IDENTIFICATION AND ASSESSMENT OF INTENTIONAL PHYSICAL INJURIES TO HOSPITALISED PRESCHOOL CHILDREN

Janine Hartweg

Thesis submitted in partial fulfilment of the requirements for the degree of

Master of Arts

in the Department of Social Work, University of Stellenbosch

Study Leader: Prof S. Green

December 2000

DECLARATION

I, the undersigned, hereby declare that the work contained in this thesis, is my own original work and has not been previously in its entirety or in parts been submitted at any other university for a degree.

SUMMARY

This research investigates the indicators, different role players and the assessment process of intentional physical injuries to children who are hospitalized.

The basic premise for this research is the importance of professionals working with children in acquiring skills and knowledge on handling physically abused children. Physical abuse affects and requires the involvement of the entire family of the physically abused child. It is therefore necessary to consider the physically abused child as a part of the larger family system, and not assessed or treated in isolation. The purpose of this research is to broaden the theoretical knowledge of professionals working with children, and specifically social workers, in identifying and assessing physically abused children.

This research report includes an investigation of risk factors, consequences and the adjustment process of physically abused children. Knowledge of these indicators of physical abuse will increase the awareness and the ability of the social worker or other professional to identify the injury as intentional. The assessment process by the multi-professional team in the hospital is also examined, focusing on the central role of the social worker in managing cases of physically abused children. The phases of the assessment process, the role of each team member, the various techniques applied as well as factors influencing assessment are described.

The empirical research involved the use of both qualitative and quantitative methods in order to explore the theoretical part of the research. This section can be divided into three phases. The first phase included setting up a profile, over a period of four months, of physically abused children under the age of five, who were admitted to the hospital and their families (N = 24). Of this sample, the characteristics and circumstances of four parents/perpetrators (n = 4) were investigated in the form of interviews, which formed part of the second phase of the empirical research. The third phase included conducting a survey with the social workers (n = 5) that assessed

physically abused children in the hospital. This was done in the form of questionnaires, which included closed and open-ended questions.

The findings and responses of the respondents were analyzed and compared with the findings from previous studies undertaken by various authors. The findings of this research can be used as guidelines for professionals in general who work with children, and more specifically social workers in a hospital that assess children presenting with intentional physical injuries.

OPSOMMING

Hierdie navorsing ondersoek die aanduidende faktore, die rolspelers en die asseseringsproses van fisies mishandelde kinders wat gehospitaliseer word.

Die uitgangspunt is die noodsaaklikheid van professionele persone wat met kinders werk, en veral maatskaplike werkers, om kennis en vaardighede te hê, ten einde kinders wat fisies mishandel is te kan hanteer. Omdat die hele gesin van die mishandelde kind geaffekteer word en betrokke is, is dit belangrik om die fisies mishandelde kind nie in isolasie, maar as deel van die familie sisteem te kan benader.

Die navorsingsondersoek het ten doel om die teoretiese kennis basis van professionele persone wat met kinders werk, en spesifiek maatskaplike werkers, oor die identifisering en assesering van fisies mishandelde kinders uit te brei.

Ten einde maatskaplike werkers se kennis van die probleem onders aandag uit te bou, vervat die navorsingsverslag 'n bespreking van die risiko faktore, gevolge en aanpassingsproses van die fisies mishandelde kind. Kennis van hierdie aanduiders sal die bewusdheid asook die vermoë van professionele persone om die fisieses mishandeling te identifiseer, verhoog. Die asseseringsproses deur die multi-professionele span in die hospitaal word ook ondersoek, met fokus op die sentrale rol van die maatskaplike werker in die hantering van fisies mishandelde kinders. Die fases van die asseseringsproses, die rol van elke spanlid, verskeie tegnieke en faktore wat assesering beïnvloed, word bespreek.

Die teoretiese doel van die verslag word uitgebrei in die empiriese ondersoek, deur 'n bespreking van die bevindinge wat deur veskeie metodes verkry is. Kwalitatiewe asook kwantitatiewe metodes is benut tydens die drie fases van die empiriese ondersoek. Die eerste fase was die opstel van 'n profiel wat oor 'n tydperk van vier maande geneem is, van fisies mishandelde kinders wat toegelaat is in die hospitaal en

hul gesinne (N = 24). Vanuit hierdie steekproef, is die eienskappe en omstandighede van vier ouers/oortreders (n = 4) ondersoek deur middel van onderhoude, wat die tweede fase van die ondersoek bevat. Die derde fase was om 'n opname te doen met die maatskaplike werkers (n = 5) wat die fisies mishandelde kinders in die hospitaal asseseer.

Die bevindinge en response van die respondente is geanaliseer en vergelyk met die bevindinge van vorige studies wat deur verskeie outeurs onderneem is. Die bevindinge van hierdie navorsing kan as 'n riglyn gebruik word deur professionele persone wat oor die algemeen met kinders werk, en meer spesifiek maatskaplike werkers wat fisies mishandelde kinders in 'n hospitaal asseseer.

ACKNOWLEDGMENTS

I hereby would like to thank the following people, who made it possible for me to complete this thesis:

To Professor Green, who is my supervisor, and has been an excellent guide. Support was given both morally and academically and her encouragements enabled me to persevere and present this thesis to the best of my ability.

The National Research Foundation (NRF) for their financial assistance towards this research. Opinions expressed and conclusion arrived at are those of the author and are not necessarily to be attributed to the National Research Foundation.

The University of Stellenbosch for awarding me several bursaries which enabled me to financially support my studies, and therefore complete this thesis.

The respondents as well as the manangement component of Red Cross Children's Hospital in the Western-Cape, without whose assistance and participation this research would not have been possible.

Numerous friends and family, of which the list of names is long, who have offered moral and emotional support that was much needed during this year. A special word of appreciation and recognition to my mother, who has been a never ending source of support and encouragement.

Our Heavenly Father, who has blessed me abundantly, without whose guidance I would not have come so far.

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INTRODUCTION

1.1 MOTIVATION OF THE STUDY

Although social awareness of the phenomenon of intentional injuries inflicted on children has increased in recent times, it is not a new phenomenon (Brissett-Chapman 1995:354). According to Wells (1995:347) it was only in 1962 that mysterious physical injuries to children were identified as being the consequence of abusive treatment by parents or caregivers. This abuse was termed the "battered child syndrome" by Dr Henry Kempe (Wells 1995:347). Since then, efforts have been made to help such children.

Many professionals in child-care disciplines were involved in raising the awareness of society regarding the responsibility society has for protecting abused children (Brissett-Chapman 1995:355). This led to the United Nations Declaration of the Rights of the Child, which includes a clause protecting children from cruelty and neglect. South Africa ratified this document on 16 June 1995, and the rights of the child are provided for in Article 28, of the Constitution of South Africa, Act 108 of 1996.

Briere (1992:3), Peltzer & Phaswana (2000:69) and Thompson & Rudolph (1988:4) all mention that there is an increase in reports on abused children. The statistics given by the South African Police confirm this. In 1998 in the Western Cape alone, 478 cases of child abuse were reported. In 1999 this number increased to 532, which shows an increase of 10% within one year, according to the Western Cape police statistics. On the basis of these figures, various authors argue that consideration should be given to the factors contributing to these statistics.

The increasing awareness of child abuse has increased demands for service provision (Argent, Bass & Lachman 1995:1317). The Department of Health in South Africa has therefore made services to children a priority, as is clear from the White Paper for Transformation of the Health System (1997:13).

The experience of physical abuse is a traumatic event, which is so intense and frightening that it overwhelms the child's ability to cope with his/her normal developmental tasks. This experience is damaging to the mental health of the child,

which has negative effects on the development of the child (Lewis 1999:6). Both Lewis (1999:181) and Briere (1992:19) mention that treatment of the effects of traumatic circumstances or events can prevent future pathology and deviant behaviour. Silvern & Kaervang (1989:421) mention that professional help is needed to assist the child in recovery and decrease the emotional ordeal. They add that to be effective in giving this help, it is necessary to take into consideration the child's circumstances. Wells (1995:53) mentions that social workers have long been in the front line regarding the identification, assessment and treatment of child abuse. Argent et al. (1995:1318) add that current service rendering for abused children rely on the essential services of the social worker. Brissett-Chapman (1995:357-8) says that professionals in the medical field are struggling to identify abuse due to lack of experience or inadequate training in this area. The pediatric community is looking for better ways to understand and intervene in cases of child physical abuse.

Extensive research has been done on the risk factors that contribute to child abuse (Ross 1996:592), and on the effects of physical abuse on young children (Briere 1992:7; Gallagher, Leavitt & Kimmel 1995:3; Monaghan-Blout 1996:47; Mullen, Martin, Anderson, Romans & Herbison 1996:7; Prino & Peyrot 1994: 871).

However, there seems to be a lack of research done on the circumstances and overall profile of abused children in South Africa. Gallagher et al. (1995:210) emphasise that the cumulative effect and circumstances of the family of the abused child should be examined. The authors explain that by understanding the impact of each traumatic experience, clinicians can develop individualised interventions to help the child. In order to have this understanding, clinicians have to determine under which circumstances the abuse took place, as the contributing factors vary across different backgrounds. Wells (1995:348) agrees and states that one needs to look at each child in his/her cultural context when evaluating abuse. Lowenstein (1995:890) adds that once this assessment is done, one can focus on a treatment plan. Gallagher et al. (1995:213), Wells (1995:348) and Prino & Peyrot (1994:883) all agree that background information is essential for planning intervention, as each subgroup differs. The child's history should therefore be used as a guide for intervention.

The Social Work Departments of the three main hospitals in the Western Cape of Groote Schuur, Tygerberg and Red Cross Children's Hospital, have stated the need

for research to be done on physically abused children. There is a high incidence of such cases, and information is needed on the social circumstances of these children.

This research springs from the need expressed by these hospitals as well as from Coohey & Braun's (1997:1081) suggestion for further research to be done on the interdependencies of domestic violence and child physical abuse, with special reference to the social circumstances under which the abuse takes place. Smith, Sullivan & Cohen (1995:32) also recommend that the worker's assessment of these risk factors should be researched because they influence interventive decisions with the physically abused children.

The study will compliment two other projects undertaken about child abuse in hospitals. Firstly, Louw, Schalkwyk, Barnes, Dhansay & Schaaf (1999:301) investigated the social work experience of child abuse and neglect at Tygerberg Hospital. The authors did not focus on physical abuse only, but gave an overview of all forms of abuse. They further stated that cases of physical abuse were usually missed in the hectic Trauma Unit, and children were often discharged without being referred to the Social Work Department (Louw et al. 1999:310). Secondly, The Pediatric Unit of Groote Schuur Hospital conducted research at Red Cross Children's Hospital in 1995, on services for abused children (Argent et al. 1995:1313).

The results of the research will provide information about contributing factors, family circumstances and the different cultural backgrounds of children with intentional physical injuries who are hospitalised. Social workers are required to decide on future target services for families where a child is at risk of being removed from the home (Tracy 1995:973). The purpose of the research is to equip social workers with information in order to increase their ability to identify and assess abuse in high-risk families. Since each geographical region presents its own profile, information received from research done in another area is often not universally applicable. Also, since current services are not tailored to the specific situation of the child and family (Wells 1995: 53), this research will give specific information on physical child abuse identified at Red Cross Children's Hospital, which will be relevant to the social workers intervening in those cases. If the social worker's assessment of physically abused children at Red Cross is based on specific information, the effectiveness of intervention strategies will be increased.

The research findings will assist physicians and other staff working with children in hospitals to identify and report physical abuse, as the survey will give an indication of the circumstances in which the abuse takes place (Warner & Hansen 1994:11). The information will also act as a guideline for professionals from a variety of disciplines. The Child Care Amendment Act (96/96) has extended the obligation for other professionals outside the medical field (such as teachers, nursery school and crèche teachers, people employed in places of safety and children's homes) to report cases of suspected child abuse.

1.2 GOAL OF THE STUDY

The goal of the study is to expand social workers' knowledge on the social circumstances of physically abused preschool children who are hospitalised.

In order to reach the goal, the following will be the objectives of the study:

- To study the indicators of physical abuse of children under six years who are hospitalised.
- To investigate the role of the social worker during intake and assessment of physically abused children in a hospital.
- To present a profile taken over a four-month period of children under five years with intentional physical injuries, who were hospitalised.
- To investigate under what circumstances the intentional injury took place, by interviewing four parents/perpetrators.
- To investigate how the social workers assess physically abused children in a hospital.

1.3 LIMITATIONS OF THE STUDY

The research was only conducted in one hospital in the Western-Cape area. It was therefore possible to only have small samples. There were a limited amount of respondents that participated. Red Cross Children's Hospital employs only seven social workers, of which only five were available to take part in the research. Only four parents were willing to conduct interviews with. The parent interviewed also had to be the perpetrator in order to increase the quality of the findings. This already limited the scope of participants, because the perpetrators did not usually accompany the child to the hospital. It also often occurred that a parent suspected of having

physically abused his/her child denied having done so, and therefore could not be included in the research. Although tendencies can be highlighted, it is difficult to generalise the findings of this study because of the above-mentioned limitations.

1.4 RESEARCH FIELD

The research was conducted at the Red Cross Children's Hospital in the Western Cape, as it is the only comprehensive children's hospital in South Africa (Argent et al. 1995:1314). It is also the major paediatric referral centre for children in the Western Cape and renders services to three million people in Cape Town. Because it is the primary care facility for children, it is the appropriate place for the research to be done. The investigation took place in the Trauma Unit of the hospital, as physical abuse cases are admitted and assessed in this unit of the hospital.

1.5 RESEARCH METHODOLOGY

1.5.1 Research method

An exploratory study was undertaken. The aim is to develop insight and understanding about the topic (Williams, Tutty & Grinnell 1995:119). The topic to be researched in an exploratory study is usually new and unknown, and the researcher has little knowledge about it, as both Mouton & Marais (1989:43) and Babbie (1989:80) explain.

Both qualitative and quantitative methods were applied. The difference between the two lies in the system used to report the findings. Quantitative studies use tables, figures and statistics to report the findings. Qualitative research is presented in the form of a narration of the event or observations made by the researcher. Babbie (1989:96) states that by using different procedures in a research design, the researcher is enabled to use the strengths of each method, and adds to the credibility of the research.

1.5.2 Sampling and data gathering

Data was gathered in different ways from the same respondents to get a complete survey, a method known as a panel survey (Dooley 1995:125).

i) Profile of physically abused children and their families

Using quantative methods, a profile of hospitalised children (N = 24) was taken over a four-month period. The identifications and circumstances of all physically abused

children under the age of six, who were admitted to Red Cross Hospital from May to August 2000, was recorded. This was done by using the files of the patients. This sample specifically included children under the age of six, as they are the most vulnerable age group for physical abuse (Argent et al. 1995:1316, Louw et al. 1999:310, South African National Council for Child and Family Welfare 1992:4).

ii) Case studies with the parents/perpetrators

The qualitative part of the study included four case studies representing different cultures and genders. Semi-structured interviews were held with the parents (n = 4), where information was gathered on family dynamics, family circumstances and history, and explanations for the physical abuse of the child that has taken place. The case studies were one-shot case studies, which according to De Vos (1998:125) is used to describe a unit, (which in these case studies refers to the family), during a certain time period. The exploration of the unit and subsequent description enables the researcher to develop insight and sound perspective into the unit. This would further enable the researcher to identify the variables that affect the unit or situation the unit finds itself in. Data is usually gathered in the form of interviews and observations, which indicates the qualitative design of this method. The findings are then carefully analysed and critically discussed. The recording of the information was done by hand-written notes and audiotapes. Observations were also made of parent-child interaction in the hospital.

iii) Survey with the social workers

Questionnaires were given to the social workers (n = 5) in the hospital assessing these physically abused children and their families, in order to gain information on assessment strategies. Of the seven social workers employed at the hospital, two were absent during the time that the survey was conducted, while the remaining five responded. The questionnaires contain six sections with open-ended and closed questions.

Participation by the respondents was voluntary and full consent was obtained. All information will be kept confidential.

Argent et al. (1995:1314) mentions that since Red Cross serves a diverse community and is also the main paediatric referral centre for the Cape Metropolitan area, and

therefore the families that will be involved in the research are a fair representation of the population.

Non-probability sampling was used, as the researcher played a role in choosing the sample (Grinnell & Williams 1990:125). The specific method to be used was purposive sampling, because the researcher chose the respondents according to certain characteristics, as a large survey would be impractical (Dooley 1995:136).

1.6 CONTENT

The following will be presented in the remaining chapters of this thesis:

Chapter 2 is a study of the indicators of physical child abuse. These indicators also help the social worker to assess the abuse and decide on long-term intervention plans.

Chapter 3 focuses on the assessment of physical child abuse in a hospital. Emphasis is on the role of the social worker during assessment.

Chapter 4 contains the results of the empirical study, and **Chapter 5** contains the conclusions and recommendations.

CHAPTER 2

INDICATORS OF PHYSICAL ABUSE IN HOSPITALISED PRE-SCHOOL CHILDREN

2.1 INTRODUCTION

Children presenting with physical injuries are often hospitalised. It is at such a facility where the injuries can be identified as being the result of abuse. Social workers in a hospital will investigate these cases and will have to be able to identify whether a case of physical child abuse exists or not.

Brissett-Chapman (1995:357) and Mullen et al. (1996:8) explain that there are different definitions of what constitutes physical abuse. Physical abuse includes acts of aggression against the child, with resulting or **potential** physical injuries, that is, exposure to potential danger. Children in today's society are all too often exposed to violence. This can be confusing as to which types of behaviours by adults would be considered as physical abuse.

There is no single explanation or formula that can be applied to explain or help identify physical abuse. Brissett-Chapman (1995:360) and Warner & Hansen (1994:11) state that identifying and assessing the abuse of a child was traditionally an informal process lead by an individual worker, where personal bias often caused faulty decisions. More consistent ways thus have to be found for working in a hospital setting to understand and intervene in child physical abuse cases.

Factors associated with identification of abuse in order to report it, is crucial and will thus be discussed. Identification rests on observation of circumstances as well as consequences of abuse and not just a direct observation of the abusive behaviour. In this chapter a cross-study of these points will be undertaken, based on the findings of the different authors.

2.2 DEFINITIONS

Before continuing with the chapter, it is essential to differentiate between two concepts that make up the different chapters in this research, namely identifying and assessing child physical abuse.

2.2.1 Identification

Identifying factors of child physical abuse is a single event that involves recognising certain characteristics of physical abuse. These include risk factors and consequences of child physical abuse that will be discussed in further detail below. Peltzer & Phaswana (2000:77) say that anyone can use their own discretion when identifying these factors.

Just identifying these factors, however, does not necessarily mean that a problem of child abuse exists. Physical wounds, for example, may be identified as a typical intentional injury, but in order to establish this, the child will have to be assessed. The ability to identify risk factors is essential for assessment.

2.2.2 Assessment

The Terminology Committee for Social Work (1995:4) defines assessment as "the process of analysing the factors that influence or determine the social functioning of the individual, family, group or community.

Assessment involves more than identifying risk factors and consequences of physical child abuse. Monaghan-Blout (1996:60) defines it as an inquiry into the domain of competence, risk factors and consequences. Assessment is a process which considers pathways for growth and future intervention for the individuals involved.

The goal of assessment is to formulate a proper treatment plan (South African National Council for Child and Family Welfare 1992:38). It is a process using scientifically based criteria with which such an inquiry is done (Smith et al. 1995:16). Such a process is conducted by professionals working with the children in the hospital.

2.3 RISK FACTORS

The social worker in the hospital needs to be able to identify risk factors, as this information is vital during assessment of the child and his/her parents. These factors need to be seen in combination with each other, as well as suspicious injuries. Risk factors are present in the child, the parent as the perpetrator, ethnicity of both, family circumstances and socio-economic circumstances.

2.3.1 THE CHILD

The concept child connotes youth, smallness, innocence and the need of adult protecion and nurturing (O'Dononhue & Geer 1992:6). Risk factors in the child that are an indication that the child may have been physically abused, include his/her age, gender, developmental stage, and personal characteristics.

2.3.1.1 Age

Age is the first risk factor. Current literature on physical abuse in children indicate pre-school children (0-6 years of age) to be most at risk (Argent et al. 1995:1316; Brissett-Chapman 1995:359; Howard, Marumo & Coetzee 1991:394; Louw et al. 1999:301; Peltzer & Phaswana 2000:69; Warner & Hansen 1994:19). De Villiers & Prentice (1996:147) indicate that children under the age of three years are the most vulnerable, as they demand full-time care from caregivers. Because this young age group is most at risk, this study will focus on children under five year presenting with intentional physical injuries. Injuries in older children, from 16 years, are usually non-abusive injuries.

2.3.1.2 Gender

The second risk factor is the gender of the child. De Villiers & Prentice (1996:149) and Argent et al. (1995:1316) state that with physical abuse there usually is an equal distributions amongst male and female victims. They also found that there is no difference between male and female age distributions. Warner & Hansen (1994:19) adds that the occurrence of abuse is closely related to age and gender, but states that it is preferable to consider other factors or characteristics than gender such as the personality and behaviour of the child.

2.3.1.3 Developmental stage

The developmental stage of the child is another risk factor of physical child abuse. There is a high incidence of physical abuse in pre-school children, which is the reason why this age group is the focus of this study. As physical abuse usually occurs in infents and toddlers, it is necessary to look at the developmental stage of this age group. De Villiers & Prentice (1996:149) links the abusive behaviour of the parent to what he calls the "troublesome two" stage. These children are restless, eager to learn new things and inquisitive. Louw & Edwards (1993:177) describe the developmental tasks of this age group, which is presented below.

Intellectual and cognitive development takes place. The child develops depth perceptions, language skills, symbolic understanding and the ability to draw using symbols. A child who is stimulated intellectually has advanced abilities in those areas, whereas in an abusive environment the child displays a lack of development in these tasks.

The child develops *socially* as well and learns how to play, share and comfort other children who are upset. Learning how to dress him/herself independently and learning correct toilet habits takes place during this phase. It is crucial to stimulate these areas of development within the first few years of the child's life, because according to Piaget's developmental model, the foundations for developmental processes are laid during the first two years of the child's life (Louw & Edwards 1993:177).

Emotional development also takes place. Warner & Hansen (1994:19) mention that bonding with the care-giver is crucial for the child during the first five years of his/her life. Healthy, non-pathological development during that time enables the young child to develop emotional reactions that are appropriate to his/her age.

Moral development, such as self-control and a healthy knowledge of right and wrong, is also influenced by external factors such as parental behaviour toward each other and towards the child. A child's moral development is apparent at an early age. Where parental-child relationships are healthy, the child develops an understanding of what it means to share with others, to exercise self-control, to develop the ability to control his/her temper and to be able to differentiate between right and wrong.

The *physical development* of the infant/toddler is a slow and delicate process. Ossification is one process that is only completed in the adult years. The growth of teeth, jaw, muscles, bones, the nervous system and cerebellum is also a continuous process. The cerebrum alone triples in size during the first three years of the child's life. Warner & Hansen (1994:19) add that due to the tiny and fragile physique of the toddlers, they are easy injured. A child at an early developmental stage has a higher risk for receiving physical injuries than an older child.

Multiple factors can contribute to the abnormal development in any of these developmental areas, which will be discussed further on in the chapter. Physical

abuse will hinder appropriate development of the child in these areas, and this can be identified by the social worker.

2.3.1.4 Personal characteristics

Another risk factor of being vulnerable to physical abuse, is the personal characteristics of the child. There tends to be a cycle of behaviour patterns and responses of abused children. Abused children frequently have lower intellectual functioning than non-abused children, and increased disabilities (Brissett-Chapman 1995:360). This in turn makes them vulnerable to continued abuse, and they also lack and understanding how their own behaviour contributes to the violent behaviour of the care-giver. Misbehaviour of the child has only recently been recognised as a contributing factor to physical abuse (Warner & Hansen 1994:12). This does not mean that the child is responsible for the abusive treatment, but recognises that the child's behaviour can serve as a trigger for the care-giver to abuse the child. A defiant child, hyperactivity, aggressiveness, incessant crying and a child that doesn't sleep well causes stress to a parent with little coping or parenting skills, and can serve as triggers for abusive discipline. On the other hand, a child who is being physically abused often presents with such behaviour problems.

Ehrenkranz, Goldstein, Goodman & Seinfeld (1989:9) add other factors that play a role in eliciting abusive patterns in the parent, such as inconvenience or crisis situations surrounding the time of the birth, an unwanted child, or a child born of a difficult pregnancy. Children that are active, fussy, hard to feed or cuddle are more at risk. These children demand a lot of time and attention from their parents, which is exhausting for many of these parents. In isolation these factors may not be a risk for the child to be vulnerable to physical abuse, but in combination with risk factors of the parents e.g. mental disorder, it can lead to the parent overstepping the boundary of normal child-discipline.

Physical and mental impairment of the child is also seen as an extra burden to some families. Other burdens such as financial problems, unemployment, raising siblings already can put high demands on the family. Brissett-Chapman (1995:362) and Corby (1993:82) both mention that having a handicapped child adds strain to parents who are already overwhelmed by child rearing tasks. The handicapped children then often become the target of physical abuse.

It is important to note that the risk factors of the child mentioned above are not internal reasons within the child that cause the abusive treatment towards them. Rather , these factors trigger a certain response from the parent. The risk factors of the child ought to be considered by the social worker together with the characteristics of the parent and the family's circumstances. All these factors in combination make the child more vulnerable to being a victim of physical abuse. Therefore the risk factors of the perpetrator/parent will be considered in further detail below.

2.3.2 THE PERPETRATOR

The perpetrator of child physical abuse is usually a family member or a friend of the family (De Villiers & Prentice 1996:147). This study will however focus on the nuclear family, and specifically the parent of the child who physically abused his/her child. The risk factors of the parents also work in combination with the child's risk factors, so during assessment the child and the parent need to be considered together as a system by the social worker.

2.3.2.1 Age

Age is the first risk factor of a parent intentionally injuring his/her child. Warner & Hansen (1994:21) indicate that it is usually younger parents, who have not reached the age of twenty yet, or who are in their early twenties, that physically abuse their children. Corby (1993:66) associates immaturity to a younger age. Young teenage parents are premature parents, not prepared for the emotional and financial responsibility of a child. The young parents experience this as stressful and most of their cognitive and problem-solving processes have not had time to mature. They lack impulse control or make decisions quickly without considering all the factors that contribute to the situation (Coohey & Braun 1997:1084). This lack of control and high levels of frustration can lead to a physical out-burst directed at the child.

2.3.2.2 Gender

It is uncertain whether the gender of the parent is a risk factor for abusing children. Studies done on physical child abuse where the gender of the parent was considered, have not reached consensus on which gender has a higher risk of physically abusing their child. Warner & Hansen (1994:19) refer to a study done where it was found that physical abuse by male parents was more abusive than by the mother. On the other

hand, Coohey & Braun (1997:1085) and Mullen et al. (1996:18) explain how violence between partners often causes the battered parent to physically abuse the children. The battered parent in most cases is the mother. Corby (1993:65) expands on the previous authors' view, and points out that abuse often takes place in single-parent families, where the mother generally is the sole caretaker. It is clear, however, that a child that receives violent treatment from both parents has higher rates of negative outcomes.

2.3.2.3 Personal characteristics

The third risk factor to be considered of parent's abusing their children, is the personal characteristics of the parent. This tends to be a more convincing risk factor than gender, in identifying traits of an abusive parent. A parent with a *history of being abusive* towards others, or who himself/herself was *abused as a child*, increases the likelihood of being an abusive parent (Brissett-Chapman 1995:361, Warner & Hansen 1994:17). Most parents deny the history of their own abuse, or have a distorted view of what happened e.g. perceiving it as acceptable discipline. While being a parent to his/her own child, the parent relives his/her own childhood, and often apply how things were done with them. Ehrenkranz et al. (1989:7) stipulate that early abuse can affect the personality development of the parent, which in turn limits their ability to bond emotionally with their children. Some parents find positive chanelling of their experiences, and others never get over the trauma of abuse.

Parents that live in *social isolation* are at risk for abusing their children. This groups includes immigrants who have broken links with their own family as well as parents who do not socialise in the larger community, but choose to isolate themselves from everyone. The parent then has to cope on his/her own with bringing up the child, and this can be extremely stressful (Corby 1993:76; Coohey & Braun 1997:1083).

Prino & Peyrot (1994:882) and Wells (1995:350) include *marital status* as another risk factor of parents abusing their children. The task of single-parenting and coping alone creates immense emotional and financial stress. A single parent often does not receive emotional or financial support from a marriage partner and is left to make decisions on his/her own. A single parent tends to be at greater risk for physically abusing his/her child.

A parent's physical impairment or *ill health* increases stress levels and coping abilities, and causes frustration. A parent suffering from a disease, which makes him/her physically ill, does not have the energy to cope with a crying or demanding child. *Mental illness* of the parent only plays a small part in the phenomenon of child physical abuse. Corby (1993:74) reports that there are some forms of mental illness, such as depression, that contribute to abusive parenting, but also adds that the cause of the depression of the parent can lie in environmental stressors.

The *intelligence and educational level* of the parent seems to play a role in physical abuse of the child. A parent with a low IQ or who left school before completing all the grades are at greater risk of abusing their children. Warner & Hansen (1994:21) say that this group of parents tends to lack understanding of the developmental stage of the child. This leads to unrealistic expectations of their children. If the child falls short of these expectations, the parent becomes enraged. Brissett-Chapman (1995:362) and Ehrenkranz et al. (1989:8) describe parents with abusive tendencies as being rigid, authoritarian, needy, impulsive, anxious, aggressive, dependant and lacking parenting skills.

Mullen et al. (1996:18) also mention that *alcohol and substance abuse* is closely correlated to environmental stressors and depression, and is a risk factor for physical abuse to occur in the home.

2.3.3 ETHNICITY

Ethnicity is another important factor to be considered when identifying risk factors of child physical abuse. The most important point that the social worker must remember, is that child physical abuse occurs in all racial, ethnic and cultural groups.

Brissett-Chapman (1995:359) found that there was an increase in the occurrence of child abuse in *minority groups*, but many authors comment on the reporting system being underdeveloped and the statistics thus do not give a valid reflection of the population. In South Africa the studies that were done on child abuse took place in specific areas of the country and in clinics that served the medical needs of the poorer population (Argent et al. 1995:1314, De Villiers & Prentice 1996:147, Louw et al. 1999:302) De Villiers & Prentice (1996:147) does mention that the findings of his study in a South African town cannot be seen as representative of the general

population. Racial distribution for physical abuse is usually area specific and no comparison can be drawn to the larger population.

Corby (1993:68) states specifically that the identification of child physical abuse in minority groups in the United States of America, is a reflection of *poverty* that many people live in. In South Africa, Lewis (1999:122) also found that poverty has a lot to do with social class, and that physical abuse tends to take place in the lower-economic class families. Stone (1990:54) mentions that the reason for the high incidence of child physical abuse in lower class families is not a direct cause of them being poor, rather that being poor makes these families more open to state surveillance. The author places emphasis on social class rather than mentioning any specific ethnic group and states that middle-class people tend to be protected from state surveillance. The same type of behaviour from a parent in a lower class would lead to investigation. Ethnicity should not be considered as a determining factor when investigating the abuse.

Corby (1993:69) says that few studies check the samples for ethnicity. It is necessary, however, according to Wells (1995:348) to consider the *socio-cultural context* of the child and his/her family when evaluating abuse. Both authors mention that due to cultural misunderstandings and the effects of racism there is an increased suspicion of abuse in certain ethnic families. In South Africa there is an association between race and whether the intentional injury is labelled to be abusive. Kotch, Chalmers, Fanslow, Marshall, Langley (1993:244) explain that there are various methods of discipline that are socially acceptable in certain communities or ethnic groups.

What also has to be taken into consideration in South Africa, is the different *healing practices* in certain cultures. Hospitals in South Africa tend to be hostile toward the traditional healing practices of certain South African ethnic groups. The staff considers the healing practices as destructive and dangerous to the child's health. Gallagher et al. (1995:212) agree that a cross-cultural approach has to be applied when identifying child physical abuse.

2.3.4 FAMILY CIRCUMSTANCES

The circumstances of the family can be a risk factor for child physical abuse to take place. The following circumstances should be taken into consideration by the social worker when assessing the family circumstances.

Socio-cultural changes that have taken place in modern society play an important role in the increase of child physical abuse cases. These changes include women entering the work place, which placed extra pressure on them to perform their roles as employees and their role as a housewife and mother. This increased the stress women experienced, as they had to cope with a lot more than before.

Immigration and the tendency of current generations to move a lot is also a socio-cultural change that has taken place. Most of these families are socially isolated from the community (Corby 1993:76). The geographical distance caused by them moving from traditional family networks, means that these parents have to sort out problems about child care on their own. They receive no hands-on assistance from family networks (Coohey & Braun 1997:1083; Howard et al. 1991:393). There is no one to relieve the parents every now and again from the burden of parenting by looking after the children for an afternoon. The parents never have a break from the responsibility of parenthood, which increases their stress levels. Being separated from the extended family is stressful. There is no longer extended or immediate family available to offer tangible help or support with children.

Views on child discipline can be a source of information to determine whether the risk for abuse is present. Physical child abuse mostly takes place when the parent is trying to correct the child's behaviour (Lewis 1999:113). Parents differing over methods of discipline can also cause conflict in the home.

The *lack of resources* can also cause family stress. Resources that the family need, include child care assistance, financial assistance, proper housing and employment. This stress can lead to partner abuse, which in turn increases the likelihood of the children being abused.

Ross (1995:595) and Lewis (1999:122) both state that often *alcohol and substance abuse* contribute to the violence in the home. A parent in the home abusing alcohol or other substances increases the likelihood of the child being abused.

Corby (1993:83) mentions that *family composition* can be a determining factor in identifying abuse. Single parents, especially with females being the sole caretaker are at risk. Several children that are close together in age is a factor that increases the likelihood of child abuse. It is not clear whether step-parenting is a risk factor, although Brissett-Chapman (1995:361) does indicate that a child living in an extended family household is more at risk.

The *size of the family* seems to be a related issue to child abuse. Families with four or more children have a higher incidence of child abuse. Larger families are therefore more at risk.

Physical abuse seems to be triggered by stressors from outside the family, which the family cannot cope with. These stressors are usually socio-economic factors and are discussed in further detail below.

2.3.5 SOCIO-ECONOMIC FACTORS

Socio-economic problems in a family are also a risk factor for child physical abuse. Life stress and lack of social support as discussed above are important contributors to child maltreatment. The parents' frustration stems from the situation they are in, which they perceive as hopeless (Ehrenkranz et al. 1989:109; Mullen et al. 1996:83).

The most important factor contributing to the stress parents can experience is *poverty*. Corby (1993:68) and Stone (1990:72) both say that there is a strong correlation between poverty and child physical abuse, because families with economic problems usually have limited resources to help them coping. An example of families living in poverty is that parents in a lower social class cannot afford day care or proper housing to accommodate the children in their own rooms. This leads to the parents experiencing a constant lack of privacy or time off from the children needed to regain their emotional strength.

Low-income or *unemployment* in families is a strong variable for identifying child abuse. Howard et al. (1991:393) and Lewis (1999:122) relate the family's stresses to low income. There is increased conflict in low-income families, which often leads to social problems such as substance abuse, marital problems and partner abuse. Thus the low-income or poor families tend to be the most vulnerable ones (Warner & Hansen 1994:19).

2.4 CONSEQUENCES OF CHILD PHYSICAL ABUSE

It is essential that the social worker in a hospital setting can identify the consequences as they manifest themselves in physically abused children. The social worker co-ordinates the assessment of a physically abused child. Identifying the impact of physical child abuse is important for proper assessment to be done by the multi-disciplinary team in a hospital.

2.4.1 Identifying the impact of physical abuse

In the beginning of this chapter the difference between identifying and assessing physical child abuse was discussed. The characteristics of child abuse first have to be identified before the child can be assessed.

It is not easy for members of a multi-disciplinary team in a hospital to predict the impact of physical abuse on children. According to Brissett-Chapman (1995:357), physical abuse can include physical acts of aggression or aggressive acts with the potential to injure the child. This, of course, broadens the spectrum of what kind of behaviour would be defined as physical abuse. Current literature refers to the long and short term effects of physical abuse that manifest after the physical abuse has taken place (Gallagher et al. 1995:212; Lewandowski & Baranoski 1994:513; Louw et al. 1999:302; Mullen et al. 1996:7; South African National Council for Child and Family Welfare 1992:11; van Dalen 1989:383).

Some children, in the immediate period following the abuse may look as if they are coping, but later the emotional and psychological effects surface. Mullen et al. (1996:8) state that if a child experiences one type of abuse, it often goes along with another e.g. physical and emotional or sexual abuse. The consequences of each type of child abuse can also overlap, and therefore it is necessary to clearly identify the characteristics of physical child abuse. A child presenting with any of the consequences of physical abuse, is an indication that abuse is taking place.

The effects of physical child abuse that will be discussed below are common (Monaghan-Blout 1996:47), but are not always universal and a social worker in a hospital cannot use only one formula to identify and later assess all abused children. Monahon (1993:59) indicates that there are different manifestations of the problems arising from the physical abuse. Hartman (1995:67) explains that different variables influence how the child will cope with the abuse. Factors such as the severity of the

abuse, resilience and social support of the child, age and gender of the child play a role. The following section investigates indicators of physical, emotional, psychological and social problems as a guideline for identifying physical abuse.

2.4.2 Physical consequences

The physical manifestation of physical abuse is the most directly observable consequence. Brissett-Chapman (1995:359) and Warner & Hansen (1994:12) differentiate between intentional/non-accidental and unintentional/accidental injuries children present with. The authors state that it is not always easy to identify physical manifestations of an injury as intentional. In the past it often occurred that accidental injuries were suspected as being caused by abusive parenting. It was necessary that physicians modified the criteria with which they evaluated physical abuse. They had to avoid concentrating on only very young children and severe injuries (Brissett-Chapman 1995:359). Kotch et al. (1993:237) point out that most intentional injuries (60 %) are moderate rather than severe, and take place at any age, although younger children are more likely to die from such injuries. Injuries that lead to death include head and neck injuries, asphyxiation/strangulation, poisoning and drowning. Indicators of non-abusive cases are mostly internal causes of the illness and occur in older children.

There are different types of injuries following abusive treatment. The South African National Council for Child and Family Welfare (1992:18) and Winship (1987:193) mention the different physical signs that the physically abused child presents with. Burns, especially those that are small, round marks are usually due to cigarette burns. Burns that leave defined lines on the feet/hands that have usually been held in hot water by force.

Bruises or cuts obtained by children in areas which are unusual to occur during play should raise suspicion in the medical doctor and the social worker identifying and assessing the physical abuse. Unusual places for bruises are on the back of arms or legs, or on cheeks. Finger-mark bruises are to be suspected, as this could indicate the parent grabbing the child violently. Physically abused child can also present with adult bite-marks on their bodies.

Swollen lips, a torn frenulem also indicate violent handling of the child, where objects were either forcefully pushed in or removed from the child's mouth.

A child constantly being admitted to hospital with fractures and sprains should arose suspicion. The fractures and sprains are usually in the forearms and lower legs of the child, where these ligaments were forcefully twisted by the perpetrator.

Abdominal or head injuries are overt indicators of physical abuse. These injuries include bleeding of the internal organs, strangulation marks on neck or open wounds caused by sharp objects on the head.

Any repeated injury for which the explanation given is inadequate or inconsistent is a strong indicator of physical child abuse (Institute for Child Health and Family Development 1996:5). Warner & Hansen (1994:18) expand on how parents' explanations of the injury can be indications that abuse is taking place. Several factors should arouse suspicion in the medical doctor or social worker who question the parents. Such factors include discrepancies in the explanation in the parent's give or the parent delays in bringing the child to the hospital after the injury occurred. Parent's who bring the child to the hospital for first-time treatment of older wounds is a strong indicator that the injury was intentional. Explanations that change over time and that do not mach the developmental capability of the child or severity of the injury should be considered with suspicion by the hospital team. Lewandowski & Baranoski (1994:514) mention the physiological consequences in the child, which includes the tendency to startle easily, increased nervous tension, somatic symptoms and repeated physiological disturbances.

These factors mentioned above are important to take into consideration when working with children in the hospital. The social worker who has a knowledge of what types of physical injuries constitutes child abuse, will be able to identify physical child abuse.

2.4.3 Emotional consequences

The emotional wounds of child physical abuse run much deeper than the physical injuries that heal with time. Farber (1991:96) explains even though physical abuse is aimed at the external body of the child, the pain is often experienced internally by the child. Fatout (1993:85) describes physically abused children as being more sad than happy. Gallagher et al. (1995:412) say that they experience constant arousal and anxiety for expected danger, while Briere (1992:32) points out that this anxiety continues even after the abuse has ended and the child is in a safe environment.

Intense rage or anger are feelings that the physically abused child has to cope with. On the other end of the emotional barometer, a physically abused child often gives bland responses which usually conceals his/her feelings of helplessness, fear, death, and fear of separation of loved ones. Lewandowski & Baranoski (1994:515) add irritability, decreased frustration tolerance, guilt, blaming, guilt, embarrassment, avoidance or emotional withdrawal as indicators of emotional disturbances.

Van Dalen (1989:384) divides the emotional responses of the abused child into **three categories**, namely the conscious, unconscious and resignation phase.

During the *conscious* phase the child searches for an explanation, but cannot understand or find a reason for the treatment he/she is receiving from the parent. Characteristics of this stage are feelings of anger, and other strong emotional reactions to the abuse such as pain, alarm, and surprise.

During the *unconscious* phase the child has concluded that the abuse is due to his own misbehaviour. At this stage the anger toward the parent is restrained. This leads to repression of anger and punishment seeking behaviour in order to gratify the feelings of guilt, also mentioned by Lewandowski & Baranoski (1994:515). At this stage the child is irritable, easily angered, difficult and testing. This phase is indicated by an absence of angry feelings, and shrugs or blank stares when asked about his feelings.

The final stage of *resignation* was rarely seen in outpatient settings, but was usually characterised by the physically abused child attempting to elicit positive responses from the abusive parent.

Lewandowski & Baranoski (1994:514) and Briere (1992:109) both conclude that physical abuse to a child leads to impairment in emotional development or even psychopathology. The emotional factors mentioned above, serve as a guide for the social worker in a hospital in identifying physical child abuse.

2.4.4 Psychological consequences

There is a greater chance for a physically abused child to develop mental health problems, than a child who has not been abused (Mullen et al. 1996:12). The *mental problems* are usually manifested as eating disorders, low self-esteem, pathological fears and phobias, panic disorders, distress, separation anxiety, psychotic symptoms and mood disorders (Monahon 1993:23; Nevid, Rathus & Greene 1997:544).

Cognitive distortions such as hypersensitivity to danger, distorted memories or incorrect perceptions of abuse, belief in omens and sleeping problems occur. The physically abused child is confused and does not understand what is happening to him/her. The physically abused child also experiences time distortions and memory problems. They often view the strangers who helped them after the trauma as the source of the hurt.

Depression is another factor mentioned by Nevid et al. (1997:545), Monaghan-Blout (1996:49) and Mullen et al. (1996:12), but the authors emphasise that it is less common in children than in adults. This is due to a natural ability the child has, to apply denial mechanisms. These children often display apathy, withdrawal, lack of interest or enjoyment in peers and play, extreme boredom, chronic sadness or the milder form of depression known as dysthymia.

Briere (1992:29) further differentiates between four denial or *defence mechanisms*. **Dissociation** is where the child does not perceive the abuse as having happened to him/herself.

Disengagement is a defence mechanism whereby the child does not internalise the experience. The child denies everything and this sense of denial is internalised.

Detachment or numbing means that the child actually comes to the point where he/she does not feel the physical pain or even his/her own body. This phase can be compared to an out-of-body experience.

A final coping mechanism is total **amnesia**. The child does not remember anything of the abuse or the event in which the abuse took place.

Monaghan-Blout (1996:99) and Lewandowski & Baranoski (1994:514) identify high rates of *Post-Traumatic Stress Disorder* (PTSD) in physically abused children. Symptoms of PTSD include hyperarousal, re-experiencing the abusive event or distorted memories. The child also displays repetitive behaviour patterns or re-enactments of the abuse, avoidance of social situations, and changed attitudes about people, life and the future. These factors impair the development of the child, and often leads to *adult psychopathology*.

Disorders that manifest at an older age are Attention Deficit with Hyperactivity Disorder (ADHD) mentioned by Monaghan-Blout (1996:49), Borderline Personality

Disorder. Multiple Personality Disorder is closely related to the physically abused child's ability of **detachment**, as was explained above (Briere 1992:367).

The severe long-term effect of physical abuse can be mental illness. It is important for a social worker to be able to identify these factors as a consequence of physical child abuse, so as to refer these children to the hospital psychiatrist or psychologist for further assessment.

2.4.5 Socio-behavioural consequences

Physical abuse that occurs over time is more severe than acute abuse, as it breeches the parent's role as a protective shield over the whole course of the child's development. Brandell (1993:52) indicates that the abusive experience does not only affect the child in the early stages of his/her development, but also as the child gets older and has to master new developmental tasks based on skills he/she learned in the previous stage. At each transitional phase, the traumatic event resurfaces, for example beginning a romantic relationship where trust and attachment are central issues. The normal development of attachment between the child and parent has been disrupted by the abuse. This leads to the impairment in the normal psychological and emotional development of the abused child, and he/she fails to develop a concern for others and finds it difficult to develop friendships (Corby 1993:109; Fatout 1993:85; Nevid et al. 1997:544).

Where the abuse took place before the age of five, the physically abused child develops behaviours that make him/her less popular and disliked by teachers and peers (Dodge 1994:53). Dodge (1994:53) and Briere (1992:31) both explain that these children socially withdraw from the other children in their age group and tend to lack interpersonal relationship skills. These children get anxious in close relationships due to a fear of evaluation and rejection. The effects remain until adulthood, where the marriages of adults, who were physically abused as a child, often end in divorce or separation. Gallagher et al. (1995:42) agree with the previous authors, and further explore the reason persons who were physically abused as a child, for lacking interpersonal relationship skills. The authors say that the abused children haven't had the opportunity to develop ego functions or coping skills. Fatout (1993:84) also describes that a physically abused child has difficulty in developing a sense of identity, which often leads to clingy behaviour that prevents them from

interacting with other children. It also causes other regressive behaviours such as thumb-sucking, enuresis and avoiding behaviour.

Prino & Peyrot (1994:872) and Mullen et al. (1996:7) both say that the abused child tends to identify with the aggressor which leads to aggressive behaviour re-enactments, acting-out behaviour and flaring into wild rages. Briere (1992:66) and Fatout (1993:85) identified self-mutilating behaviour, while Lewandowski & Baranoski (1994:515) mention nightmares, hyperactivity, difficulty with sleeping, phobic behaviours and other uncustomary conduct patterns.

Younger children who are physically abused are often behind with certain developmental tasks, such as language delay and display behaviour that is inappropriate to his/her age. As the physically abused children get older, they have lowered school performance and many do not graduate from school. (Mullen et al. 1996: 13; De Villiers & Prentice1996:147; Corby 1993:111). The authors also mention that these children often enter and continue the cycle of abuse or intergenerational transferral of violence, drug taking and delinquency.

Each child will develop his/her own unique behavioural pattern and may differ from another's, depending on certain factors, such as dissociation, detachment or aggressiveness. Shapiro (1990:264) explains that coping with a traumatic event is a person and situation specific phenomenon, and therefore different for each abused child.

Terr (1991:11) indicates that the disruption that physical abuse causes in a child's life is extensive. Physical abuse changes the child's attitudes about people, aspects about his/her current and future life. The abused child finds it difficult to adapt to current circumstances.

Behaviour patterns that deviate from the normal behavioural development of a young child, are important to be recognised by the hospital social worker, or other hospital staff members, in order to identify signs of physical abuse. This can be done by observing the child in the hospital ward, while he/she is interacting with other children and staff members.

2.5 THE PROCESS OF ADJUSTMENT OF A PHYSICALLY ABUSED CHILD

Children go through the phases of adaptation in response to a traumatic event that are different to an adult's response to trauma. The child lacks understanding of what happened to him/her and uses primitive defence mechanisms to cope with the abuse. The abuse usually begins before the young victim develops sophisticated ways of dealing with distress. The abused child does not have the cognitive maturity that gives clarity and explains events. This sometimes confuses some young children who were abused. They may perceive the person who rescues them out of the situation as the source of hurt or pain, instead of the actual perpetrator (Monaghan-Blout 1996:52).

Monaghan-Blout (1996:52) and Prino & Peyrot (1994:876) name different elements that influence the child's adaptation or ability to gain homeostasis. Factors such as the child's age, gender, ability to understand what happened, family cohesion and social support, the type of physical abuse, and the child's personality disposition play a role in the child's ability to adapt. Lewis (1999:10) describes personality disposition as resilience, which is an ability to thrive in difficult situations or traumatic experiences. Some children are able to survive these experiences and develop normally, becoming even more competent due to the experience.

Lewis (1999:15) and Shapiro (1990:265) differentiate between phases through which the child goes after the abusive experience. The first phase is known as the **impact phase** and is characterised by a state of shock or a sense of helplessness. The child either displays a lot of emotion or is extremely calm. The extreme stress causes a distorted sense of reality, and it is necessary that the child be placed immediately in a safe environment.

Denial is the second phase where the child displays false bravade or courage.

Aggression or the **recoil phase** indicates that the reality of the trauma has sunk in, and the child has feelings of anger, guilt and powerlessness. Post-traumatic stress disorder usually becomes apparent at this stage.

Depression is another phase that follows the recoil phase. It is characterised by sadness, fear, tension, apathy, withdrawal and clingy behaviour.

Reintegration or **acceptance** is a phase that young children do not go through yet, as they do not have the cognitive maturity or frame of reference to understand what has happened to them. This should be dealt with in therapy sessions as the child reaches an older age.

Nevid et al. (1997:157) and Louw & Edwards (1993:671) describe an adjustment disorder to be a maladaptive reaction to a traumatic event that manifests itself within a short time after the event. This leads to developmental impairments in functions the child has to perform at each developmental stage. The General Adaptation Syndrome (GAS) as named by Hans Seyle, is a term used that describes a biological response pattern to extreme stress. The authors mention three phases. The alarm reaction mobilises the body for defence, also known as fight-or-flight. The abused child is constantly alert for expected danger. The resistance or adaptation phase is where the body tries to renew or repair the damage. If the stress continues, the child reaches a stage of exhaustion. He/she may develop what Seyle called diseases of adaptation, which include allergic reactions, weak immune systems.

It is necessary for a hospital social worker to take cognisance of the different phases of adjustment to trauma, so that physical child abuse can be identified and the information about such abuse can be applied during the assessment process.

2.6 SUMMARY

There is an increased awareness of children presenting with a combination of indicators of physical abuse mentioned. The reason for the wide discussion of factors that could possibly indicate physical abuse is to guard against focusing only on one factor to the exclusion of the others. This could lead to a child that is being abused, to go unnoticed by the social worker or other member's of a hospital team.

The causes of abuse are multiple and interactive. Risk factors that have to be taken into account are characteristics of the child, the perpetrator, family circumstances, ethnicity of the child and his/her parents and socio-economic circumstances of the family of the abused child. Certain characteristics increase the child's vulnerability to physical abuse, and when present in combination with suspicious injuries to the child, the risk factors could be a strong indication that the child is being abused.

The consequences of physical abuse are wide, and include physical signs of the abuse, emotional, psychological and socio-behavioural consequences. The identification of

child physical abuse depends on the observation of these consequences, rather than on the direct observation of the abuse.

Physical signs are manifested in injuries such as bruises, cuts, welts, burns or fractures. The emotional consequences of physical abuse are extensive as well, but differ for each abused child, depending on the child's resilience, social support or type and duration of the abuse.

Physical abuse is not a psychological disorder in itself, but the consequences of physical abuse are wide and can be pathological in nature. The physically abused child often presents with psycho-pathology, which also differs amongst the abused children.

There are also socio-behavioural consequences. The physically abused child often does not display appropriate behaviour in social settings which effects the abused child's social relations.

The adaptation ability of the child is also an indicator that the child is being physically abused, if the child displays behaviour that can be identified as a phase in the adaptation cycle as a response to a traumatic event.

To have knowledge of the risk factors, consequences, and the child's ability to adapt to the physical abuse experience, increases the hospital social worker's ability to identify and assess physical abuse. The ability to identify physical abuse is crucial to an integrative practice with physically abused children as well as their families, because it lays the basis for the phases of the intervention cycle, which will be discussed in the following chapter.

CHAPTER 3

ASSESSMENT OF PHYSICALLY ABUSED CHILDREN IN PRE-SCHOOL CHILDREN WHO ARE HOSPITALISED

3.1 INTRODUCTION

There are increased cases of children being admitted to hospital who have been physically abused, and most of these children are pre-school aged. Assessment is needed to determine whether the child has been abused as well as to determine future interventions. As already mentioned in the previous chapter, intervention cannot begin until the physical abuse of the child has been identified and assessed.

In a hospital, the multi-disciplinary team has to ensure that cases of physical abuse are identified, and that planning and treatment is effective (Brissett-Chapman 1995:362). Argent et al. (1995:1313) and De Villiers & Prentice (1996:147) agree that managing child abuse cases requires competent staff, and therefore it is essential that all health personnel are trained in being able to identify, assess and treat child abuse.

Assessment of physical child abuse is important for confirming the abuse and deciding on effective treatment. That is why it is important for a professional in a hospital to know how to identify and explore certain indicators of physical child abuse as it was discussed in Chapter 2.

Legislation has made provision for all professionals working with physically abused children to report suspected cases, and these professionals contribute to the assessment phase, by giving certain information (Child Care Act 96/96).

Wells (1995:53) does point out, however, that social workers are in the front line in identifying and assessing child abuse. Brissett-Chapman (1995:354) mentions that social workers are, however, often ill equipped to tackle assessment of physical child abuse and Peltzer & Phaswana (2000:75) reported that this is often the reason for not even reporting child abuse. The families of the physically abused children then do not receive treatment. It is thus essential that social workers have the skill to assess whether a child has been physically abused or not.

This chapter will investigate assessment as part of the intervention cycle. The focus of this chapter will be specifically on the role of social workers in assessing physically abused children. There are however other professionals working in a hospital that

abused children. There are however other professionals working in a hospital that also play a vital role in identifying and assessing physical child abuse. Their roles in the context of a multi-disciplinary team, will also be discussed in the following chapter. Finally, there will be a discussion on factors that influence effective assessment of physical child abuse.

3.2 ASSESSMENT AS PART OF THE INTERVENTION CYCLE WITH PHYSICALLY ABUSED CHILDREN

It is important to know where assessment fits into the intervention process, as one phase cannot be implemented before the previous one has not been completed. The manner in which tasks were carried out in one phase usually determines the success or the failure of the next one.

Compton & Galaway (1994:10) and Johnson (1995:213) both define intervention as a scientific process, done jointly with a client by a professional. The intervention process is characterised by different phases, each one with specific tasks (Johnson 1995, Tracy 1995:977). These phases will be discussed in order to gain an understanding of where assessment fits in, to indicate the importance of this phase.

The first phase is known as the **beginning or intake phase** (Compton & Galaway 1994:346). Emotional and functional preparation by the social worker is necessary. Tasks include collecting data about the case, based on the indicators of intentional injuries to children mentioned in the first chapter. This phase can also be regarded as suspecting/identifying the indicators of child abuse. Tracy (1995:977) describes this phase as the intake phase in the hospital. The social worker makes contact with the child, who was brought to the hospital presenting with physical injuries. In this phase, it is also important to engage the family in the assessment of the physically abused child, in order to ensure their future involvement. This includes forming a trusting relationship and joining with the family to overcome any hostility. The author explicitly mentions that paperwork and assessment forms need to be avoided at this stage. Focus should be on immediate or concrete help for the family, e.g. meeting their basic needs.

The second phase is **assessment** and involves investigating the indicators of physical child abuse identified in the beginning phase. This phase will now be discussed in further detail. Assessment is a complex phase and at the centre of the intervention process (Johnson 1995:258). Briere (1992:99) states that assessment is part of the intervention cycle, but that it must precede treatment or the remaining three phases. It is necessary to first have an understanding of what the problem is before one can help. Lewandowski & Baranoski (1994:514) and Monahon (1993:144) indicate when assessment should take place. They suggest assessment should be done immediately, as soon as the child is hospitalised, and should be an ongoing process during the course of the child's hospitalisation. Therefore, assessment is not a single event or an isolated procedure, but an ongoing process during intervention. Certain details may have been suppressed at first, but become an issue at a later stage (Briere 1992:99). Ehrenkranz et al. (1989:25) thus differentiate between intake assessment and interventive assessment. During intake assessment, data that is relevant to determine whether a case of physical child abuse is presented or not, is analysed. Interventive assessment looks at the effectiveness of the treatment program, which can be compared to evaluation discussed further on, or assesses new issues that surfaced during intervention.

Assessment with a child is different to the normal consultation model used when doing assessment with adults. With children it is an ongoing process and has to occur within the family context (Lewandowski & Baranoski 1994:514). It is a joint process that includes the family, doctor, nurse, social worker and child. Tracy (1995:973, 977) adds that the involvement of the family during assessment of physical child abuse is especially important, because family dynamics, culture and lifestyle can be taken into consideration. The assessor can also identify further risk factors of child abuse, and assess the safety of other siblings at home.

Silvern & Kaervang (1989:427) state that exposure to the trauma of physical child abuse, requires immediate attention. During assessment, the child needs to be reassured and encouraged to formulate and disclose what he/she experienced. Numb reactions from the child do not mean that the child is fine. Assessment therefore must not only be done of the situation or the abuse, but also of the degree to which the child experiences the trauma (Lowenstein 1995:890).

Thorough assessment is necessary for deciding on a treatment plan, as the therapeutic method will depend on the needs of each individual. Corby (1993:131) links assessment with prediction, as one can determine future events/ results of plans made from thorough assessment.

The goal of assessment is to integrate information about children presenting with intentional injuries in order to formulate a treatment plan, finalise decisions on protecting the child and make recommendations to the court if there is an action against the perpetrator. It is done by placing and inquiry into the competence of the child, understanding the child in his/her environment, gathering missing information, looking at pathways for growth, strengths and weaknesses of all involved and risk factors (Monaghan-Blout 1996:60, Ross 1995:1371). Certain risk factors identified might only come into effect once exposed to other factors, such as a hyperactive child will only be at risk if the mother is mentally ill, or has other stresses. The parent's characteristics in turn only might be a risk factor if e.g. certain environmental risk factors are present. These risk factors need to be examined so as to place the child in the right environment e.g. foster home, children's home or treatment program (Blatt, Saletsky, Meguid, Church, O'Hara, Haller-Peck & Anderson 1997:336, Smith et al. 1995:15).

Peltzer & Phaswana (2000:77) warn against basing the assessment purely on discretion, and Smith et al. (1995:16) emphasise that one needs scientifically based criteria in order to assess physical child abuse effectively. Professional assessment is therefore the result of a response to factual knowledge as well as intuition (South African National Council for Child and Family Welfare 1992:184). The social worker uses his/her knowledge base to develop an understanding of the client's situation, and also uses forms for assessment so that vital information is not left out or forgotten. This must be done even though each assessment is individualised and will be different for each child (Johnson 1995:260). Information about the problem is gathered by using files, reports, interviewing the child and the parents, as well as other family members.

Assessment can take between three to five hours, and is a time consuming process. There is a limitation to understanding the child, and developing this understanding takes time. No assessment is ever complete (Lewis 1999:186), but Smith et al.

(1995:26) states that assessment, which is carried out thoroughly, will determine whether the suspected case of physical child abuse is founded and reported.

Gallagher et al. (1995:214) explain that deciding on a treatment approach depends on the overall goal one wants to achieve with the child. This is established through assessing the child and his/her family. Assessment thus forms the basis of goal formulation and planning intervention. Without a plan of intervention, assessment is meaningless (Ross 1995:1371).

The third phase in the intervention cycle, is known as the **intervention phase.** When a child is hospitalised and presents with physical injuries, a crisis already exists and help must be given quickly. Intervention for a physically abused child and his/her family should thus begin as soon as possible (Compton & Galaway 1994:12; Johnson 1995:261; Lewandowski & Baranoski 1994:519; Monahon 1993:44).

Different programs or models can be used for intervention strategies, either alone or in combination. The type of intervention model to be used will depend on the results of the assessment as well as whether the goal of intervention is short-term or long-term (Ehrenkranz et al. 1989:22,29).

Short-term intervention would include temporarily removing the child from home or providing concrete services to meet basic needs (Tracy 1995:977).

Most often, the crisis intervention model is applied in the hospital setting. This model provides a knowledge base and guidelines for a response to a crisis. Johnson (1995:321) describes that a crisis exists when the child/family looses their steady state of equilibrium to a stressful situation or event. Situational factors such as the experience of the pain, injuries and hospitalisation are stressful for the child. The threat of exposure, involvement of the police and possible removal of their child from home are stress factors for the parents (Ross 1995:1370, Silvern et al. 1989:427). Immediate emotional support can facilitate coping (Monahon 1993:136). The goal is to resolve the crisis and restore the normal functioning of the child and family. A true crisis situation lasts for four to eight weeks, after which the individuals find new and often maladaptive ways of coping if help is not received (Gilliland, Burlt & James 1997; Shaefor, Horejsi & Horejsi 2000:102).

Help needs to be immediate and intensive. The professional needs to develop an understanding about the person and the crisis, which is possible through assessment.

A helping relationship needs to be developed with the child and the family, which facilitates the processing of fears and disclosure of what happened.

Long-term intervention includes providing the child and family with different forms of therapy such as, play therapy, cognitive-behavioural approaches, family therapy; educational services; out-of-home treatment; foster care and concrete services e.g. housing. The professional in the hospital setting will have to refer for this kind of intervention (Dobson 1988:15; Ehrenkranz et al. 1989:30; Oaklander 1988; Schoeman & Van Der Merwe 1996; Smith 1989:129; Tracy 1995:977; Wachtel 1994).

Evaluation is the fourth phase in the intervention cycle. The extent to which the goals (which were formulated during assessment) were achieved is evaluated. The effectiveness of the intervention plan is considered, and whether there is future support and services needed by the family and the child. If intervention was not successful in meeting the needs of the child/family, the situation needs to be reassessed (Tracy 1995:977). Two domains can be evaluated according to Johnson (1995:379). The first is known as summative evaluation in which the outcome and effectiveness of the intervention is evaluated. Formative evaluation is looking at the how the process of the work, during the various phases of intervention, influenced the outcome. Different methods and techniques can be used. Evaluation makes use of many of the same methods and techniques as intake assessment does.

After the evaluation has been done, it can be determined whether the intervention was successful or not. Either a new intervention plan should be implemented, or the professional relationship can be terminated.

Termination is the final stage of the intervention cycle, but the process of termination already begins at the first contact made with the client system by stating the time limit of the service (Tracy 1995:377). In the hospital, the process of intervention often only goes as far as assessment by the professional team, after which referrals are made to community resources for intervention plans or follow-up contacts (Institute for Child Health and Family Development 1996:19). Ending the professional relationship with the client can bring about strong feelings, especially when one is unsure of what will happen to the physically abused child after he/she has been discharged from the

hospital. Handling this phase is an important skill for hospital social workers to develop (Johnson 1995:397).

It is important to note how essential thorough assessment is, as this will determine the effectiveness of the remaining intervention phases. It will also determine whether the physical abuse of the child is reported and followed-up (Peltzer & Phaswana 2000:75).

3.3 ASSESSMENT OF PHYSICAL CHILD ABUSE BY A MULTI-DISCIPLINARY TEAM IN A HOSPITAL

This following section will look at what the tasks of the multi-disciplinary team are during assessment, and specifically the role of the social worker.

3.3.1 The multi-disciplinary team

The term multi-disciplinary team refers to a team which consists of members from different helping disciplines who are directly involved in investigating, assessing and treating physical child abuse (South African National Council for Child and Family Welfare 1992:37). Child abuse cases often need to be handled by a multi-disciplinary team to ensure the child's physical safety and emotional well being (Blatt et al. 1997:345, Lewis 1999:198).

Each discipline is driven by a different frame of reference, models of intervention and ideologies due to their diverse professional education. This sometimes causes and inability to agree on suspected cases of physical child abuse and conflicts among team members can occur. Especially when working with other professionals outside the hospital, collaboration tends to be an ideal rather than a reality (Brissett-Chapman 1995:357, Cowles & Lefkowitz 1992:62, Waterhouse 1993:140). Working together is however required by government, and according to legislation, any persons in the hospital or who may be involved in the assessment process of suspected cases of child physical abuse (Child Care Amendment Act 86 of 1991, Warner & Hansen 1994:11,Wells 1995:351). Lewandowski & Baranoski (1994:527) include even staff who work closely with the abused children in assessment, and sees them as a rich source of information.

Skibinski (1995:983) emphasises that no single team member has the sole responsibility of assessment of the physically abused children. Each team member has a responsibility for a particular aspect of the problem, and thus a framework for interaction and co-operation has to be developed. Lewandowski & Baranoski (1994:527) advise close communication between the professionals who are most involved with the child and the family, and to consider the opinion of the team before a choice is made. Thorough assessment of medical, developmental, social and psychological needs of each physically abused child should take place at multi-disciplinary meetings to decide whether the case presenting is physical abuse and how the report should be made (Blatt et al. 1997:343; Corby 1993:131). Skibinski (1995:982) states that multi-disciplinary assessment also minimises the trauma the child experiences, as interviews can be done in conjunction with another team member, and the child does not have to go through the same process twice.

3.3.2 Disciplines involved in assessment

Professionals involved in assessing physically abused children are medical and nursing staff, educational experts, social workers and psychologists. The South African National Council for Child and Family Welfare (1992:65) and Argent et al. (1995:1318) even suggest the involvement of community health nurses, trained volunteers and any other health care professional in the region, as these professionals are a valuable source for referrals/follow-ups, especially when managing cases from a hospital setting. The tasks of each multi-disciplinary team member will be discussed below.

- ***Physician***

Wells (1995:351) found that in the past, the physicians had taken the more assertive role or responsibility of leadership in the team. Their tasks include gathering information about the etiology, type, severity and location of the injury. The physician has to evaluate that information together with explanations by the parent's of the injury (Warner & Hansen 1994:13). Furthermore, the injuries and other physical consequences of the abuse have to be treated. Often the physician can be called upon to give medical evidence in court about the physical abuse. It is thus essential that data be kept for evidence (South African National Council for Child and Family Welfare 1992:65). The physician needs specific training to work with the

trauma of child abuse. Paediatric experience is essential in order to increase the physician's knowledge as well as their skills of working with abused children, according to Argent et al. (1995:1318).

- ***Nurse***

The nurse is the team member most closely connected to the child and family, as they see to the daily care in the ward. Lewandowski & Baranoski (1994:527) indicates that this creates a relationship for disclosure. The nursing staff can observe the daily behaviour of the child and parent-child interaction when the parents visit the child in the hospital. Another important source of information for assessment is the community health nurse, who may have been the person who initially identified the problem and who can be a link for follow-up services to the family of the physically abused child (South African National Council for Child and Family Welfare 1992:65).

- ***Psychiatrist/Psychologist***

These professionals see the child and family members and assess the psychodynamic factors of each individual. Tests are done to see whether there are any physical reasons for the parent or child's behaviour e.g. mental disorder. Psychological assessment is also done of the child, considering the developmental level, personality, emotional state and intellectual functioning of the child (Lewis 1999:186). These professionals offer consultative services to the social worker and treat seriously disturbed cases.

- ***Social worker***

In the assessment and management of physical child abuse cases in a hospital, social workers are the leaders of a multi-disciplinary team, assisted by the team of professionals (Ehrenkranz et al. 1989:59). The hospital system relies on the central role of the social worker to co-ordinate the assessment, the investigation of the social circumstances of physical child abuse, provide counselling, as well as arranging practical issues (Argent et al. 1995:1318, Lewis 1999:118). Wells (1995:351) points out that social workers have long been in the front lines of identifying, assessing and treating physical child abuse, and therefore the role of the social worker in assessing physical child abuse will be discussed in further detail later in this chapter.

- ***Police***

Social workers will have to involve the police in certain circumstances. Protection of aggressive responses by the parent's to intervention is sometimes needed. The police obtain a sworn declaration or other evidence needed to investigate the case further for criminal offences (South African National Council for Child and Family Welfare 1992:32). They play a central role if a criminal charge is laid against the parents who abused the child. Police statements from the child must be taken in consultation with the social worker (Institute for Child Health and Family Development 1996:24). Skibinski (1995:981) reported that traditionally, police gathered legally useful information separately from the hospital team, and specifically the social worker. This caused secondary trauma to the child. Waterhouse (1993:145) suggests that the hospital team should work towards police presence at all multi-disciplinary meetings. Investigations by the police should be guided by decisions made by the team. The ideal would be a special joint police/social work assessment team.

- ***Attorneys***

Attorneys play an important role in mediating in court when a decision has to be made on future custody/placement of the physically abused child, as well as prosecuting the perpetrator. Information received from the hospital team will increase the attorney's effectiveness in court and in protecting the child (Ross 1996:597). Many people believe that implementing the legislation is the wrong response to child abuse, and that a prison sentence have not proved effective in deterring offenders (Stone 1990:50). In South Africa it seems to be difficult to work with the criminal justice system, and it is often difficult to obtain convictions for crime against children (Peltzer & Phaswana 2000:69)

Increased interaction between the different disciplines will enhance understanding of each other's work. Through co-operation, the effectiveness of each discipline's tasks during the intervention cycle will be enhanced. There is not one discipline more important than the other; all have to work together in order to assess the physically abused child and his/her family effectively. The social worker's role seems to be pivotal in managing physical child abuse, according to authors such as Argent et al.

(1995:1318), Ehrenkranz et al. (1989:59), Lewis (1999:118), Wells (1995:351). The role of the social worker will thus be considered in further detail.

3.3.3 Role of the social worker in assessment

The social worker needs to understand the need for psychosocial intervention in cases of suspected child physical abuse. The initial goal of assessment is to validate the allegation of abuse. This has to be ascertained in consultation with other team members. Brissett-Chapman (1995:360) says that once the abuse is established, the social worker has to report the abuse to law enforcement and respond also to the emotional needs of the child as well as the parents. Knowledge about the dynamics of child abuse is necessary, as well as the ability to identify physical, behavioural, emotional and psychological signs of abuse. The social worker needs to remain objective and control his/her own feelings (South African National Council for Child and Family Welfare 1992:22).

Brissett-Chapman (1995:362) and Cowles et al. (1992:59) both mention that during assessment, the social worker often acts as a liaison between other team members, and provides support to the team and also liases and refers to child protection agencies. Johnson (1995:119) indicates that this means that the social worker needs to gain knowledge of other disciplines and have the skills for interacting with them. Argent et al. (1995:1318) and Ross (1995:1373) state that the hospital system relies on the role of the social worker to provide the co-ordination of management of child abuse cases and implementing team decisions. For a hospital social worker, collaboration with the team is a corollary of assessment and involves facilitating understanding of the physically abused child and his/her family and the psychosocial dimension of abuse.

Supportive evidence about the physical abuse has to be gathered and barriers have to be identified that prevent full disclosure that the injury was intentional. The social environment of the family has to be assessed, which includes possible solutions to the problem (Smith et al. 1995:32, Cowles & Lefkowitz 1992:59). Carlson (1984:571) uses the ecological framework to assess the individual, the family, socio-economic circumstances, socio-cultural factors and the influence of the environment on the problem.

The social worker has to be prepared to interview the child and family, and needs skills in utilising interviewing techniques. Parental history, marital cohabitation, child vulnerability, social circumstances and parental attitudes need to be assessed.

The following section will investigate at how assessment is done by interviewing the child and the parents, and using assessment measurements.

3.3.3.1 Interviewing the child

It is important for a hospital social worker to have skills in interviewing the child. Effective assessment is based on being able to communicate with a young child using play methods and also being able to control one's emotions.

- *Factors that need to be considered during the assessment interview*

The social worker gathers social and psychological information. It is important to keep in mind that this process of interviewing the child is not child therapy, although talking about the abuse is therapeutic for the child (Wachtel 1994:75).

Corby (1993:131) and Briere (1992:99) mention two domains, which need to be assessed when considering physical child abuse. The **first** one is the child's current knowledge of his/her history, and assessment of the risk factors that first come to light. This is information for short-term intervention. This means exploring the child's memories of events or family circumstances. This will reveal information on the abuse type and severity. The **second** domain of assessment is the psychological state of the child. This means focusing on the personality and emotional state of the child. Lewis (1999:185) also points out that this is not a form of treatment, but necessary in order to understand the child better. Intelligence tests can be used to evaluate the intellectual functioning of the child. Other helping aids can be used, such as drawing pictures and telling stories that are of relevance to the child and his/her family. The child's current internal experience needs to be evaluated. Some children avoid the painful experience e.g. by denial or dissociation as discussed in the previous chapter. This may cause the social worker doing the assessment to overlook the façade and move on. To prevent this from happening, the social worker needs to ask him/herself questions such as whether the current behaviour makes sense, if the affect is deep enough and if the child's body language is congruent with what he/she experienced.

Assessment with the child should not be long and tiresome (Wachtel 1994:75). Children are more difficult to get to know than adults. Seeing them alone enables the social worker to develop a bond with the child necessary for disclosure of the physical abuse. Argent et al. (1995:1319) mentions specifically the importance of conducting an interview in private and non-threatening rooms during assessment. The rooms need to be physically comfortable and equipped with toys.

A basic requirement of interviewing and establishing rapport with a child is to be able to speak the language of the child. This is often a problem in South Africa, where many different cultures exists and 11 languages are spoken. The social worker needs to be sensitive to cultural differences, and determine how the child experiences the abuse in his/her cultural context (Gallagher et al. 1995:211). Lewis (1999:117) states that skill is needed in talking to children at different age levels, and the social worker should clarify the terminology that the child uses.

For a non-threatening therapeutic relationship to be established, confidentiality should be maintained. The child needs to know that he/she can trust the social worker. Should others be included in the assessment or information needs to be shared, this has to be discussed with the child (Wachtel 1994:79). This will also alleviate the child's anxiety. Focus should be on not causing conflict between the parent and the child, because disclosing the abuse creates enough tension for the child (South African National Council for Child and Family Welfare 1992:28).

Lewis (1999:53) mentions that talking about the abuse is very important for the child in order for him/her to understand what happened to them. An important factor to consider is that children might be mistaken about details, but they should not be interrupted or stopped. A child under the age of five has no sense of time. It is necessary to use events to pinpoint dates. Open-ended and indirect questioning should be used rather than direct questioning to establish the events (Lewis 1999:53, South African National Council for Child and Family Welfare 1992:28). Any comments made by a child of that age group should still be supported by other evidence e.g. behaviour when with the parents, overall physical evidence. Statements should be obtained as soon as possible, as the child could deny everything afterwards due to fear or guilt.

- *How to handle a child who doesn't talk or tell the truth*

Young children do have vivid imaginations, but this is no reason to discredit what they are saying. Further questioning and asking for details will clarify whether the child is telling the truth or not, as a young child cannot be consistent in an imaginative story (Thompson & Rudolph 1988:37). A child should never be confronted directly about the truth of the story, but rather be asked to explain what he/she meant by giving further detail, or telling the story from a different perspective. The social worker should say that he/she does not fully understand and that further explanation is necessary.

Children under the age of three cannot give a verbal description of what happened, and with these children other evidence has to be collected. There are several reasons why children might not talk. They may have been threatened with violence, or have been made to feel guilty for what happened. Another reason may be that the child is afraid of getting the adult into trouble, who is often also their primary caretakers. It is important to make the child feel at ease, and the above-mentioned factors, such as a cosy playroom often allows the child to open up. The social worker can give the child the authority in the initial conversation by letting him/her talk about e.g. his/her cartoon hero or any other topic the child will feel at ease with (Wachtel 1994:83).

- *Play methods*

Play is the child's most natural form of communication. Through play the child expresses concerns and works through what is troubling him/her (Oaklander 1988; Schoeman & Van Der Merwe 1996; Smith 1989:129; Wachtel 1994:79). Ehrenkranz et al. (1989:44) encourages the use of play, as it is a way for the social worker to get to know what is bothering the child, understanding his/her affects and what defences the child uses. Through play, the social worker is able to get information that would otherwise take a long time to get. Wachtel (1994:79) also explains that the social worker has to actively direct the play in such a way that explores themes that need to be investigated for the assessment process. During assessment factual play is used, whereby the actions and feelings of real people are used e.g. playing out a family scene instead of using imaginative characters such as monsters. The following forms of play can be used during the assessment interview with the child.

Puppet play is useful when the child will not talk, and Wachtel (1994:79) encourages the use of puppets to break the ice, as young children respond well to personified toys. They find it less threatening to talk to a toy than to the social worker. The child should choose a character itself with which to do the puppet play with. The child can be asked to re-enact a situation similar to one that happens at home, by using the puppets.

The child can be asked to **draw** a picture of him/herself or the family unit. This enables assessment of family relationships or who the perpetrator is (Lewis 1999:186).

Stories can either be read from a book or created. The story needs to construct a similar situation to that of the child's, and is narrated in the third person (Smith 1989:134). The child can be encouraged to tell the ending, which often reveals his/her wishes and fears.

Role-play is according to Ehrenkranz et al. (1989:44), Fatout (1993:91) and Smith (1989:134) a very effective way for enabling the child to distance him/herself from the situation and relieves anxiety. It is a reversal of roles, or acted-out play, where the child takes on the powerful character/toy. Toys or puppets can be used as helping aids.

Movement and physical interaction helps assess the child's ability to express him/herself and to see whether the behaviour of the child is congruent with his/her feelings. Fatout (1993:91) suggests letting the child act out words such as "frozen", "funny", "scary". It also assesses the developmental level and motor functioning of the child, to determine whether it is age appropriate or not. Smith (1989:133) also shows that this form of play can be used for relaxation and calming the child down.

Clay and building blocks are used to assess the developmental and intellectual level of the child. The social worker looks at the ability of the child to recognise shapes and build puzzles (Smith 1989:133, Wachtel 1994:80).

There are thus different methods that can be used in the interview in order to obtain information needed to assess physical abuse. The effectiveness of each method will depend on what information needs to be obtained by the social worker. Information obtained from the child has to be compared to information obtained from the parents. The process of interviewing the parents is discussed in the following section.

3.3.3.2 Interviewing the parent

Various techniques can be used to interview the parent. It is important for the social worker to have skills to interview the parents, who may also have been the perpetrators.

- *Assessment within the family context*

Assessment of physical child abuse is not only concerned about establishing the abuse, but also considering the capacities of all involved for future intervention. What needs to be assessed is the circumstances surrounding the abuse and the family history (South African National Council for Child and Family Welfare 1992:26). Assessment involves the whole family. Corby (1993:133) says that the best interests of the child cannot be considered in isolation, and Tracy (1995:978) adds that developing an understanding of the family's day-to-day functioning is central to the assessment process. Issues such as need of resources, skills in parenting and coping, and views of child discipline are investigated.

Rubenstein & Hochstadter (1990:362) make the important remark that the family is still a system, even though it might be dysfunctional or disrupted by an event such as physical abuse. The social worker thus has to enter the system in a natural manner.

Family processes can already be observed where the parent interacts with the different team members, as it is often a reflection of behaviour patterns that occur at home. In South Africa, it often is a problem assessing the family unit in a hospital context, as the family is not always available or do not come to the hospital.

Wachtel (1994:26) states that it would be preferable to interview the parent separately from the child. The social worker's knowledge about the child will help, when challenging the parent's conflicting explanations of the abuse. The author does emphasise that confrontation should not take place too early in the interview, but only at a later stage when a trusting relationship has started to form.

The child and the parent can be interviewed together. Brekke (1987:337) however states that separation will be necessary if the safety of the child is threatened by retaliation of the abuser later. The mere presence of the parent may also prevent the child from talking. The social worker needs to observe the parent-child interaction. The parent needs to be informed that they are in charge of the child, so as to prevent

confusion of who has authority over the child. Wachtel (1994:45) also indicates that techniques and methods can be combined. Play can be used during family assessment e.g. while the child draws the parent talks. This enables the parent to focus more on him/herself during the interview, as the child is kept busy. The social worker must watch for interruptions, verbal and non-verbal interactions while the parent and child are doing their separate activities.

It often seems more difficult to interview the parents as the possible perpetrator, than interviewing the child. The social worker needs to remain objective, and Rubenstein & Hochstadter (1990:362) discourages pre-judging the situation.

Establishing rapport with the parent is important. This, according to Goldberg (1975:281) entails showing respect for his/her feelings, concerns and fears. Resistance is often a response to anxiety, and Wachtel (1994:45) states the importance of putting the parent at ease. This can be done by informing them about what will happen to the child as well as to them. Aggression displayed by the parent should not distract the social worker, who must remain firm in the interview.

A starting point would be to focus on the child and his/her difficulties. The parent will then feel involved and not attacked. Part of the assessment goal is to establish the attitude of the parent toward his/her child. The social worker must listen carefully to the adjectives used to describe the child (Wachtel 1994:25, Waterhouse 1993:79).

Explanations of the abuse are often embedded in the description given by the parent of their child's behaviours. The parent needs to be encouraged to elaborate on describing the child. A difference in attitudes amongst the parents may be a reflection of marital problems or could be a cue as to which parent is the perpetrator (Wachtel 1994:28). Omissions of basic information are also very important to take note of.

Ehrenkranz et al. (1989:85) says that other areas of assessment such as control and discipline of the child needs to be put within the context of the general relationship between the parent-child and spouse relationship. It is also important to remember that different social and cultural groups accept different forms of disciplining (Gallagher et al.1995:212). Taking cross-cultural disciplinary forms into consideration would be especially relevant to the South African context, where many different cultural groups exist.

- *Interviewing techniques*

Various techniques can be used by the social worker when interviewing the parents.

a) Behaviours of the social worker

Goldberg (1975:276) mentions six interview techniques that the social worker can employ when interviewing a parent.

The first technique is **positioning,** which refers to non-verbal behaviour, such as body positioning, distance, direction of gaze. The social worker should sit at a 60-degree angle, as face-to-face interaction signals confrontation. Direct gazing and rapid speech should be avoided as it signals uneasiness.

Reaching for feelings means using statements that verbalise non-verbal behaviour or describe the feelings of people. This is important where the parent does not express his/her emotions, and will give him/her a chance to verbalise his feelings.

Waiting can also be referred to as silences, and is used after the social worker has reached for feelings. This gives the parent an opportunity to speak.

Getting with feelings can be described as showing an understanding of what the parent is feeling. It is hard for a parent to talk openly when the social worker does not show understanding.

Asking for information is done by using open-ended questions, which leaves room for exploration of the topic. Questions also need to be asked in a less threatening way, such as "What made you angry" instead of "Why were you angry".

Giving information reduces the uncertainty the parent experiences in connection with what lies ahead, alternatives and consequences.

These techniques are applied during the interview, and helps establish rapport with the parents.

b) Funnelling

Brekke (1987:336) says that this technique is the best way to detect child abuse. Funnelling helps bring up the subject of abuse gradually, and enables the social worker to obtain more complete information. The following sets out the ten steps used in this technique. The social worker

- directs the interview to the conflict

- asks the parent to define the meaning of conflict
- normalises and generalises conflict, showing that everyone experiences conflict
- asks the parent to personalise an area of conflict, specifically with the child.
- addresses general solutions to the conflict just mentioned
- asks the parent to personalise solutions to the conflict, that is to say how problems with the child was handled in the past
- asks the parent to give a recent example of conflict
- requests the parent to give an example of the most serious conflict he/she had with the child and what happened
- probes for violence
- reviews and reflects what has been disclosed above.

The technique of funnelling requires skill, but is very effective to use for parents who keep denying that they have any knowledge of the abuse. Interviewing techniques should be used in conjunction with this method.

c) History-taking

History taking is a primary tool used in achieving the goal of assessment. The social worker can obtain this information by using standardised forms (South African National Council for Child and Family Welfare 1992:38). At this stage inconsistencies can be confronted, which Wachtel (1994:26) warns about doing too soon in the interview. The personal history of each parent is taken, as well as the history of having the child (such as child birth, planned/unplanned pregnancies) and an assessment is done on the personality of each parent. Lewis (1999:186) mentions that the role of the psychologists is important for psychological testing.

3.3.3.3 Assessment instruments

The South African National Council for Child and Family Welfare (1992:38) suggests that assessment should be done with the use of forms, so that no information is alleviated during the interviews. Prino & Peyrot (1994:882) state the need for more refined assessment measurements that are able to distinguish between incongruent

behaviours that would make it easier to identify a child with problems. Peltzer & Phaswana (2000:77) warn against using only discretion as a means for assessing, and Smith et al. (1995:16) adds that scientifically based criteria are needed for accurate assessment. Assessment forms should however be avoided while still establishing rapport with the parents (Tracy 1995:977).

Measurement instruments being used need to be valid and reliable. An instrument is valid if it fulfils the purpose for which it was intended, or the intended concepts are being measured. A measuring instrument is reliable if it gives repeatable and consistent results in different circumstances (Magura, Moses & Jones 1987:3, Dooley 1995:235). Structural risk assessment instrument help to objectively estimate the parent-child relationship, the child's safety at home and the family's ability to protect the child. The instruments guide removal or placement decisions, assess child characteristics, parent related problems and environmental circumstances. The format may be a matrix, checklists, decision trees, scales and open-ended questions (Brissett-Chapman 1995:362)

- *Examples*

a) Magura et al. (1987) set up the Family Risk Scales, which focus on parent-centred risk, child centred risk and economic factors. Theses are different assessment scales of indications of physical child abuse.

b) Lewis (1999:186) mentions intelligence tests and personality tests. These are done in conjunction with the psychiatrist/psychologist.

c) Ross (1996:591) employed the Conflicts Tactics Scale (CTS) for measuring physical child abuse and marital violence. The scale measures verbal aggression and physical aggression in the parent-child relationship. The parent is asked to think about problems/conflicts that occurred during the last year and respond to questions on what he/she did in that situation.

d) Brekke (1987:337) used the Domestic Abuse Scale (DAS), which measures how serious the abuse is. The scale investigates psychological abuse, physical aggression and life-threatening violence. The more serious the abuse is measured, the more likely the physical abuse is to be the primary problem.

The use of some of these scales may require skill and even extra training, but can increase the quality of information obtained while assessing physical abuse cases.

3.3.3.4 Referral

Referral is a process by which the child/family are enabled to use additional services to meet their needs (Johnson 1995:119). The social worker has to collaborate with other agencies. Contacting other agencies outside the hospital is part of the task of the social worker during assessment. Previous files are studied and other agencies, crèches and the police are contacted to obtain background information on the child and his/her family (Cowles & Lefkowitz 1992:59).

Referral is especially effective in South Africa, where funding and resources are limited, and posts have been reduced. To prevent overlap or unequal distribution of resources and services, Waterhouse (1993:149) suggests that professionals from different agencies should co-operate.

As soon as the child/family has been assessed, and the physical abuse has been disclosed, additional mental health and out-of-home services will be needed (Brissett-Chapman 1995:363). The social worker's task is to find the appropriate resource or service within and outside the hospital setting. Referral within a hospital takes place during assessment. All available information about the child is passed on to another team member, for them to fulfil their assessment tasks. Requests can be made verbally or by telephone and includes confirmation of abuse or need for further investigation, identifications or signing of forms (Institute for Child Health and Family Development 1996:22).

3.3.3.5 Removal of the child from home

The child welfare system is legally responsible for protecting the child. The goal of assessment is to determine whether it is safe for the child to return home after hospitalisation (Brissett-Chapman 1995:363).

Lewandowski & Baranoski (1994:517) states that separation from the family ought to be kept to the minimum. The child should be reunited with the family as soon as possible, as the child experiences fear, anxiety and depression during the separation.

Skibinski (1995:982) says however, that it will be necessary to separate the child from home as a protective measure. Gallagher et al. (1995:214) add that the right environment is determined by the assessment. The child has to be prepared to stay in the temporary placements. Even if the child has to be removed from home, the social worker has to ensure that the parents stay involved with the progress of their children. The risk of siblings remaining in the home has to be assessed as well.

Children are better off with their own family and they need the stability of a familiar environment. Tracy (1995:973) mentions that many more children could stay at home if intervention would be provided earlier or more intense.

The hospital social worker makes recommendations to the court on who gets custody of the hospitalised child, based on the assessment of the physically abused child (Ross 1996:597). Section 11 of the Child Care Act of 1983 deals with the removal of the child from home. According to this section the court may authorise the social worker to keep the child from returning to the abusive home (South African National Council for Child and Family Welfare 1992:33). It is clear that the social worker does not work in isolation when assessing physically abused children, but even liases with agencies/professionals outside the hospital set-up.

3.4 FACTORS THAT INFLUENCE EFFECTIVE ASSESSMENT OF PHYSICAL CHILD ABUSE

There are several factors that may interfere with objective or effective assessment by the social worker of the physically abused child. These factors are discussed below.

3.4.1 Emotional maturity

It is of utmost importance that the person assessing the physically abused child has the emotional maturity to do so. This includes being able to control feelings of shock, hurt or anger. Such feelings should not be displayed to the child or the parents (South African National Council for Child and Family Welfare 1992:58). Wachtel (1994:76) warns against transference, whereby feelings are displaced onto the social work relationship with the child/parent. It is human to experience those feelings, but the person assessing the child needs to recognise such feelings. Corby (1993:135) acknowledges that working with involuntary clients can be emotionally draining. A skill also needs to be developed to look for the positive in the perpetrator. If this is

not done, assessment with the parent will be hostile and important information can be missed.

3.4.2 Supervision of the social worker

Louw et al. (1999:311) says that supervision is essential for persons handling child abuse cases. It provides a safe environment where the social worker can ventilate feelings and receive support. Tracy (1995:977) indicates that if supervision is not adequately received, it can lead to burnout or low staff morale. Supervision also offers direction in decisions that have to be made during assessment, and ensures that procedural matters are not neglected. Not all social workers receive professional supervision, and Louw et al. (1999:311) suggests then that this function should be carried out within the multi-professional team, where experiences can be shared. Johnson (1995:118) calls this method peer supervision or consultation, a process by which the help of another professional within the team is accepted whereby the tasks of the other (e.g. assessment) are made more effective. Supervision of social workers is essential to deal with issues that occur when dealing with physical abuse cases (Schamess, Streider, Connors 1997:423). Problems during the intervention cycle and specifically during assessment can occur, if emotional issues cloud judgement.

3.4.3 Team support

Problems can occur with assessment tasks if professionals of the same team in the hospital do not work together or support each other (Waterhouse 1993:141). Ross (1995:1373) and Corby (1993:154) agree that differences occur if there are unrealistic expectations from each other and an inability to find a common ground due to different functions, ideals, statuses and pay. The different disciplines need an understanding and respect for each other's positions. Another weakness in the team that effects assessment, is a lack of inter-professional contact, as each on performs his/her own task and makes decisions without consulting the other's contribution to assessing the child.

3.4.4 Insufficient training

A lack of skill in assessment influences the outcome of the physical abuse case. The social worker needs skill in helping the child disclose information in order to obtain supportive evidence of the abuse. Tracy (1995:977) mentions that not all social

not done, assessment with the parent will be hostile and important information can be missed.

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workers and medical staff have sufficient training, knowledge or skill to assess child physical abuse cases. Professional skills are needed to handle such children. Brissett-Chapman (1995:357) states that inadequate training and lack of experience will make it difficult to detect and assess physical child abuse.

3.4.5 Racism and sexism

Even though racism and sexism are separate entities, Stone (1990:91) considers them together. During assessment, racism and sexism cause the professional to overlook some children whose injuries are intentional and who are at risk for further abuse. Child physical abuse spans over all races and genders. The professional should remain neutral and alert while assessing any child. Mistakes have been made because of cultural ignorance or assumptions based on racist and sexist stereotypes (Corby 1993:152).

3.4.6 Personal and professional variables

During assessment it is very important to build positive relationships with every member of the family, including the parent or perpetrator. The professional needs to understand parental reactions. An attitude of rejection by the professional will cause the parent to close up (South African National Council for Child and Family Welfare 1992:40). It is essential to take note of how personal variables such as physique, gender, age, values and professional variables such as years passed since training, current knowledge and skill can influence these professional relationships as well as assessment (Warner & Hansen 1994:19). Assessment could be hampered by subjective bias based on the above-mentioned factors, such as racism (Brissett-Chapman 1995:357). Since discretion is an element in assessing, these factors will influence objective assessment.

Peltzer & Phaswana (2000:75) also mentions fear as a factor that influences assessment. The professional could be hindered in assessing physically abused children effectively due to fear of parent's negative reactions, such as threat, anger or aggression. Fear of having to appear in court and personal upset may be reasons why assessment is not done thoroughly. The fear of loosing clients if suspicion is confirmed through assessment is another influencing factor.

3.4.7 Other

The availability of and the ability to identify evidentiary factors are crucial to effective assessment (Smith et al. 1995:17). The evidentiary factors include indicators of physical abuse in the child, risk factors of the perpetrator, and willingness of witnesses to give a statement.

Procedural factors include the co-operation of the police to react quickly and effectively to protect the child (Peltzer & Phaswana 2000:73 and South African National Council for Child and Family Welfare 1992:32). Lewis (1999:132) says that a fast and certain response by the criminal justice department ensures disclosure and co-operation by the parents during assessment. A response done in collaboration with a hospital team member, such as a social worker, also prevents secondary abuse of the child (Corby 1993:133).

3.5 SUMMARY

Assessment is the most important phase in the intervention process. The success of the following phases depends on how thoroughly the assessment is done. It is crucial to have the skill to carry out this phase in the hospital. Future interventions that the child receives, and other plans made for future protection of the child, depend on the results of the assessment. Assessment is also an ongoing process throughout intervention.

All members of the multi-disciplinary team have a part in the assessment of a child presenting with suspected intentional injuries. Each professional in the team has certain tasks that need to be done, and are complimentary to the tasks of the other's. For assessment to be effective there has to be collaboration between the disciplines in the team. No team member's tasks are more important than another's. Each professional needs to develop special skills and knowledge when working with abused children.

The role of the social worker during assessment of physically abused children is essential, and was considered in more detail. The social worker in the hospital co-ordinates the management of the physical child abuse case, and executes the investigative interviews. Special techniques and skills are needed when assessing the young child. Different techniques are required when interviewing the parents and possible perpetrator of the child. Using assessment instruments is essential to get

complete information. Other tasks that the social worker must fulfil during assessment was discussed, such as referral or obtaining a court order to remove the child from home.

Finally, factors that may hinder effective assessment were considered. These include emotional immaturity, inadequate supervision of the social worker, lack of co-operation amongst team members in the hospital, insufficient training in working with abused children by the staff of the hospital, discriminations based on racism and sexism, personal and professional variables that may intimidate the client or affect the helping relationship, and other factors such as faults in evidentiary and procedural procedures.

CHAPTER 4

A SITUATION ANALYSIS OF ROLE PLAYERS IN INTENTIONAL PHYSICAL INJURIES

4.1. INTRODUCTION

Social workers in a hospital setting rendering services to physically abused children need to have guidelines on how to assess the child and the family. Assessment will determine whether the child has been abused and what intervention plan will be implemented. The social worker that carries out the assessment has to know what criteria to consider. According to Brissett-Chapman (1995:354), social workers are usually ill equipped to tackle assessment of physically abused children, which Peltzer & Phaswana (2000:75) indicate is often the reason for certain cases of physically abused children not being reported.

The objectives of this study was to present demographic data on children with intentional physical injuries and their families; to describe the experiences of the perpetrators and circumstances under which the abuse took place; and also how social workers assess children who are suspected of having been physically abused and what type of problems the social workers may experience.

These objectives were formulated in order to achieve the aim of the study, which was to present guidelines for identifying and assessing physically abused children for professionals, especially social workers, in a hospital.

This chapter entails the results of the study undertaken with physically abused children, the perpetrators and the social workers assessing the cases at Red Cross Children's Hospital, and will now be discussed.

4.2 EMPIRICAL STUDY

The following section contains the findings of the empirical research undertaken.

4.2.1 RESEARCH METHOD

This study has been limited to the Red Cross Children's Hospital in the Western Cape. The reason for this demarcation was explained in Chapter 1. Both qualitative and quantitative research methods were applied in this study.

4.2.2 SAMPLING AND DATA GATHERING

i) Profile of physically abused children and their families

The sample for this study was drawn from the patient population at Red Cross Hospital. The specific method used was purposive sampling, as the researcher chose the respondents according to certain characteristics (Dooley 1995:136). The study sample thus consisted of 24 children (N = 24) under the age of six presenting with intentional physical injuries. A profile on the identifications and circumstances of the physically abused children was drawn up over a four-month period from May to August 2000. This information was obtained from the files of the patients.

ii) Case studies of the parents/perpetrators

The qualitative part of the study included four case studies. The case studies were undertaken with the parent, who was also the perpetrator, in order to gain in-depth information on the family dynamics and social circumstances under which the physical abuse took place. This was done by conducting semi-structured interviews (Appendix A) with the parent/perpetrator of the abused child. Respondents were chosen according to specific characteristics as well as willingness to participate, a method known as purposive sampling (Dooley 1995:136).

iii) Survey with the social workers

There were seven (N = 7) social workers in the hospital, of which two were absent during the time that the survey was conducted. Data was gathered from five social workers (n = 5) assessing the cases in order to obtain information on assessment strategies and problems. This was done in the form of questionnaires (Appendix C). The questionnaires were divided into six sections, and contained structured and open-ended questions. Section A contained information about personal data, Section B on the interaction with other professionals in the hospital, Section C on interviewing the physically abused child, Section D on interviewing the parent/perpetrator, Section E on liaising with outside agencies, and Section F on other factors that have an influence on the assessment.

The empirical study was based on the aim and objective of the study as described in Chapter 1, and also on the content of the literature review as presented in Chapter 2 and 3 of this report. Voluntary participation was emphasized at all times. Written consent was obtained from all respondents (Appendix B and D), which included assurance of confidentiality and anonymity. Access to the results of the study was promised to the respondents, which highlighted the value of their participation.

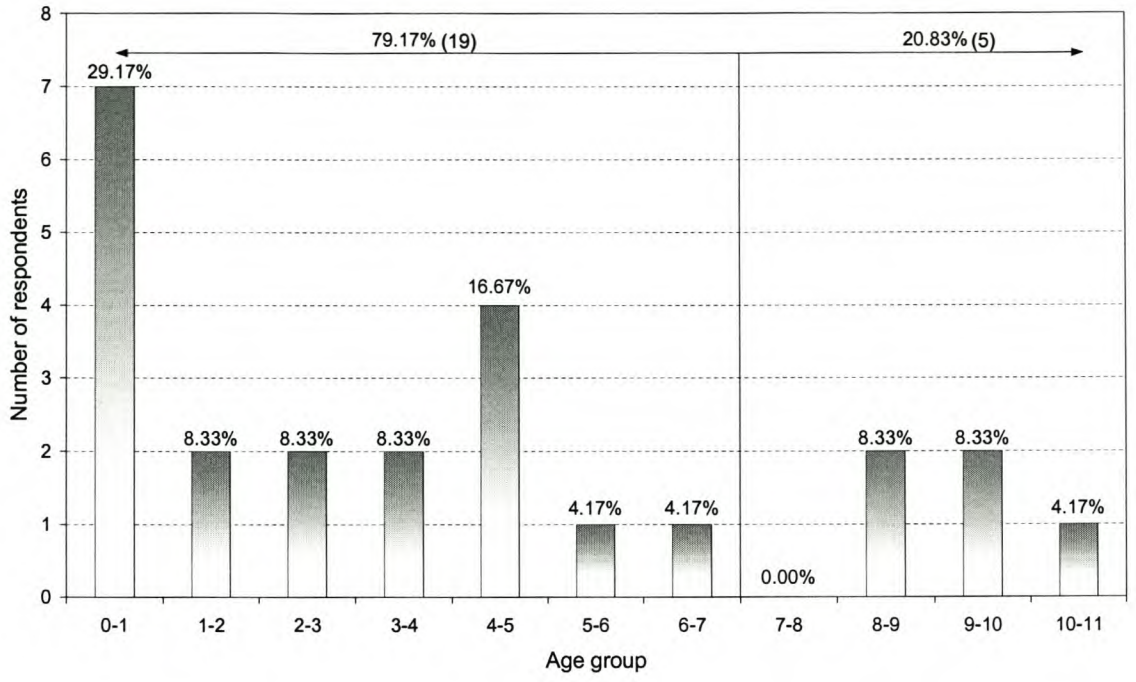
Quantative data is presented in the form of tables and figures. Responses to open-ended questions were analyzed and used to elaborate on the demographic data collected. Qualitative data obtained from the four parents/perpetrators is presented in the form of quotations and analytical discussions, in order to elaborate on the nature of the identified variables.

4.2.3 DEMOGRAPHIC FACTORS OF RESPONDENTS

The following data presented in the profile physically abused children and their families, was gathered from 24 files of the patients and information reported during intake at the hospital from May to August 2000. Additional information was obtained by case studies with four parents/perpetrators in the form of semi-structured interviews.

4.2.3.1 *Age of the children*

The first factor that was investigated was the age of the children. The distribution is reflected in the graph below.



N = 24

FIGURE 4.1 : AGE DISTRIBUTION OF THE CHILDREN

As shown in Figure 4.1 most children (19 or 79,17 %) who presented with intentional physical injuries were under the age of six, and the remaining five (20,83 %) were between the ages of 8-11. This finding corresponds with Argent et al. (1995:1316), Brissett-Chapman (1995:359), Howard et al. (1991:394), Louw et al. (1999:301), Peltzer & Phaswana (2000:69), Warner & Hansen (1994:19) who all stated that children under the ages of five and six are a vulnerable group for physical abuse. Out of the under-six age group, the highest concentration (7 or 29,17 %) of the abused children was under the age of one. As was found by De Villiers & Prentice (1991:147), who explained that the very young children of under the age of three, are the most vulnerable for physical abuse. Young age is therefore a strong indicator that the injury may have been intentional.

4.2.3.2 *Gender of the children*

Another aspect that was investigated was whether there was any difference between the number of female and male children presenting with intentional injuries. The findings are presented in Table 4.1.

TABLE 4.1 : GENDER OF THE CHILDREN

GENDER	f	%
Male	13	54,16
Female	11	45,83
TOTAL	**24**	**100**

N = 24

Table 4.1 shows a close relation between male and female children who were physically abused. The male victims of physical child abuse outnumbered the female victims by two (8 %). Although the findings indicate more males than females with intentional injuries, gender does not seem to be a defining factor, as was stated by Argent et al. (1995 :1316) and De Villiers & Prentice (1996 :149) who found that there usually is an equal distribution between male and female physically abused children, but that age and gender could make a certain group more vulnerable than the other.

4.2.3.3 *Type of external injury*

Physical injuries are the most easily observable consequence of physical abuse. The table below thus contains the external injuries that the patient's presented with.

TABLE 4.2 : INJURIES INCURED BY THE CHILDREN

TYPE OF INJURY	f	%
Head injuries (haematomas/skull fractures)	14	58,33
Gun-shot wound	3	12,53
Lacerations/bruises	2	8,33
Femur/leg fracture	2	8,33
Arm fracture	1	4,16
Burns	1	4,16
Stab wound	1	4,16
TOTAL	**24**	**100**

N = 24

Table 4.2 reflects the injuries most commonly incurred by the children. Fourteen (58,33 %) patients presented with head injuries that included fractured skulls and haematomas. Although Kotch et al. (1993:237) state that intentional physical are mostly moderate than severe, in the form of lacerations and small fractures, the findings of this study are however that most children presented with severe injuries,

which lead to the death of the child in five out of the fourteen (35.8 %) cases presenting with head injuries. The reason for the high incidence of severe injuries could be that it is easier to establish physical abuse in such cases than moderate ones, as a head injury is usually an overt indicator of physical abuse, according to Winship (1987:193). The findings about the occurrence of head injuries are followed in number by three (12,53 %) patients who had gunshot wounds. No mention is made in the literature of gunshot wounds, although it is the second most prevailing injury to occur in this study. Two (8,33 %) children in the sample had lacerations and bruises, and a two (8,33 %) had leg fractures. The remaining injuries were equally dispersed, with one (4,16 %) patient having an arm fracture, another one (4,16 %) patient presented with burns and a further one (4,16 %) had stab injuries. The South African National Council for Child and Family Welfare (1992:18) and Winship (1987:193) both mention that fractures in the forearms and femurs (lower legs) are indicators that the injury was intentional, as well as bruises and lacerations in unusual places. Warner & Hansen (1994:18) state that to establish whether such injuries were intentional, one has to consider a history of injuries and parent's explanations.

The findings indicate that head injuries and gun shot wounds are the most frequent form of physical abuse. It can be concluded that the type of abuse taking place in the homes is extremely violent. It also seems that moderate injuries are detected less than severe ones, which could be an indication of a lack of enquiry into seemingly minor or moderate injuries by professionals assessing the physical injuries.

4.2.3.4 *Case studies of perpetrators*

The information reflected in figure 4.2 below was obtained by conducting in-depth interviews with four parents who had physically abused their children. Only those parents who were the perpetrators and who were willing to participate were included in this part of the research.

DEMOGRA-PHICS	RESPONDENT A	RESPONDENT B	RESPONDENT C	RESPONDENT D
Age	29	28	26	18
Gender	Female	Male	Female	Female
Marital Status	Married	Single	Married	Single/living together
Children	3, and 1 step-child	2	2	1
Background	Parents abused alcohol, verbal and physical abuse in home.	Parents abused alcohol, emotional and physical abuse in home.	Large family, children from different fathers and cramped housing. Physical and emotional abuse.	Grew up in stepfamily, was abused (sexually and physically) by stepfather who drank a lot.
Housing/envir-onment	Happy with area, although high crime rates. Nine people live in two- bedroom house with her.	Not happy in area, high crime rates and violence. Stays with eight people in two-bedroom house.	Not happy in area, very violent with a lot of crime. Four People live in one-bedroom shack.	A lot of gangsterism in area, not happy there, but glad to stay with family. Eight people in two-bed roomed house.
Employment/ income	Unemployed, husband does not earn enough.	Currently unemployed.	Employed as char once a week, does not earn enough to survive on.	Unemployed, only works casual jobs when available.
Social environment	Lives close to hometown, family members support. No other social contact than with family.	In same neighborhood as he grew up in. Family and friends support him, no other social contact	Near to hometown, good support from friends and especially mother. Sometimes social contact with church, but not regular.	Close to hometown, lives with family. Good support from them. No other socializing may not leave house often.
Family size	Three children all from the same father, 3 years apart which helps with parenting. One stepchild whom she has problems with.	Two children. Extended family lives in house, but do not help with the children anymore. Children very young, and not far apart in age.	Two children, not of same father. Extended family (mother) stays in house - she finds it has a positive effect on her parenting.	One child. Extended family (mother) in house – finds her interfering with her own parenting.
Marital Relationship	Do not discuss anything, a lot of conflict. Argue about relationship and finances. Husband hits her at times.	N/A – but family relationships between people staying in the house characterized by conflict and physical violence.	If argue, partner leaves the house refusing to talk to her. Conflict about another woman. Has led to physical violence between them.	Boyfriend lives with her, who has final say. Gets angry quickly. Conflict about money. There is violence between them.
Substance abuse	Alcohol consumption on weekends. Has led to verbal and physical fights with her partner, but not with her own children.	Alcohol consumption on weekends, and occasionally during the week. Has caused him to get physically abusive with others, family members and his children.	Denies using any substances.	Only socially. Boyfriend has drinking problem-wastes the family's money on drink.
Physical injury to child	Injury incurred while beating her stepchild, in order to discipline her. Caused severe head injury and child went into coma. Feels responsible and scared.	Aimed a blow at his sister while under the influence of alcohol, but missed and then hit his child on the head, causing a haematoma.	Were arguing about the other woman again. She got angry and threw a bottle at her husband, missed him and hit the child on the head. Skull fracture.	Arguing about money-he spent it all on drink. She lost control, grabbed a stick. Hit him while he was on the bed with the baby-caused a haematoma.

FIGURE 4.2 CASE STUDIES OF FOUR PERPETRATORS

From the information above and further details given in the interviews, trends will be highlighted and discussed as part of the remaining factors investigated in the profile below.

4.2.3.5 *Age of the perpetrators*

The third factor that was investigated in the profile was the age of the perpetrators.

TABLE 4. 3 : AGE DISTRIBUTION OF PARENTS

AGE	f	%
Under 20	1	4,2
20 -25	9	37,5
26 – 30	9	37,5
30 +	5	20,8
TOTAL	**24**	**100**

N = 24

Table 4.3 shows that there is an equal distribution between the age categories of 20-25 and 26-30, with nine (37,5 %) respondents in each age category. Five (20,8 %) respondents were above the age of 30, while only one (4,2 %) of the perpetrators was under the age of twenty. The findings seem to be in conflict with Corby (1993:66) and Warner & Hansen (1994:21) who mention that younger parents under the age of twenty are most likely to physically abuse their children. The age group between 20 and 30 years, reflects young parents who are expected to be independent and in the employment market. Howard et al. (1991:393) and Lewis (1999:122) explain that this age group are expected to cope with family, work and financial stresses on their own, which creates a lot of tension for the parent.

From the above findings and other studies which were mentioned above, it would appear that the perpetrators are not usually young parents under twenty, but young adults between 20 and 30 years.

4.2.3.6 *Marital status of the perpetrator*

According to literature (Prino & Peyrot 1994:882; Wells 1995:350), marital status was a factor that played a role in parents physically abusing their children. This was therefore a factor considered while compiling the profile.

TABLE 4.4 : MARITAL STATUS OF THE PERPETRATOR

STATUS	f	%
Married/living together	8	33,33
Single	14	58,33
Divorced	2	8,33
TOTAL	**24**	**100**

N = 24

Table 4.4 indicates that the most (fourteen or 58,33 %) of the perpetrators where single, while eight (33,33 %) were married or living together on a permanent basis, and two (8,33 %) were divorced. These findings correspond with the findings of Prino & Peyrot (1994:882) and Wells (1995:350) that marital status is a risk factor that can act as a guide in identifying perpetrators and intentional injuries. Both authors emphasize that single parents are more at risk of abusing their children, because the parents have to cope emotionally and financially on their own, without the support of a partner. Corby (1993:83) also supports this finding, and states that there is a higher incidence of physical abuse where a parent is the sole caretaker. Respondent B (mentioned in Figure 4.2) is a single parent. He expressed his frustration by having the sole responsibility for the children and household in the following statement:

Respondent B:"I don't know what to do. I come home, and my sister doesn't want to look after the children anymore. She sometimes never comes home. I don't know what to do; I can't look after them on my own. I "sukkel" to find work. If my sister doesn't cook, there is no food."

The reason for the high incidence of abuse taking place where the parents are married (33,33%), is explained by Lewis (1999:113) and Ross (1995:595) who maintain that a lack of resources, for example finances, can cause stress in the relationship. The authors explain that increased stress, and low coping abilities can lead to substance abuse, which in turn can cause partner abuse. Partner abuse increases the risk of the children being physically battered as well.

Respondents A and C (refer to Figure 4.2) elaborate further on how the marital relationship contributed to the physical injury of the child in the following statements.

Respondent A:"He came home drunk again and didn't bring the money. We always fight. He never talks to me anymore, he gets angry or he walks

out...he hit me before ....whenever we fight I get angry with my children too because I don't have patience for them giving me problems ..."

Respondent C: "We fight a lot about money...and he always goes to visit this other woman. This day, he didn't come home the whole week, and I know where he was. So ask him, but he say that I musn't, like, tell him what to do. I start crying and hitting him, and he hit me back...I picked up a bottle...to throw at him, but it hit her head. I knew she was there..."

The injury to the child of Respondent C occurred during one of the fights, which she and her husband had, where the child was caught in the crossfire. This was a similar reason for Respondent D, where the injury occurred during one of their fights about money.

Respondent D: "I knew the child was on the bed with him, but I got so angry...I didn't think right then, I just wanted to hit him."

In conclusion to the above findings, there seems to be a lack of coping mechanisms in both single and married parents, and specifically conflict in the marital relationship, which leads to the physical injury of the child.

4.2.3.7 *Family composition*

Marital status can closely be related to family composition, except that the latter entails the presence of other persons in the family besides the partner/parents. This factor was further investigated in the profile and interviews, of which the findings are presented in Table 4.5.

TABLE 4.5 : NUMBER OF CHILDREN PER PERPETRATOR

CHILDREN	f	%
One	5	20,83
Two	5	20,83
Three	8	33,33
Four	6	25,01
TOTAL	**24**	**100**

N = 24

From table 4.5 it can be concluded that the majority (eight or 33,33 %) of physically abused children who came from a home where there were three children, followed by six (25,01 %) physically abused children came from homes where there were four children. Five (20,83 %) children had one sibling, while the remaining five (20,83 %) were the only child. The mean average of children per household was 2,6.

These findings support Brissett-Chapman (1995:361) who mentions that family size does play a role in increasing the risk of physical child abuse, in that larger families, especially with four or more children, are more at risk, as are step-families. The author attributes increased caretaker and financial stress to this factor.

All four respondents in the case studies had extended families staying with them (see Figure 4.2). Respondents A and B stated that their children shared the same parents, while respondent C said that both children came from different fathers. Respondent A was a stepparent as well, and made the following statement on the effect her family size and composition had on her parenting:

Respondent A:"My children are all three years apart, and that helps because the older ones can help me with the young ones...and the other family help with cooking and sometimes look after the children. ...I get angry with "my step-child"...she doesn't listen like my children...she is just like her mother."

Respondent A never physically abused her own children, but had a history of repeatedly beating the step-child, reflecting a greater risk for step-children to be exposed to physical abuse.

Respondents B and C stated that living with extended family members actually helped with the workload and their parenting, while Respondent D saw them as interfering.

Respondent C stated:

> "My mother often gives me advice, and looks after the children when I want to leave the house...it helps me a lot to get away from it sometimes..."

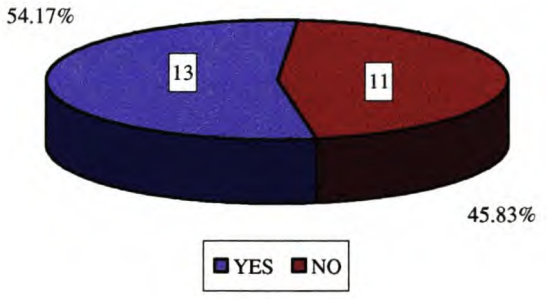
Respondent D on the other hand found that although they helped with the workload, the effect the maternal mother had on her parenting was not positive:

> "...she always mixes in with what I say, and tells me how to be a mother...don't do this and don't do that!...the whole time. It makes me angry because she treats me like a child. I just give up then."

It is thus important to find out the size and composition of the family, when assessing an alleged case of intentional injuries to a child. It is not only a risk factor to consider during assessment, but also an indicator that the other siblings are in danger of being exposed to the abuse of the parent. Step- or extended families have an increased risk for physical abuse to take place. It also appears that having a larger age gap between the children is seen as having a positive effect on parenting.

4.2.3.8 *History of abuse in the family*

As this factor was indicated as being a strong contributory factor to parents also abusing their children, it was investigated in further detail. The findings are described below.



N = 24

FIGURE 4.3 : RESPONDENTS WITH HISTORY OF ABUSE

As indicated in figure 4.3, the majority (13 or 54,17 %) of the respondents had a history of abuse in the home, which included spouse abuse and physical abuse as a child. The other eleven (46,83 %) respondents said there had not been a previous incidence of physical abuse in the home. Brissett-Chapman (1995:36) and Warner & Hansen (1994:17) mention that a history of abuse in the home of the child, as well as a history of abuse to the perpetrator as a child, was an indicator that the current injury was intentional. Other authors such as Coohey & Braun (1997:1085) and Mullen et al. (1991:18) further elaborate on this factor by stating that there is an increased risk of a parent physically abusing the child where there is physical violence between the

spouses. These findings of previous studies are reflected in the case studies (Figure 4.2), where all four respondents stated that there had been emotional and physical abuse in the home where they grew up in, while Respondent D experienced sexual abuse. After exploring this topic further, the following statements explain how the history of abuse in their homes could contribute to the physical abuse of their own child:

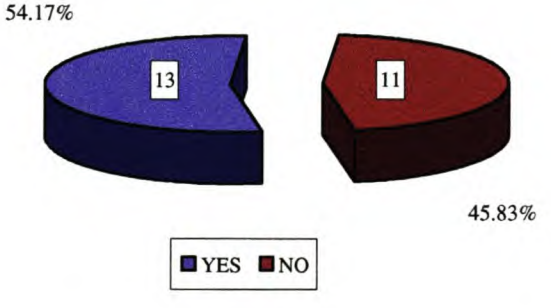
Respondent C: "There were so many different men that came in and out of our house. We didn't even know who our father's was...My mother hit us when she drank, they would hit us too, because we were in the way. I always felt very scared and alone...Even now, I just sometimes "crack", and I just hit my child to teach her."

Respondent D:"I always felt very scared. My father would be drunk a lot...and he would hit us...I never knew where to go. I don't like feeling like that anymore...I am not a child...I am now in control."

Feelings of helplessness and powerlessness experienced as a child were despised by both the respondents, and they attempted to "stop feeling like that" by acting out the role of the controlling parent. Their own parents acted as role models to this. In conclusion, discovering a history of abuse in the home of the child as well as the parents during assessment is a strong indicator that the injury incurred by the child was due to physical abuse by the parent.

4.2.3.9 *Substance abuse*

Another indicator of an injury to the child being intentional, was a parent abusing alcohol and/or other substances in the home. This factor was further investigated.



N = 24

FIGURE 4.4 : SUBSTANCE ABUSE BY THE PERPETRATOR

In figure 4.4 above, more than half (thirteen or 54,17 %) abused alcohol or other substances, and eleven (46,83 %) stated that they did not use any substance. Two of the respondents in the case study (Figure 4.2) confirmed that they abused alcohol, but mainly on weekends, while one only drank socially. Respondent A had been involved in previous physical assaults towards her partner while under the influence of alcohol, and Respondent B had been physically violent toward his previous partner and children before while under the influence of alcohol. This confirms the findings of other studies conducted by authors such as Lewis (1999:122), Mullen et al. (1996:18) and Ross (1995:595) who indicate that parents abusing substances increased the risk of physical abuse in the home.

From the above-mentioned findings, it appears that substance abuse is an indicator that the injury may have been intentional, and needs to be considered during assessment.

4.2.3.10 *Employment*

Another factor addressed in the research was whether the parents were employed. Income levels were considered in further detail in the case studies.

TABLE 4.6 : NUMBER OF RESPONDENTS EMPLOYED

EMPLOYED	f	%
Yes	13	54,16
No	11	45,83
TOTAL	**24**	**100**

N = 24

It is evident from table 4.6 above that the majority (thirteen or 54,17 %) of the respondents were not employed, although eleven (46,83 %) were employed. According to Howard et al. (1991:393) and Lewis (1999:122) parents that are unemployed are more at risk for abusing their children. The reason for physical abuse where the parents were employed is explained by Stone (1990:72) and Warner & Hansen (1994:19). Both authors state that even though the parent may be employed, low-income is also a risk factor. There is increased conflict in low-income families, which often leads to social problems such as substance abuse, which was reflected in Figure 4.4, marital problems and partner abuse. The findings of the respondents in the case studies also showed that substance abuse can increase marital conflict. Only Respondent C had employment, but stated that the earnings were "not enough to

survive", while Respondents A, B and D had no employment. All four respondents mentioned that marital conflicts and conflicts at home were often due to these financial problems as can be seen in Figure 4.2. Respondent D explained how the lack of income contributes to their marital conflict:

> "We only fight on weekends when he doesn't bring home money, because he drank it all out in the shebeen...I get very angry...and he gets very violent."

From the findings above, it is essential to consider not only whether the parent of the physically abused child is employed, but also the income of the parents in order to identify risk factors.

4.2.3.11 *Housing and social environment*

To further explore whether factors such as housing and the social environment contributed to the parent abusing his or her child, the responses of the respondents in the case studies (see Figure 4.2) was analyzed. Only respondent A and D stated that she was happy where she lived, while the other two were not happy. All four respondents mentioned that crime rates were very high in the area that they lived, and that they did not feel safe in that area. Respondent A had nine people living in a two-bed roomed house, respondent B had eight people in a two-bed roomed house, respondent C had four people in a one-roomed shack, while respondent D lived with seven other people in a two-bed roomed house. According to the findings in the cases of the four respondents, there is an average of four persons sharing one bedroom. These are extremely crowded living conditions where privacy is lacking. The statements of Stone (1990:72) and Lewis (1999:113) that crowded and unsafe conditions contribute to the parent's frustration and may cause them to take it out on the child, support the findings of this study.

The following statement was made by respondent C, which expresses a lot of frustration with her living situation and her child whose behavior causes conflict with the other housemates:

> "...I can never be alone, there is always people around. And if someone fights I have to leave my own house to get away...my baby cries a lot at night, and everybody gets cross with me, because she wakes them up...they say it's my fault, but I can't help when the baby cries."

A common trend identified in the cases of all four respondents, was their lack of social contact with people, other than with the people sharing the house with them. Only respondent C stated that she would sometimes go to church in order to fellowship with other people. The fact that none of the respondents socialized with people other than family members is a risk factor for child abuse according to Corby (1993:76) and Coohey & Braun (1997:1083). Parents who are socially isolated and who do not socialize in the larger community are at risk for abusing their children.

All four respondents lived near to their hometown, which meant that they had family networks close by. Only respondents A, C and D mentioned that they received emotional, financial and material support and assistance with caring for the children, from the family members. Although Howard et al. (1991:393) and Coohey & Braun (1997:1083), state that having family members close by should decrease the risk of child abuse, due to the different forms of support the parents receive from them, it was however was not reflected in the case studies.

According to the findings of this study, it appears that crowded living environments and lack of social contact are factors that contribute to the parent incurring intentional physical injuries on their children. Immigration, or distance from the hometown does not seem to play a role in intentionally injuring the child, as it occurs even with positive family support that is close-by.

4.2.4 SOCIAL WORK ASSESSMENT OF PHSYICALLY ABUSED CHILDREN

Only five (n = 5) of the seven social workers (N = 7) employed at Red Cross Children's Hospital participated in the study by responding to the questions contained in the questionnaires (see Annexure C). Two of the social workers were absent during the period that the survey was taken. The findings of the survey will be discussed below.

As previously explained in Chapter 3, social workers were involved in assessment of physically abused children. Assessment of physically abused children is important for confirming whether the injury was intentional, and for deciding on future intervention strategies with the child and the family. The respondents, who participated in this part of the study, were five (n = 5) qualified social workers, who assessed alleged cases of physically abused children. The social workers were predominantly female (four or 80 %), with only one (20 %) male social worker on the team. The average age of the social workers was 30,1 years with and average of 8,4 years working experience in the field. The following section contains the results from the questionnaires that the social workers filled in.

4.2.4.1 *Interacting with other professionals in the hospital*

It was necessary to investigate the interaction between the social worker and other team members, because according to Skibinski (1995:983), no single team member has the sole responsibility for assessing physically abused children, but that each team member has the responsibility for one particular aspect of the assessment process.

i) Role of the social worker in the team

The importance of the social worker in assessing physically abused cases was addressed in the survey.

All five (100 %) respondents indicated that the role of the social worker is central in the team, and that the social worker usually co-ordinates the assessment of physically abused children by the team members. These findings correspond with the views of various authors. Wells (1995:53) does point out that the social worker is in the front line and has the central role in identifying and assessing physically abused children. Argent et al. (1995 :1318) and Ross (1995 :1373) add that the hospital system relies on the social worker to co-ordinate and manage cases of physically abused cases.

From the above findings it is clear that the social worker does play a central role in the hospital team when assessing child abuse cases, and it is therefore pivotal that the social worker has enough knowledge and skill to do so.

ii) Liaising with other team members

Another factor investigated in the survey was how often and in what ways liaising with other team members took place. Three (60 %) respondents stated that they liaise with the other team members during assessment with every case of physically abused children they have to assess; while two (40 %) mentioned that they liaise on every second case. All five (100 %) respondents indicated that liaising took place by referral, giving advice, asking advice and case meetings. These findings correspond with the views expressed in the literature. Lewandowski & Baranoski (1994:527) advise that professionals in the hospital communicate with each other on each case, and consider the opinion of the team before a decision is made. Thorough assessment of physically abused children on their medical, developmental, social and psychological needs are made by the input of all team members (Blatt et al. 1997:343).

It is thus important for social workers to co-ordinate and co-operate with the other professionals in the hospital, in order to increase the effectiveness of the social worker's assessment.

iii) Efficiency of training of other team members

A further factor investigated was how social workers viewed the effectiveness of the training other professionals received in assessing physically abused children. All five (100 %) respondents mentioned that other professionals in the hospital who are involved in identifying and assessing physically abused children needed more training in order to increase their skills in this field. The respondents also mentioned that this should be done at regular intervals, especially with physicians who rotate through the wards and do not spend enough time in the trauma units in order to gather enough experience to work with physically abused children.

These findings indicate that there is a need for further training of team members, and specifically physicians, assessing physically abused children. This corresponds with Argent et al. (1995: 1318) who mention that physicians need specific training and pediatric experience in order to assess children presenting with intentional injuries.

iv) Conflicting findings amongst team members

This was the final aspect addressed under section B in the questionnaire (Annexure C) completed by the social workers. Table 4.7 indicates whether social workers found that there were conflicting findings between professionals on children presenting with intentional injuries.

TABLE 4.7 : OCCURENCE OF CONFLICTING FINDINGS

RESPONSE	f	%
Yes	4	80
No	1	20
TOTAL	**5**	**100**

n = 5

In table 4.7 above, it is clear that the majority (four or 80 %) of the respondents stated that there were conflicting findings amongst the team members when assessing children who had been physically abused, while one (20 %) did not experience it. Two (50 %) of the four respondents whose response was affirmative, explained that sometimes physicians assessed a child incorrectly as having been physically abused, or sometimes missed such a case. The other two (50 %) respondents stated that differences also occurred amongst team members on what would be acceptable or non-acceptable parental discipline, and what type of discipline should be classified as physically abusive. These findings support those of Blatt et al. (1999:345), Kotch et al. (1993:244), Lewis (1999 :198) and Wells (1995:348) that conflicting findings may occur between professionals as each discipline has a different frame of reference, socio-cultural and educational background. Conflicting findings can cause and inability to agree on suspected cases of physical abuse.

However, all five (100 %) respondents indicated that despite conflicting findings, the other team members were very tolerant of the role of the social worker during assessment and respected their views. This finding corresponds with Warner & Hansen (1994:11) and Wells (1995:351) who maintain that these type of conflicts amongst professionals can be overcome by collaboration, ongoing training and involvement of all team members during the assessment of physically abused children.

In conclusion it can be stated that conflicting findings can prevent effective assessment and may even lead to charges being pressed incorrectly to an innocent party. Conflicting findings do not necessarily reflect conflicting relations between the team members. It is important for the social worker to collaborate with the other team members during assessment to facilitate and understanding of the psychosocial dimension of physically abused children.

4.2.4.2 *Interviewing the child*

Because play is the most effective way of communicating with the child (Smith 1989:129, Wachtel 1994:79), respondents were questioned in section C of the questionnaire (Annexure C) to indicate which methods of play were most effective during the assessment interview with the child.

i) Methods of interviewing the child

As shown in table 4.8 below, the questionnaire listed seven options of play, which were discussed in greater detail in Chapter 3 of this report.

TABLE 4.8 : METHODS OF INTERVIEWING

PLAY METHODS	*f	%
Puppet Play	5	27,8
Draw	4	22,2
Stories	3	16,7
Role play	2	11
Movement	1	5,6
Clay/Building blocks	0	0
Other	3	16,7
TOTAL	***18**	**100**

n = 5

*Respondents could give more than one answer

Table 4.8 shows that puppet play is used by most (five or 27,8 %) of the social workers use puppet play, which supports Wachtel's (1994:79) advice to use puppets when the child refuses to talk, or to break the ice, as the child perceives this as less threatening. Four (22,2 %) of the respondents let the children make drawings during the interview, which Lewis (1999:186) found to be an effective method for social workers to assess family relations of the child. A further three

(16,7 %) respondents used stories, which Smith (1989:134) mentions as an effective method that encourages the child to disclose what happened. Two (11 %) respondents applied role-play during the interview and only one (5,6%) applied movement techniques, which Fatout (1993:91) and Smith (1989:133) found to have a calming effect on the child. None of the respondents used clay or building blocks, and three (16,7) mentioned other methods that they applied. The other methods included direct questioning of the abusive event, which Lewis (1999:53) finds to be less effective than open-ended or indirect questioning. The respondents stated that different play methods were used together during the assessment interview with the child. The findings are in accordance with the findings of Ehrenkranz et al (1989:44) and Wachtel (1994:79) who found that by employing these play methods, the social worker is able to obtain information needed for assessment that would otherwise take a long time to uncover.

In conclusion, it appears that puppet play and drawings are most effective when interviewing a physically abused child, and in obtaining information needed for assessment.

ii) Criteria used to identify intentional injuries

The respondents answered an open-ended question on how they identified injuries as being intentional. The response of all five (100 %) respondents corresponded with each other, and could be classified in three categories. The first guideline was investigating the child's explanation of how the injury occurred while paying attention to current behavioral/emotional responses. Lewis (1999:53) emphasizes the importance of the child talking about the abuse and understanding what happened to him/her. This also correlates with the criteria that Corby (1993:131) and Briere (1992:99) apply when assessing an abused child, where the child's current knowledge of the situation needs to be assessed. The second guideline used was medical findings on the injury that the child sustained. Wachtel (1995:978) states that medical findings can support any disclosure made by a young child, or help the social worker explore suspected cases of physically abused children. The third guideline was the history and circumstances/dynamics of the family of the physically abused child, which was obtained by drawings the child drew and questions in connection with that drawing. Tracy (1995:978) points out that the child cannot be assessed in

isolation, because risk factors that are present in the family may be an indicator that the injury was intentional.

From the findings of the study and corresponding literature, it appears that the above three mentioned factors are central criteria for assessing children with suspicious injuries in a hospital.

4.2.4.3 *Interviewing the parent*

The respondents were questioned in section D of the questionnaire (Annexure C), on how the parents/perpetrators of the physically abused child was interviewed. The findings are explained below.

i) Establishing rapport with the parent

The responses to the two open-ended questions referring to this, was analyzed. Four categories of interview methods applied by the social workers were identified. The respondents could give more than one response. All five (29,4 %) respondents emphasized **confidentiality**. Confidentiality was ensured by giving only essential feedback to other professionals, keeping folders locked, verbally reassuring the parent and contracting with the parent. Five (29,4 %) respondents named the different **interview techniques** of a social worker, which Goldberg (1975:276) divides into six categories, such as getting with feelings and listening. The techniques assist in building a relationship with the client, and increase the effectiveness of interviews. Four (23,5 %) respondents mentioned being **non-judgmental** toward the parent, which Rubenstein & Hochstadter (1990:362) mention is an important principle to be applied in order to remain objective, and let the parent feel more at ease. Three (17,6 %) respondents named **clarifying the social worker's role** to the parent as the protector of the child, and acting in the interest of the whole family. This is done by placing the parent at ease, by informing him/her of what will happen with the child, and the family and where possible to always involve the parent, which Wachtel (1994:45) also confirmed.

From the above mentioned findings, the four guidelines to be used by a social worker in order to build rapport with the parent are confidentiality, applying interview techniques, the principle of being non-judgmental, and emphasizing the social worker's role as protector of the child and family system. By involving the

parent, the social worker is not perceived as a threat by the parent, which increases the parent's co-operation.

iii) Use of assessment instruments

The question of whether the social workers use assessment or measuring instruments during the assessment interviews was also included in the questionnaire (Annexure C) under section D. The response of all five (100 %) respondents is a clear indication that assessment instruments were not used during the interview with the parents. These findings seem to be in conflict with the South African National Council for Child and Family Welfare (1992:38), who advise that assessment should always be done with the use of forms so that no information is alleviated during the interview. Prino & Peyrot (1994:882) strongly suggests that more refined measuring instruments should be used that will assist the social worker in assessing parents who are suspected of physically abusing their children.

In conclusion, it can be stated that assessment instrument should be applied by the social workers assessing physical abuse cases.

4.2.4.4 *Liaising with agencies outside the hospital*

Brissett-Chapman (1995:363) and Cowles & Lefcowitz (1992:59) found that part of the social worker's tasks during assessment is to contact agencies outside the hospital, because the hospital social worker's services are limited to the hospital. Responses to Section E of the questionnaire (Annexure C) are explained below.

TABLE 4.9 : LIAISING WITH OUTSIDE AGENCIES

REASON	*f	%
Follow-up	5	35.7
Removal of the child	5	35.7
Other	4	28.6
TOTAL	***14**	**100**

n = 5

*Respondents could indicate more than one reason

As table 4.9 indicates, the reasons for liaising with agencies outside the hospital are multiple. The reasons indicated the most by all five respondents were for follow-up (35,7 %) and for removing (35,7 %) the child. Even though section 11 of the Child

Care Act of 1983 empowers the social worker to remove the child from home, it is not the social worker in the hospital that removes the child, but the social workers in the welfare agencies to perform this task on the recommendation of the hospital social worker. The recommendation is based on the assessment made at the hospital by the team. Four (28.6 %) respondents mentioned other reasons, such as continued care, further investigations and obtaining background information on the families. It is often necessary that background information, follow-up services or further investigation be conducted by these agencies, which cannot be done by the social worker in the hospital. Argent et al. (1995: 1318) and the South African National Council for Child and Family Welfare (1992:65) therefore encourage the inclusion of community sisters and investigating police officials on the hospital team for purposes of assessing physically abused children. All the respondents (five or 100 %) stated that contact with other agencies/professionals outside the hospital occurred by referral. This indicates that no direct contact took place between the professionals.

From the findings above, it seems to be of importance for having regular contact with professionals from outside the hospital system, for follow-up, removing the child from home and further investigations to take place. It appears that including community nurses and police officials either directly or indirectly in the hospital team is vital in order to assess physically abused children more effectively.

4.2.4.5 *Other factors that influence assessment*

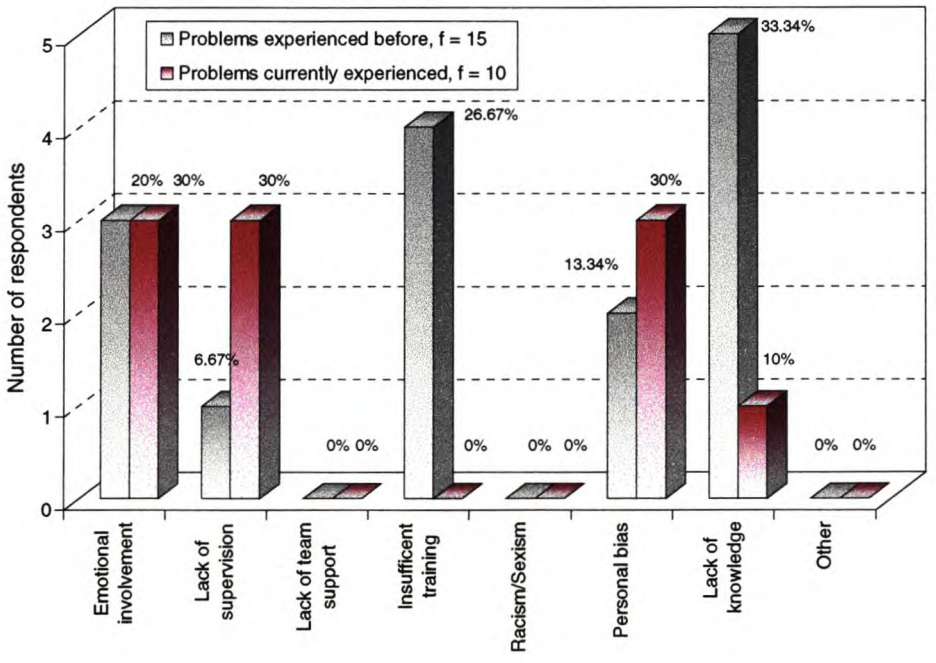
Respondents were questioned on personal and professional factors that prevent effective and objective assessment of physical abuse cases. The questions were contained in section F of the questionnaire (Annexure C).

i) Stress

A factor that was investigated was the stress that social workers experience during assessment of physically abused children. The majority (three or 60 %) of the respondents indicated that they experienced stress when working with child abuse cases, while two (40 %) stated that they did not experience any stress. There are several factors that can contribute to the stress that social workers experience when assessing physically abused children, which are indicated in figure 4.4 and discussed in further detail below.

ii) Factors that influence effective assessment

Several factors were listed in the questionnaire in order to establish what affected the assessment process the most. Problems that the respondents experienced at the beginning of their professional career in this field were compared to problems they are currently experiencing. The findings are indicated in figure 4.4 and are discussed further below.



n = 5

*Respondents could indicate more than one factor

FIGURE 4.5 : FACTORS THAT INFLUENCE EFFECTIVE ASSESSMENT

As shown in figure 4.5, lack of knowledge on physically abused children was the factor that effected all five (33,34) respondents when they first started working in the field, which now only affects the assessment of one (10 %) respondent. Peltzer & Phaswana (2000:73) and Smith et al. (1995:17) confirm that a lack of knowledge will affect assessment, because the social worker will not know what information to obtain in the interviews, or will fail to follow correct procedural matters. Four (26,67 %) respondents mentioned that when they first started in the field, they discovered that they had received insufficient training in the

management of physically abused children, even though they were qualified to do so. Tracy (1995:977) confirms this by stating that not all social workers or medical staffs have sufficient training or knowledge to assess physically abused children, even though they have qualifications. Currently none of the respondents feel they have insufficient training, which can be attributed to the experience they gained while in the field. Three (20 %) respondents experienced emotional involvement as factor that interferes with effective assessment, and the three (30 %) of the respondents still experience emotional involvement as a problem. Corby (1995:135) also acknowledges the fact that working with physically abused children and the families can be emotionally draining, for which the author strongly advises professional supervision. Personal bias shows and increase of 16,66 %. This includes factors such as reactions of the social worker toward the parent; physical attributes, fear and professional variables will affect assessment of physical abuse cases (Warner & Hansen1994:19). Brissett-Chapman (1995:357) also mentions that personal variables, and specifically bias, will affect assessment because discretion is an element of assessing children presenting with intentional injuries. The reason for the increase of this factor over the years of working with physically abused children and their families could be explained by the fact that stereotypes and expectations develop of whom and what fits the profile. This decreases objectivity during assessment. When the respondents first started working in the field, only one (6,67 %) experienced that the lack of supervision affected the respondent's assessment of physical abuse cases. Currently, three (30 %) respondents feel that the lack of supervision is causing them to assess physical child abuse cases less effectively. This factor shows a noticeable increase of 23,43 %.

From the findings above, it is clear that emotional involvement, lack of supervision, and personal factors are problems that strongly influence the effectiveness of the assessment conducted by the respondents with physically abused children, and social workers should be aware of this.

iii) Supervision

Another factor that was investigated was the supervision of the respondents. The respondents were asked whether there was a need for increased professional supervision.

TABLE 4.10 : THE NEED FOR MORE SUPERVISION

RESPONSE	f	%
Yes	3	60
No	2	40
TOTAL	**5**	**100**

n = 5

The majority (three or 60 %) of the respondents expressed the need for increased professional supervision, as shown in table 4.10 (see also figure 4.5). The respondents indicated that current supervision was in form of the weekly team meetings/peer supervision. The two (40 %) respondents who expressed no such need did however add that more training would be appropriate. Tracy (1995:977) warns that if no supervision is adequately received, that it can lead to burn-out or low staff morale.

In conclusion, it can be stated that professional supervision should be ongoing in a social worker's career, and not only an area that receives attention when the social worker first starts in his/her career. The social workers are not receiving sufficient supervision, even though it is necessary for addressing factors that interfere with effective assessment of physically abused children. Ongoing training is also an indicated need.

4.3 SUMMARY

The research findings contained in this chapter reflect a wide scope of the risk factors that were present in families of physically abused children. Most of the findings correlated with the findings of studies conducted by other authors who were referred to in Chapter 2 and 3 of this report, and a few minor differences were highlighted.

Guidelines for social work assessment were established, and the findings clarified the role of the social worker in the hospital team, during the interview with the child and the parent. The findings exposed problems and strengths experienced by social workers assessing the physically abused children.

The information obtained from the findings will be able to give social workers and other professionals more insight into working with physically abused children and their families. It is also crucial information for social workers currently working with

physically abused children, and ongoing training is necessary for ensuring effective assessment, as well as improved intervention plans for the physically abused children.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

There has been a constant increase in reports on physically abused children. This is reflected in this year's police statistics, which show an increase of 10 % on the previous years reports. For a case to be reported, it is necessary to establish whether the injury was intentional. Factors that indicate whether the injury was intentional were discussed in Chapter 2. To establish whether the injury is intentional, an assessment is made of the injury as well as the psychosocial circumstances of the child and his/her parents. This process demands the involvement of all team members in the hospital, and the dynamics of this process was discussed in Chapter 3. In order to reach the objectives of this study, three categories were investigated. The first category was a profile on all children admitted to the hospital during a period of four months presenting with intentional injuries. The second category was in the form of four case studies in which in-depth interviews were conducted with the parents/perpetrators. The final domain of investigation was how social workers assess physically abused children. The findings of the areas of investigation are presented in detail in Chapter 4. These findings will now be evaluated in the following sections of this chapter.

5.2. CONCLUSIONS

The conclusions can be divided into two main sections, namely conclusions based on the findings of the indicators of abuse, and conclusions based on social work assessment of physically abused children

5.2.1 Indicators of physically abused children

This is the first section, from which several conclusions will be made and discussed below.

- **Age and Gender of the child**

  Very young children, under the age of one, are the most vulnerable. According to the findings, the age of the child is a strong indicator and should be taken into account when assessing physically abused children. Gender is also an indicator, in that it seems more male children are victims of intentional injuries.

- **Type of external injury**

The type of injury incurred by the child, should be regarded as a guideline when assessing physically abused children. According to the findings, the injury that occurred the most was head injuries, which also reflects the physical vulnerability of children under one. The types of injuries, such as severe head injuries and gunshot wounds, indicate extreme violent abuse in the homes of these children, and the communities they live in. The lower rate of less severe injuries, such as bruising, could be an indication that the professionals assessing the physical injuries of the children do not notice these types of injuries. This in turn could be a reflection of a lack of knowledge or training in assessing physically abused children. This conclusion can be supported by the findings that conflicting results between social work findings and those made by the physicians do occur.

- **Age of the perpetrator**

The age of the perpetrator is also an indicator of groups more vulnerable to physically abusing a child. The findings reflect an older age group of 20 - 30 year olds, in contrast to the findings of other authors in the literature, who indicate a much younger group of under 20 year olds to be more at risk. According to the findings of the study, the age group reflects young adults, who would normally be employed, self-supportive and emotionally more mature than younger parents. The reason for older parents being the perpetrators is explained under the following factor.

- **Economic status**

It can be concluded that parents who are most vulnerable to abusing their children, are unemployed. The physical abuse to their children could be a reflection of their frustration of not having work or an income. It can be concluded that poverty leads to stress and conflict in the home, as indicated by the findings. Unemployment is not the deciding socio-economic indicator, but rather low levels of income.

- **Marital status**

It can be concluded that single parents are more prone to physically abuse their children. Single parents deal with increased emotional and financial stresses, as they do not have a consort to share the burden with. On the other hand, a lack of these resources can lead to conflict within the marriage, of which children are often the victims of physical outbursts of the parent.

- **Lack of financial or emotional support**

It can be concluded that a lack of financial and emotional support, whether the parent is married or single, is a strong indicator, and focus should not be placed solely on marital status. The conclusion can also be made that although the parents lived close to their home town and received some kind of support from their friends and family, the support was not regular, and this contributes to the stress that the parent experiences.

- **Size and composition of family**

The size and composition of the family is also an important factor to consider when assessing physical abuse cases, as well as the risk that the parent poses to other siblings. Contrary to what was indicated in the literature, the findings of this study indicated that the families were reasonable sized, with 2.6 children as the mean per family. The number of children therefore does not seem to be the deciding element in determining physical abuse. A clearer indication of physical abuse in the home would be the composition of the family. Factors that play a role are small age gaps between the children, and children living with stepfamilies, even though the literature expressed uncertainty on the latter factor.

- **History of abuse**

Parents, who themselves were abused as children, repeated the behavior patterns of their parents. Partner abuse or spouse battering is also a strong indicator of physical child abuse occurring in the home.

- **Substance abuse**

Substance abuse by the parents played a role in physically injuring their children, as more than half of the respondents abused substances and one of the case studies the injury had taken place while the parent was intoxicated. It can be concluded

that the social worker should establish, during assessment, whether the parent abuses substances or alcohol.

- **Social circumstances**

It can be concluded that crowded living conditions lead to physical abuse of the child, in that it caused conflict, lack of privacy, which in turn increased the frustration and stress experienced by the parent. An unsafe and violent area also plays a role. Gangsterism and violent crime in the community sets the scene by which parent's model their own behaviour, and is reflected in violent outbursts toward their children.

- **Conclusion**

It can be concluded that above-mentioned factors that contribute to parents physically abusing their children could serve as a guideline for identifying physically abused children. The following section contains conclusions about social work assessment of these cases.

5.2.2 Social work assessment

It was established from the findings, that social workers play a central or co-coordinating role during the assessment of children presenting with intentional injuries. This means that social workers are responsible for liaising with the other team members in the hospital.

- **Conflicting findings amongst professionals**

Because conflicting findings occur amongst professionals during the assessment of physically abused children, one could conclude that there is insufficient inter-professional involvement during assessment, a lack of representation on case meetings or not enough co-ordination that takes place. It could also be an indication of lack of knowledge or training of some professionals who assess children presenting with intentional injuries.

- **Effective forms of play**

When the social worker interviews the child, the most effective forms of play to utilise are puppet play and drawings. The first method serves as an icebreaker and

building trust with the child, while the latter reveals information on family dynamics, which the social worker needs to assess.

- **Criteria used to identify the injury as abuse**

In conclusion, the social worker applies three criteria to identify whether the injury was intentional. The first is to investigate the child's explanation on how the injury occurred, while observing behavioural or emotional responses of the child. This should be compared with the second and third criteria, namely, the medical findings of the injury, and the history, circumstances and dynamics of the child's family.

- **Establishing rapport with the parent/perpetrator**

In conclusion, rapport with the parents is established by four factors. These four factors include emphasising confidentiality, applying interview techniques during the interview, and focusing on being non-judgmental. There are several methods in which the social worker can ensure he/she portrays a non-judgmental attitude towards the parent. These include emphasising the social worker's role as protector of the child and family, reassuring the parent and involving the parent during all phases of intervention.

- **Measuring instruments**

It can be concluded that the social workers in practice do not use measuring instruments in addition to the above-mentioned criteria used, even though it is referred by authors as being a vital addition during the assessment process.

- **Liaising with outside agencies**

In conclusion, it is important that representatives of these community resources be directly or indirectly involved with the professional team in the hospital. It is important for social workers to liaise with agencies/professionals outside the hospital, as tasks that are pivotal to the assessment process and subsequent intervention, can be fulfilled by these agencies, which social workers in the hospital cannot do (such as follow-up, home investigations).

- **Supervision**

It can be concluded that supervision is an important need of social workers that has to be met in order to address the above mentioned problems, such as stress experienced while working with physically abused children and their families. According to the findings, most social workers experience stress during assessment of physically abused children. Factors that influence assessment and add to the stress social workers experience the most are emotional involvement, lack of supervision or continued training, and personal bias.

These are several conclusions made by the findings of social work assessment of physically abused children.

5.3 RECOMMENDATIONS

The following section contains recommendations based on the findings and conclusions made in the research.

- **Framework for assessing intentional injuries**

It is recommended that a set form should be drawn-up listing factors that contribute to physical abuse, and along with a training session, be distributed amongst professionals in the field of pediatric work. The factors that occur most often amongst physically abused children, should be considered as indicators of physical abuse, and should be used as guidelines or for training of professionals who assess physical abuse cases. Other criteria used to establish intentional injuries (such as play methods, interview methods) should be included in this framework.

- **Ongoing training of professionals**

Ongoing training at regular intervals is also suggested for all professionals on the team assessing physically abused children.

- **Assessment instruments**

Social workers should increase the use of assessment instruments in order to guide interviews, especially in places where there is a lack of supervision. The necessary training to be able to use the scales should be undertaken. The

management of the hospital should enforce the above-mentioned recommendations.

- **Supervision**

The management of the hospital should take the need for professional supervision for social workers into consideration and, if necessary, employ a social worker from outside the hospital, possibly on a voluntary basis, or at long-term intervals, due to the financial restrictions most state hospitals experience. Supervision increases the effectiveness of social work assessment, which in turn will ensure increased quality of service received by the patients.

- **Team representation**

It is recommended that efforts should be made by the team on having representatives from relevant agencies or role-players, such as community nurses and the police (which play a vital role during the assessment and intervention phases), on the hospital team, and that a social worker from the hospital should attend the meetings of these agencies. This will increase relations between tertiary and primary care services, and could prevent the problem of physical child abuse already at a primary level. The social worker in the hospital also relies heavily on outside agencies/professionals. Increased co-operation would also prevent an overlap of services, which is important for South African services, as resources are limited.

5.3.1 Further research

It is recommended that further research be conducted on the following topics:

a) Stress experienced by social workers and the effect of supervision on assessment of abused children.

b) Training programs aimed at preparing/continued training of professionals assessing abused children.

c) Factors that would decrease the incidence of child abuse in a home.

d) The effectiveness of community agencies/institutions in detecting child abuse in the homes of the community.

5.4 SUMMARY

There are several conclusions and recommendations that were made based on the findings of this study.

The contents of this chapter also indicate that the goal of the study, which was to develop a social work program to identify and assess physical child abuse, was obtained. This was done by following the objectives, of investigating the abused children, the circumstances under which the abuse takes place, and considering how social workers in the field assess physical abuse.

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ANNEXURE A

UNIVERSITY OF STELLENBOSCH
Department of Social Work
2000

IDENTIFICATION AND ASSESSMENT OF INTENTIONAL PHYSICAL INJURIES TO HOSPITALISED PRESCHOOL CHILDREN

INTERVIEW GUIDE WITH THE PARENT/PERPETRATOR:

A. Personal Data:

1. Age:
2. Marital Status:
3. Children:
4. Education:
5. Profession:

B. Background Information:

1. Where did you grow up?
2. How many members were there in your family?
3. Did either of your parents abuse alcohol/other substances?
4. Was there violence in the home?
5. If yes. what kind?

C. Housing/area living in:

1. Are you happy in the area that you live in?
2. Is it safe in that area?
3. Is there a lot of crime/violence?
4. How big is your house?
5. How many people live in it?
6. How often have you moved and why?

D. Employment/Income:

1. Are you employed?
2. If yes, what kind of employment?

3. How long have you been employed for at your current job?
4. How often have you changed jobs, and why?
5. Are you happy with your job?
6. Do you earn enough to meet your needs?
7. What is your monthly income?

E. Immigrant/Social Involvement:

1. Do you live far from your home town?
2. What was the support like from your friends and family there?
3. Do you have parents/other persons supporting you now?
4. What kind of support –financial
   -material
   -care of children
   -emotional
5. Do you have social contact with other people?
6. If so, what kind of socialising do you participate in and how often?

F. Family Size/composition:

1. How many children do you have?
2. Are they all from the same parents?
3. Do you have step-children?
4. What is the age difference between the children?
5. Who still lives in the house with you?
6. How do you feel about your family composition and the effect it has on your parenting?

G. Marital Relationship:

1. How are decisions made?
2. Do you discuss them with each other?
3. What happens if you don't agree?
4. How do you try and solve it?
5. Do you try and compromise? In what areas/topics?
6. On who's conditions are the decisions finally made?
7. How do you feel about your partner?

8. Can you notice any difference between the way your parents solved their arguments and the way you and your partner solve your arguments?

9. Who do you think holds most of the power in your relationship?

10. Which are the most severe conflicts in your relationship?

11. How often do they occur?

H. Substance Abuse:

1. Do you drink /take other substances?

2. If so, how often?

3. Does your drinking ever interfere with your work e.g. being absent from work?

4. Has your drinking ever caused you to get into a fight with/harm -someone else
   -your partner
   -your child

I. The Physical Injury of your child:

1. Describe the event as it happened.

2. What do you think caused it to happen?

3. Could you do something to prevent it?

4. If yes,-what could you have done
   -how does it make you feel?

5. If no,-how does it make you feel?

6. Do you feel responsible for the injury?

7. If so, in what way?

8. How does it make you feel that you were involved?

9. What can you do in the future to prevent the physical injury from happening again?

ANNEXURE B

UNIVERSITY OF STELLENBOSCH
Department of Social Work
2000

IDENTIFICATION AND ASSESSMENT OF INTENTIONAL PHYSICAL INJURIES TO HOSPITALISED PRESCHOOL CHILDREN

DECLARATION BY/ ON BEHALF OF THE RESPONDENT

I, the undersigned,.....(ID.....), as the respondent or in the capacity as .....of the respondent (ID.....) of .....(address)

A I confirm that:

1. I/the respondent was invited to take part in the above-mentioned research project which is to be undertaken through the Department of Social Work of the University of Stellenbosch, directed by Ms J Hartweg.

2. It has been explained to me that:

2.1 the goal of the study is to determine the circumstances under which intentional injuries to children take place in order to increase the effectiveness of hospital social workers in identifying and assessing physically abused children.

2.2 the procedures to be followed for this part of the study is qualitative, and will take place in the form of semi-structured interviews with the parents of the physically abused child. There will be one interview per respondent and will not exceed one hour.

2.3 there will be four other respondents taking part in the study.

3. I have been warned that there may be a certain amount of emotional discomfort during the interview, due to the sensitive nature of the topic, which involves the discussion of marital relationship and the physical abuse of the child.

4. It has been explained to me that participation in the study will contribute to the understanding of parents who incur intentional injuries on their children, and the overall achievement of the research. The findings will assist social workers in protecting and making effective decisions about the respondents' child who was physically abused.

5. I have been informed that the information that is gathered during the interview will be treated confidentially, but will be applied to the findings as contained in Chapter 4 of the Master's Thesis.

6. I have been informed that I may refuse to take part/let the respondent take part in the research, and that this refusal will not affect in any way my/the respondent's current/future interests at Red Cross Children's Hospital. I also understand that the researcher may withdraw me/the respondent from the study if it is in the interest of myself/the respondent.

7. The information that has been given above by Ms J Hartweg, has been explained to me/the respondent in Afrikaans. English, Xhosa or other....., and that I speak/understand this language or that it has been translated to me in satisfactory manner by..... (Name of translator), and that I have been given the opportunity to ask questions which have been answered in a satisfactory manner.

8. I/the respondent have/has not been coerced into participating in this study, and that I/the respondent my withdraw at any time during the interview without any penalisations.

9. Participation in the study will hold no additional costs for me/the respondent.

B I herewith confirm that I participate voluntarily in the above mentioned study.

Signed/confirmed..... on..... 20....

.....	.....
The respondent/representative of respondent	Witness
Signature or right thumbprint	

DECLARATION BY THE RESEARCHER

I, Janine Hartweg, declare that I:

1. Explained the information that is contained in this document to the respondent/representative of the respondent.....;
2. Encouraged him/her/them to pose questions on anything that was unclear;
3. That this discussion was held in Afrikaans, English, Xhosa, other (.....) and that no translator was used/ that this conversation was translated by

Dr/Mr/Ms.....
Signed at..... on..... 20....

.....	.....
Researcher	Witness

ANNEXURE C

UNIVERSITY OF STELLENBOSCH

Department of Social Work

Enquiries: J. Hartweg

2000

IDENTIFICATION AND ASSESSMENT OF INTENTIONAL PHYSICAL INJURIES TO HOSPITALISED PRESCHOOL CHILDREN

QUESTIONNAIRE FOR SOCIAL WORKERS

Please answer the following questions by indicating with a mark or writing on the lines provided:

A. PERSONAL DATA

Age: _____

Gender:_____

Qualification:_____

Work experience:

less than 2 years
2 – 5 years
5 – 10 years
More than 10 years

B. INTERACTING WITH OTHER PROFESSIONALS

1. What is the role of the social worker in a multi-disciplinary team during assessment of physical abuse to children?

Co-ordinator/central	Assistance	Peripheral/not important

2. What is the degree to which you liaise with the other members of the team during assessment of physical abuse cases?

Every case	Every second case	Every third case	Never

3. How?

Referral	Give advice	Ask advice	Case meetings	Other-specify

4. How do you regard the training of the other team members in identifying and assessing physical child abuse?

_____
_____
_____

5. How tolerant are the other team members of the tasks of the social worker during this assessment?

_____
_____

6. Are there sometimes conflicting findings to the assessment of physical child abuse cases?

Yes	
No	

If yes, give an example_____

C. INTERVIEWING THE CHILD

1. How do you interview the child?

Play	
Stories	
Draw	
Role play	
Movement	
Clay	
Other- specify	

2. What criteria do you use to identify physical abuse to children and what information do you gather? _____
_____
_____
_____

D. INTERVIEWING THE PARENT

1. How do you establish rapport with the parents so that they feel comfortable to disclose the abuse?_____
_____
_____

2. How do you ensure confidentiality?

_____

3. What information do you gather to establish whether physical abuse of the child has taken place?_____
_____

_____

_____

4. What techniques do you use during the interview?

_____

_____

5. Do you use any measuring instruments during the assessment interview with the parents?

Yes	
No	

If yes, specify_____

E. LIAISING WITH OUTSIDE AGENCIES

1. How do you liaise with agencies/professionals outside the hospital?

Referral	Give advice	Ask advice	Other

2. For what purpose?

Follow-up	
Removal	
Other- specify	

F. PERSONAL INFLUENCE

1. Do you experience stress during assessment of physical child abuse?

Yes	
No	

If yes, explain_____

2. What difficulties did you experience the most during assessment of physical child abuse when you first entered into this position?

Emotional involvement	
Lack of supervision	
Lack of team support	
Insufficient training in managing physical abuse cases	
Racism/Sexism	
Personal bias	
Lack of knowledge on physical abuse to children	
Other- specify_____	

3. What difficulties do you experience now?

Emotional involvement	
Lack of supervision	
Lack of team support	
Insufficient training in managing physical abuse cases	
Racism/Sexism	
Personal bias	
Lack of knowledge on physical abuse to children	
Other- specify_____	

4. Do you feel you need more supervision than you are currently receiving in order to increase the effective management of child physical abuse cases?

Yes	
No	

Explain_____

_____

ANNEXURE D

UNIVERSITY OF STELLENBOSCH
Department of Social Work
2000

IDENTIFICATION AND ASSESSMENT OF INTENTIONAL PHYSICAL INJURIES TO HOSPTALISED PRESCHOOL CHILDREN.

Consent Form for Social Workers

DECLARATION BY/ ON BEHALF OF THE RESPONDENT

I, the undersigned,.....(ID.....), as the respondent or in the capacity as .....of the respondent (ID.....) of .....(address)

A I confirm that:

1. I/the respondent was invited to take part in the above-mentioned research project which is to be undertaken through the Department of Social Work of the University of Stellenbosch, directed by Ms J Hartweg.

2. It has been explained to me that:
2.1 the goal of the study is to determine the circumstances under which intentional injuries to children take place in order to increase the effectiveness of hospital social workers in identifying and assessing physically abused children.
2.2 the procedures to be followed for this part of the study is quantative, and will take place in the form of questionnaires.
2.3 there will be five other respondents taking part in the study.

3. It has been explained to me that participation in the study will contribute to the understanding of social workers who assess intentional injuries incurred on pre-school children, and the overall achievement of this research. The findings will contribute to social work knowledge of identifying and assessing intentional physical injuries to children.

4. I have been informed that the information that is gathered during the interview will be treated confidentially, but will be applied to the findings as contained in Chapter 4 of the Master's Thesis.

5. I have been informed that I may refuse to take part/let the respondent take part in the research, and that this refusal will not affect in any way my/the respondent's current/future interests at Red Cross Children's Hospital. I also understand that the researcher may withdraw me/the respondent from the study if it is in the interest of myself/the respondent.

6. The information that has been given above by Ms J Hartweg, has been explained to me/the respondent in Afrikaans. English, Xhosa or other....., and that I speak/understand this language or that it has been translated to me in satisfactory manner by..... (Name of translator), and that I have been given the opportunity to ask questions which have been answered in a satisfactory manner.

7. I/the respondent have/has not been coerced into participating in this study, and that I/the respondent may withdraw from the study at any time without any penalisations.

8. Participation in the study will hold no additional costs for me/the respondent.

B I herewith confirm that I participate voluntarily in the above mentioned study.

Signed/confirmed..... on..... 20....

.....	.....
The respondent/representative of respondent	Witness
Signature or right thumbprint	

DECLARATION BY THE RESEARCHER

I, Janine Hartweg, declare that I:

1. Explained the information that is contained in this document to the respondent/representative of the respondent.....;
2. Encouraged him/her/them to pose questions on anything that was unclear;
3. That this discussion was held in Afrikaans, English, Xhosa, other (.....) and that no translator was used/ that this conversation was translated by

   Dr/Mr/Ms.....
   Signed at..... on..... 20....

.....	.....
Researcher	Witness