain development occurs in childhood and adolescence. Components of this development are variably genetically programmed and experience dependently. According to Carey (2008:2) failure or distortion of requisite experiences through abuse and victimization, may have long-term effects on brain function and even structure. Poorer functioning commonly affects mood regulation, frustration-tolerance and levels of attention. This may result in depression, temper-tantrums and attention deficit in sexually abused children. The implication for foster care is that the foster parent must see this in the context of the abuse and put measures in place to take care of the behaviour of the child. This may result in extra financial expenses in order to provide medication or professional services to assist the child to function effectively.

American psychiatrist, Dr Bruce Perry, is one of the leading experts in the field of sexual abuse of the infant child (Earl-Taylor & Thomas, 2003:1). He stipulates that the human brain has multiple ways to “recall” experience. Perry argues that the brain is designed to store and recall all sorts of information – motor, vestibular, emotional, social, and cognitive. Perry notes that all incoming sensory information creates neuronal patterns of activity that are compared against previously stored patterns (Earl-Taylor & Thomas, 2003:2). He states that new patterns can create new memories. Yet the majority of these stored memory templates are based upon experiences that took place in early childhood. According to Perry, the majority of our “memories” are non-cognitive and pre-verbal. “It is the experiences of early childhood that create
the foundational organisation of neural systems that will be used for a lifetime.”

This is why, contrary to general public perception, infants and young children are more vulnerable to traumatic stress – including sexual abuse. If the original experiences of the infant, with primary care-giving adults involve fear, unpredictability, pain, and abnormal genital sensations; neural organisation; in many key areas will be significantly, and detrimentally, altered. Perry (as quoted by Earl-Taylor & Thomas, 2003:2) sites as an example, that abnormal associations may be created between genital touch and fear, thereby laying the future foundation for problems in psychosexual development. He points out, that depending on the specific nature of the abuse, the duration, the frequency and the time during the child’s development, a host of dysfunctional symptoms can result.

Sexual abuse of an infant will result in the association of fear, pain, and unpredictability into the very core of future human functioning – the primary relational templates. Earl-Taylor and Thomas (2003:2-3) argue: “…if these ‘original templates’ for all future relationships are corrupted by sexual exploitation and abuse, the child will have a lifetime of difficulty with intimacy, trust, touch, and bonding – indeed, the core elements of healthy functioning and development throughout the life cycle will be altered”. These effects will definitely have an important implication for the child in foster care. Certain behaviour patterns will have implications for the foster parent and their parenting style and skills. Foster parents should develop an understanding and respect for the way the foster child communicates his/her turmoil (Guishard-Pine, et al. 2007:13).

Furthermore, if the child is sexually abused during early childhood, he/she may not have any “cognitive” memory and is completely unaware of the source of his fears, difficulties with intimacy and relationships, having, as its roots, betrayal in infancy. This can, and invariably will, lead to problems in self-esteem, and will make any parenting and intervention efforts even more difficult. Foster parents would need training to increase their understanding of
children, but also to increase self-understanding of the range of feelings that the child evokes in them (Guishard-Pine, et al. 2007:13).

According to Wieland (1997:23) a child who is abused, experiences both abuse and lack of protection. Also refer here to Maslow’s theory and effect on future development. It is extremely important for the child that a significant person protects him/her from abuse. It is also stated that although certain memories may be suppressed, the emotions of anger, fear and sadness often remain and the child cannot associate these feelings with any specific incident. The foster parent plays a very important protection role in order to protect the child from intensifying further trauma and Post Traumatic Stress Disorder symptoms.

19. OTHER IMPLICATIONS FOR FOSTER CARE PLACEMENT

When a child already in their home, discloses sexual abuse, caregivers experience an array of emotions, including fear, helplessness, sympathy, and anger. Anger towards the birth parents may prevent foster parents from being supportive of birth family connections. All of these feelings and realizations are sometimes too much for the prospective or new foster and adoptive parents (Gillespie, 2000:1). Foster parents need to gain control over their own experiences, but also need to protect and care for the child in an appropriate way. The best interest of the child, as prescribed in Section 28(2) of The Constitution of South Africa (SA, 1996) should be standard and adhered to. Foster parents will have a protective and educational role to play in this regard.

Research conducted by Pollock and Farmer (as quoted by Spies, 2006b:274) suggests it will be of greater benefit to the abused child if foster parents understand the life and survival skills of a sexually abused child. Such understanding could minimise the mistakes foster parents make during their interaction with these children, and thus contribute to their healing. This research further confirms that sexually abused children prefer that foster parents be aware of their special needs, as it contributes towards creating a more secure environment in which the sexually abused child can learn to take
more risks in life. Most of the time these children do not understand why they act the way they do. Some of them even indicate that they often feel foster parents do not believe that they themselves do not understand their behaviour. However, children often voice the fear that professionals will share this information with the foster parents without their consent. In such instances, the children do not know what information has been shared, and in order for them to feel in control of their lives, they need to be part of the sharing process.

The following statement represents the all-encompassing and devastating impact of child sexual abuse: “Young people who have been sexually abused, especially by a trusted adult, suffer damage to almost every aspect of their personal development: sexual, physical, emotional, and spiritual.” (Treating Adolescent Survivors of Sexual Abuse, 2008:2.) To this it can be added that every aspect will produce symptoms, overt or covert that will have implications for foster care.

20. CONCLUSIONS

It is impossible to describe the exact physical and emotional pain the child experiences when sexually abused. It leaves scars that linger in children’s lives in a multitude of ways, threatening their physical and emotional wellbeing and development, their sense of self and their right to health, happiness and a life free from all forms of violence. These scars often persist well into adulthood. When sexually abused child is placed in foster care, it is part of the healing process of the child.

Often children who are abused are removed and placed in foster care to protect them. Because of the impact of sexual abuse on the functioning, development and behaviour of children, it has certain implications for foster parents of sexually abused children.

To support the sexually abused child during his or her healing process, foster parents of sexually abused children need to have knowledge of the process,
impact, dynamics and negative effects of child sexual abuse. They should also be aware of the implications it has for foster care.

The impact of child sexual abuse on the emotional, physical, psychological, moral, social and educational development of the child depends on various factors like the age of the child, the amount of force used, the relationship between the child and the perpetrator, and the period over which the abuse took place.

Symptoms of child sexual abuse - overt or covert -, might be different at different developmental stages of the child’s life and the impact may vary from individual to individual. All of this might have implications for foster care.

The psychological impact of sexual abuse on the child can be described according to two models, the traumagenic model and the internalizing model. In the first the impact is described in terms of the trauma that it causes the child on traumatized sexualisation, betrayal, stigmatization, hopelessness. According to the internalizing model, a child, is likely to have a damaged or distorted sense of self due to various messages that he has internalised about himself, as a result of the sexual abuse.

The negative effect of sexual abuse on the normal development of children can be demonstrated and theoretically founded by making use of Maslow’s theory on basic needs and Erikson’s theory on psychosocial development. It is necessary for foster parents to have an understanding of these theories in order for them to understand the negative effect of sexual abuse on normal development of children.

Certain areas affecting the relationship between the sexually abused child and the foster parent are trust, communication, need for information, experience of loss and sexualized behaviour. The foster parent needs to have knowledge about these aspects and what implications it will have for the foster care situation.
When a sexually abused child is placed in foster care it equals to ‘double trauma’ because the child has been traumatized by the sexual abuse and also by the removal of their parents or formerly primary caregiver. It requires foster parents who have the knowledge of this impact on the child and the insight into how to intervene in assisting in the healing process of the child.

21. **RECOMMENDATIONS**

Foster parents should be empowered by knowledge of the impact of sexual abuse on the child.

Foster parents should be empowered with skills on intervention to neutralize the impact of sexual abuse on the foster child and how to assist the child in overcoming the trauma in the best possible way.

In order to empower foster parents optimally in caring for children in their care who have been sexually abused, it is imperative they first establish their specific and general needs in this regard.

It should be seen as a matter of urgency that foster parents be empowered by a programme that informs them about child sexual abuse and the dynamics and impact thereof on the life of children.

As foster parents might also be traumatized by the stories of the foster children’s sexual abuse and the demands on them for patience and coping with different kinds of behaviour, it is recommended that they be supported through support groups and opportunities for debriefing. Support groups can also assist in devising various alternatives to challenging behaviour.

22. **REFERENCES**


Constitution see South Africa


Department of Social Development see South Africa. Department of Social Development.


Muller & Holley. 2002. Introducing the child witness. Cape Town: (s.n.)


SA *see* South Africa.


